ACE
Advocacy Centre for the Elderly

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VIA EMAIL (LawCommission@lco-cdo.org)

Law Commission of Ontario
Legal Capacity, Decision-making and Guardianship
2032 Ignat Kaneff Building
Osgoode Hall Law School, York University
4700 Keele Street
Toronto, ON M3J 1P3

Dear Madam/Sir:

Re: Comments on Legal Capacity, Decision-making and Guardianship: Interim Report

The following are the comments of the Advocacy Centre for the Elderly (ACE) on the Law Commission of Ontario's (LCO) Legal Capacity, Decision-making and Guardianship Project Interim Report (Interim Report)[1] for your consideration.

Judith Wahl, Executive Director of ACE, currently participates on the Advisory Committee for the LCO Project on Legal Capacity, Decision-making and Guardianship. Owing to this participation, Ms. Wahl has asked the other staff at ACE to comment on the Interim Report without her input. This is to ensure that ACE brings a fresh perspective to the Interim Report.

The Advocacy Centre for the Elderly (ACE)

ACE is a specialty community legal clinic, funded by Legal Aid Ontario. It was established to provide a range of legal services to low income older adults in Ontario. These legal services include individual and group client advice and representation, public legal education, community development, and law reform activities. ACE has been

[1] Law Commission of Ontario, *Legal Capacity, Decision-making and Guardianship: Interim Report* (October 2015), online:< http://lco-cdo.org/en/capacity-guardianship-interim-report> (Interim Report)

operating since 1984 in Toronto, and is the first and oldest legal clinic in Canada with expertise in legal issues of the older population.

ACE staff have extensive experience in issues related to health care consent, and have been involved in many of the law, policy, and education initiatives relating to these issues in Ontario over the last 30 years. These have included:

- Participating as a member of the Fram Committee, the work of which resulted in the passage of the *Consent to Treatment Act, 1992*, and subsequently the *Health Care Consent Act, 1996 (HCCA)*;[2]
- Acting as one of the principal authors of the training materials for health care professionals produced as part of two of the Alzheimer Society of Ontario Initiatives (# 2 and #7) on Physicians' Education and Advance Directives on Care Choices;
- Participating on the Ontario Medical Association President's Advisory Committee on Palliative Care and Advance Care Planning;
- Engaging presently, and for the past two years, in a number of educational initiatives for health care practitioners on health care consent and advance care planning. These include, but are not limited to, initiatives in the Erie-St Clair LHIN, Central East LHIN, Hamilton Niagara Haldimand Brant (HNHB) LHIN, and Northwest LHIN. These initiatives have involved interactive, detailed training sessions as well as the production of an online training course on health care consent and advance care planning. This course has become a requirement for licencees signing Long-Term Care Home Service Accountability Agreements in the HNHB LHIN;
- Providing comments on Ontario's Bill 148, *Protection of Vulnerable Seniors in the Community Act, 2015*, amending the *Substitute Decisions Act, 1992 (SDA)*[3]; and,
- Providing comments on previous College of Physicians and Surgeons of Ontario (CPSO) policies addressing health care consent in Ontario.

ACE also co-authored a major research paper with the firm of Dykeman, Dewhirst and O'Brien for the LCO Project entitled *Health Care Consent and Advance Care Planning in Ontario.* [4]

Our comments are based on extensive case experience in the area of consent and capacity, and dealing with issues of property and health care. ACE has represented allegedly incapable adults in the context of guardianship proceedings, brought actions for restitution in cases of financial abuse by attorneys of property and other individuals, represented patients regarding consent to treatment or admission to long-term care in

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[2] *Health Care Consent Act*, *1996,* S.O. 1996, c. 2, Sched. A (*HCCA*)
[3] *Substitute Decisions Act, 1992*, S.O. 1992, c. 30 (*SDA*)
[4] Judith Wahl, Mary Jane Dykeman and Brendan Gray, *Health Care Consent and Advance Care Planning in Ontario: Legal Capacity, Decision-Making in Guardianship,* Law Commission of Ontario: January 2014, online:< http://www.lco-cdo.org/capacity-guardianship-commissioned-paper-ace-ddo.pdf>

court proceedings and before the Consent and Capacity Board (CCB), and served older adult clients in many other contexts that raise issues of consent and capacity.

Given our decades of working on consent and capacity law and policy issues that affect older adults in Ontario and across Canada, we trust that our comments on the Interim Report will be of assistance.

Commentary on the Interim Report

The LCO Project on Legal Capacity, Decision-making and Guardianship has taken an ambitious look at the legal regime for decision-making in Ontario. ACE applauds the efforts that have gone into consulting a wide range of stakeholders to ensure that the Interim Report represents diverse perspectives and makes practical recommendations to improve access to justice for the most vulnerable.

ACE will not be addressing all the recommendations made in the Interim Report. Our comments will be focused on the following:

1. Retaining the cognitive and functional approach to legal capacity and issues around supported decision-making;

2. Assessing incapacity;

3. Detaining residents in long-term care and tenants in retirement homes;

4. Holding attorneys and substitute decision-makers accountable;

5. Restricting the use of professional decision-making representatives;

6. Supplementing the jurisdiction of the CCB;

7. Assisting section 3 counsel appointed under the *SDA*;

8. Guardianship of property and person;

9. Using mediation in consent and capacity disputes;

10. Promoting education in consent and capacity; and,

11. Minor edits to “Section II: Overview of the Ontario Systems for Legal Capacity, Decision-Making and Guardianship”.

1. Retaining the Cognitive and Functional Approach to Legal Capacity and Issues around Supported Decision-making

i. Cognitive and Functional Approach to Legal Capacity in Ontario

ACE supports the recommendation of the LCO to retain the substitute decision-making model in Ontario, as provided in recommendation 3. ACE has previously indicated its concerns about transferring to a model based on supported decision-making.

ACE is concerned that the supported decision-making approach ascribes legal accountability to the supported person, even though that person may not have decisional capacity. ACE is further concerned that support people may substitute their decisions for the individual's. Because the entire decision-making process is obfuscated by the supported decision-making approach, it becomes extremely difficult to determine where a decision originates. This creates a situation in which the individual at issue is both vulnerable to abuse and legally accountable for decisions they may or may not have had a hand in making.

In ACE's experience, older adults are already vulnerable to informal decision-making processes that are purportedly "supported" by others. They often find themselves sidelined when it comes to making decisions about their own lives, for example: if and when to sell their homes; decisions around health care; and whom they may or may not receive as visitors.

Where there is a power of attorney granted, it is clear who has decision-making authority if the person is incapable. Moreover, there is some scope for the grantor to challenge the decisions made by the attorney.

LCO's support of Ontario's current functional and cognitive approach recognizes that there is a threshold beyond which a person does not have the capacity to make decisions for himself or herself. Generally, decisional incapacity exists where the individual is not capable of understanding the decision or appreciating its consequences. In this instance, another person, whether appointed by the person themselves, an external entity, or as the highest in the *HCCA* hierarchy, will make the decision for the incapable person.

ACE strongly supports recommendation 18, that accommodations be made in order to assess capacity to make certain decisions.

ACE has found, for example, that health care providers are prone to speaking directly to the purported substitute decision-maker without ever assessing the capacity of their elderly patient. Where seniors require alternate communication accommodations, this situation can be exacerbated. Those with alternate communication requirements must be accommodated with assistive devices and/or translators in order to ensure their capacity to make health care decisions is accurately assessed.

ii. Support Authorizations

As ACE understands recommendation 19, the LCO is advocating support authorizations where the person authorizing support understands the nature of the agreement they are entering into and appreciates the consequences of making, or not making, the agreement. As indicated in the Interim Report, in Alberta, if a person loses their capacity to make the support agreement, the agreement becomes void.[5] The decisions covered by such agreements would be limited to routine decisions about personal care and property.

This approach prevents labelling people as incapable where they require assistance with a decision. However, support authorizations also raise several areas of concern.

Firstly, the agreement ends when a person loses the capacity to understand or appreciate the agreement itself. As such, in the context of property, a limited continuing power of attorney may be more effective as it continues beyond the determination of incapacity to make a power of attorney.

Secondly, it is unclear from the LCO recommendation who would assess a person's capacity to enter into a supported decision-making agreement. The arrangement would be highly susceptible to abuse if the supporter were to make that assessment.

Thirdly, ACE finds that designation of decisions under a support agreement as the decisions of the individual who has signed the support agreement is highly problematic. Where the individual is incapable of making the decision, it is absurd to suggest that the decision is nevertheless theirs. Nowhere does the agreement purport to assess the individual's capacity for making a particular decision. In this regard, a limited continuing power of attorney for property or a limited power of attorney for personal care would offer more protection as it is clearer that the attorney is making a decision for the individual. There is also an established court process through which an attorney's decision can be challenged.

Overall, ACE does not believe that support authorizations demonstrate any advances in the law. Capable people can enter into agreements for assistance in investing their money with an investment advisor. Capable people can hire personal assistants to help them with day-to-day banking and purchases. And, as they must be capable of making decisions about their money under such agreements, they can be held accountable for their decisions. Where they are not capable of making these decisions, limited continuing powers of attorney would permit others to act for them. The attorneys can then be held accountable for the decisions that they make.

Given the lack of legal accountability and recourse, and the fact that limited powers of attorney would achieve the same effect without the same potential harms, ACE does not support recommendation 19.

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[5] Interim Report, *supra,* note 1, pp. 158 to 159

iii. Network decision-making

Similarly, ACE does not agree with the network decision-making approach. Although some iterations of this model are formal and institutionalized with internal checks and balances, the process by which decisions are made and most importantly, whose decisions they would be, remains opaque. As such it is open to abuse. While the participation of the individual in the centre of the network is promoted, the decision itself may belong to the network, not the individual.

In this situation, legal accountability is that of the network, however, the decisions being made are about the person. The ability of the person to remove themselves from this network is unclear. Should the person regain some decisional capacity would they still be obligated to make all decisions through the network?

This model of decision-making may be in line with the substitute decision-making approach where the corporation/network is the person's substitute decision-maker. If this is the case, ACE queries how this approach differs from a continuing power of attorney for property where two or more persons are appointed as attorneys acting jointly.

In light of these concerns, ACE does not support recommendation 20.

2. Assessing Incapacity

i. Assessments by Capacity Assessors under the SDA

ACE is in favour of recommendation 5, which seeks to limit the circumstances under which capacity assessments under the *SDA* are appropriate. Limiting the criteria for conducting a capacity assessment to situations where there is reason to believe a person is not capable of making decisions on their own behalf, and where there is a need for decisions to be made, will limit the number of capacity assessments completed for an improper purpose.

ACE has received calls from residents of long-term care homes who have had capacity assessments thrust upon them by the homes where fees are being dispute. The homes are concerned about resolving the disputed payment of their fees, and utilize this process in hopes that the Public Guardian and Trustee (PGT) will become the resident's statutory guardian and responsible for payment of fees.

The capacity assessment process is highly intrusive and should only be used to trigger a statutory guardianship where there are legitimate concerns about a person's capacity to manage property and the person faces risk to their property as a result. They should not be used for improper purpose, such as resolving fee disputes between residents and long-term care homes.

ACE further suggests that Form 4 under the *SDA*[6] (the form requesting a capacity assessment) be amended to include a section requesting particulars of the alleged incapacity where someone other than the alleged incapable person is making the request. This will ensure that capacity assessments are requested for a proper reason. Further, it will assist the allegedly incapable person in challenging a finding of incapacity before the CCB.

The Interim Report also notes that capacity assessments may be requested by interested parties under the *SDA* in order to legitimize the drafting of a will or powers of attorney.[7] However, these assessments are letters of opinion rather than findings under the *SDA.* In order to mitigate confusion around these letters of opinion, ACE suggests there be a disclosure accompanying private opinions provided by designated capacity assessors under the *SDA*. This disclosure should indicate that the assessor is only providing a statement of opinion, and that the allegedly incapable person may be charged for the opinion.

ii. Assessments under the Mental Health Act

ACE supports recommendation 6, that physicians only conduct capacity assessments under section 54 of the *Mental Health Act,*[8] where "there are reasonable grounds to believe that a person is incapable of managing property and will suffer consequences as a result, and not automatically upon admission to a psychiatric facility." ACE also supports the recommendation of the Mental Health Legal Committee (MHLC) that the test be stronger, requiring "reasonable grounds to believe that the person is incapable". This highly valuable suggestion will limit the reach of this presently overbroad law and restrict the number of unnecessary assessments of capacity – and statutory guardianships – where less intrusive mechanisms would be more appropriate.

iii. Rights Advice following a Finding of Incapacity

Once a finding of incapacity is complete, the individual must be informed of the consequences of this finding and how it can be challenged. As such, ACE is in strong support of recommendation 9, on the provision of rights advice.

In our experience, health care providers do not always advise patients of the consequences of a finding of incapacity or how it can be challenged. Recommendation 9 will help rectify this as it requires that health care providers reasonably assist patients who express a wish to challenge the finding. Further, it requires that health care providers complete a notice to the patient following a finding of incapacity under the *HCCA*. This notice will act as a reminder to both patient and health care provider of the finding, and of the patient's right to have the finding reviewed. ACE also recommends that a specific form be created for evaluators under the *HCCA* regarding findings of incapacity with respect to admission to long-term care.

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[6] Form 4, *SDA,* online:< https://www.attorneygeneral.jus.gov.on.ca/english/family/pgt/SDA1992-Form4-EN.pdf>
[7] Interim Report, *supra,* note 1, p. 107
[8] *Mental Health Act,* R.S.O. 1990, c. M. 7

3. Detaining Residents in Long-term Care and Tenants in Retirement Homes;

As noted in the Interim report, there are sections of the *Long-Term Care Homes Act, 2007 (LTCHA)*[9], the *Retirement Homes Act,*[10] and the *HCCA*[11] authorizing secure units and enshrining the rights of residents in those units to challenge their detention. However, these sections remain unproclaimed.

Under Ontario law, a substitute decision-maker does not have the authority to consent to ongoing detention unless:

- The person has a "Ulysses clause" in their power of attorney for personal care. A Ulysses clause essentially binds the grantor of the power of attorney into the future. It ensures that the grantor cannot refuse specific measures, like detention, at a later date. These clauses give the attorney for personal care significant power and are uncommon.
- The person is under court-appointed guardianship of the person with a specific provision for detention.

However, at present, many retirement homes and long-term care homes detain persons without authority.

Although there are unproclaimed sections of the *Retirement Homes Act* authorizing detention, ACE is unequivocal in its position that retirement homes should not be permitted to detain or restrain tenants, other than in accordance with the common law.

The common law ability to detain exists only in an emergency situation where it prevents serious bodily harm to others.[12] Otherwise, as private tenancies, retirement homes should have no right to offer secure units or otherwise detain their tenants. ACE argues that where detention is required, a person should be placed in a long-term care home, which are regulated by the Ministry of Health and Long-Term Care and are public health care facilities. Nevertheless, the practice of detaining tenants in retirement homes continues. ACE recommends that section 70 of the *Retirement Homes Act* , authorizing detention, be repealed.

However, as long as section 45 of the *LTCHA* and sections of the *HCCA* addressing secure units in long-term care noted below remain unproclaimed, any detention in long-term care is contrary to the *Canadian Charter of Rights and Freedoms (Charter)*.[13] In

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[9] *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8 (*LTCHA*), ss. 32 and 45
[10] *Retirement Homes Act,* S.O. 2010, c. 11, s. 70
[11] *HCCA, supra,* note 2, ss. 42(3), 46(2.1), 53.1 and 54.2
[12] See *Conway v Fleming*, [1996] 1242 ACWS (3d) 62, para 282-285; W (Re), 2006 CarswellOnt 9390 (ON CCB) at para 28 and 30
[13] See "Detention in Long-Term Care", *ACE Newsletter,* Vol 12, Number 2 (Fall/Winter 2015), online:<http://www.advocacycentreelderly.org/appimages/file/Final%20Newsletter%20Fall%202015%203Dec2015.pdf>; *Canadian Charter of Rights and Freedoms*, s 2, Part I of the *Constitution Act, 1982*, being Schedule B to the Canada Act 1982 (UK), 1982, c 11 (*Charter*), s. 9; and *PS v. Ontario*, 2014 ONCA 900.

fact, these sections must be broadened to include any detention in long-term care, no matter what form this detention takes. The provisions in the *HCCA* would prohibit substitute consent to admission to a secure unit unless, "the admission is essential to prevent serious bodily harm to the incapable person or to others, or allows the incapable person greater freedom or enjoyment."[14] A resident would be entitled to apply to the CCB for a determination of whether their substitute decision-maker has complied with this section.[15]

It is important that strict safeguards be maintained in relation to detention. Section 45 of the *LTCHA*, must be revised prior to proclamation to offer more protection to residents. For example, section 45(1)(4) permits a physician, a registered nurse in the extended class *or another prescribed person* to make recommendations about confining residents to a secure unit.[16] ACE believes that the deprivation of liberty warrants that only a physician or a registered nurse in the extended class make such recommendations.

Further, in order to be in compliance with the *Charter*, the sections in both the *LTCHA* and the *HCCA* must be revised to ensure that <u>any</u> resident who is the subject of detention, not just those on a "secure unit", is entitled to the same protections. This would include, for example, residents who are prevented from leaving a long-term care home by the use of electronic means such as wanderguards, locked elevators or elevator alarms.

Most importantly, ACE strongly recommends that, where the detention of a resident has been consented to by a substitute decision-maker, there should be an automatic hearing that includes the resident, substitute decision-maker and evaluator as parties. The hearing would be to determine compliance with section 42(3), which requires that detention is, "essential to prevent serious bodily harm to the incapable person or to others, or allows the incapable person greater freedom or enjoyment."[17] Such a hearing should not require the resident to make an application for a hearing themselves, as provided in s. 53.1 of the *HCCA.* ACE has found that it is difficult for many allegedly incapable residents to make such an application to the CCB. An automatic application places the onus on the evaluator and the substitute decision-maker to justify the detention.

Finally, detention should be reviewed periodically. ACE suggests these reviews takes place every six months. A person's care needs may change over time and continued detention may not be justified. A lack of periodic review could be considered a violation of a patient's *Charter* rights.[18]

ACE recommends that the detention provisions of the *LTCHA* and *HCCA* be amended and proclaimed accordingly.

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[14] *HCCA, supra,* note 2, s. 42(3)
[15] *LTCHA*, *supra,* note 9, s. 45(2)
[16] *Ibid.,* s. 45(1)(4)
[17] *HCCA, supra,* note 2, s. 42(3)
[18] In the recent case of *P.S. v. Ontario*, the Court of Appeal found that the detention of a patient under *the Mental Health Act* for 19 years lacked the necessary procedural safeguards to have the conditions of his detention periodically reviewed. The Court found that the patient's rights under section 7 of the *Charter* were violated as a result.

4. Holding Attorneys and Substitute Decision-Makers Accountable

i. Mandatory Statement of Commitment to be signed by Substitute Decision-Makers and Attorneys for Property or Personal Care

ACE receives many calls from substitute decision-makers and attorneys for property or personal care seeking clarification of their roles vis-a-vis the incapable person. Although the person making the finding of incapacity is expected to advise substitute decision-makers or attorneys of their duties,[19] often this does not occur. Alternately, someone may be acting on a power of attorney where no external finding of incapacity is required. ACE believes that recommendation 21, requiring that an attorney for property or personal care, or a substitute decision-maker, sign a mandatory statement of commitment will be very helpful and will provide substitute decision-makers with a greater understanding of their obligations.

ii. Notice when Acting on a Power of Attorney

Recommendation 22, which provides that an attorney must give notice where he/she is acting under a power of attorney, will be of assistance to family members and other interested parties. ACE often receives calls from people who indicate that while a family member is making decisions on behalf of an allegedly incapable person, it is unclear whether that family member is acting under any legal authority at all.

iii. Monitors under a Power of Attorney

ACE receives a significant number of calls regarding abuse using powers of attorney. While theft by an attorney for property is a crime under the *Criminal Code*,[20] ACE finds that it is often difficult to prove theft. Furthermore, police may be reluctant to act, viewing the matter as a civil, rather than a criminal, matter. The allegedly incapable person often does not have access to their financial records, thereby making it difficult to be specific in their allegations.

Where a third party suspects financial abuse, it is even more difficult for them to support their claim, as they will be unable to obtain records. The rogue attorney may even prohibit family, friends and advocates from accessing the older adult in order to prevent such complaints from being investigated and/or pursued. The appointment of a monitor who is authorized to review accounts and visit with the person, as suggested in recommendation 23, will vastly improve this situation.

ACE also suggests that monitors be given standing to bring Form G applications if they believe that an attorney is not complying with the principles for giving or refusing consent under the *HCCA.*[21] ACE also supports the recommendation of the MHLC that the PGT have an expanded role in investigations resulting from monitor's reports.

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[19] *M. (A.) v. Benes*, 1999 CanLII 3807 (ON CA), para. 24
[20] *Criminal Code*, RSC 1985, c C-46, s. 331
[21] *HCCA, supra* note 2, s. 21, s. 37, s. 42 and s. 54

iv. Removing Persons from Substitute Decision-Making Hierarchy

ACE has had clients who have been abused by one or more of their relatives and do not wish to have any contact with them. However, if the person is incapable of making treatment or admission to long-term care decisions, these clients are placed in the untenable position whereby the abusive family member may be their highest ranking decision-maker pursuant to the hierarchy of substitute decision-makers under the *HCCA.*[22] If they have no one available to apply to the Board to be a decision-maker, the person is unable to have them excluded or removed as the decision-maker.

Recommendation 41 would permit a patient to exclude certain individuals as substitute decision-makers, and as such, ACE strongly supports this recommendation. It is important that the threshold for legal capacity in this regard is low, and specifically that it is lower than the legal capacity required to make a power of attorney for personal care.

v. Changing "Substitute Decision-Maker" and "Guardian" to "Decision-making Representative"

ACE disagrees with recommendation 17, changing "substitute decision-maker" and "guardian" to "decision-making representative". While this change is intended to signal to the substitute decision-maker or guardian that the person's values, interests or beliefs must be taken into account rather than the substitute decision-maker or guardian imposing his or her own values, it may not be an effective change.

The term substitute decision-maker has specific meaning in the health care context under the *HCCA*. It would not be easy to supplant this term. Furthermore, one term for all decision-makers would not indicate the source of the person's authority to make decisions on another's behalf. This might lead to confusion when determining who would be a substitute decision-maker according to the hierarchy set out in the *HCCA.*

ACE does not believe that the value added would be significant enough to warrant such a change in terminology.

5. *Restricting the Use of Professional Decision-Making Representatives*

In exploring options for decision-making representatives, the LCO has reviewed professional decision-makers, such as trust companies or professionals acting as attorneys for property.

As the Interim Report has identified, for-profit substitute decision-making contains significant risks.[23] Maximization of profit may be seen by these entities as more important than acting in accordance with their clients' best interests. ACE has heard from callers when lawyers or accountants have acted as attorneys for property and charged significant fees to incapable clients. While the mechanism for for-profit substitute

[22] *Ibid.,* s. 20 and s. 41
[23] Interim Report, *supra,* note 1, p. 277

decision-making currently exists in the property management sphere, there is no need for a recommendation to make it easier for professionals to act as attorneys for property.

Where a person has no substitute decision-maker, the law presently authorizes the PGT to act as statutory guardian upon completion of a certificate of incapacity to manage property under *Mental Health Act*, or a finding of incapacity to manage property under the *SDA.*[24] This public institution does not aim to make a profit, although it does seek reasonable compensation for its services.

Similarly, although community organizations, as suggested in recommendation 44, may provide a not-for-profit alternative to for-profit substitute decision-making, these organizations already have significant control over the day-to-day lives of the people who live within their walls or use their programs. Where these organizations provide accommodations (i.e. not-for-profit long-term care homes), they may be involved in providing health care, personal support services, food, and transportation for these individuals. This creates a significant conflict of interest where they are providing personal care services and making decisions about paying bills for, and accessing, these same care services. In ACE's experience, this is fertile ground for abuse given the limited ability to monitor the provision of these services. It was this recognition of conflict that led to the *SDA* prohibition of those who provide health care, residential, social, training or support services for compensation from acting as attorneys for personal care for the person.[25]

Given the above comments, ACE does not support recommendations 43 or 44.

6. Supplementing the Jurisdiction of the Consent and Capacity Board

Recommendation 24 provides that the *HCCA* and the *SDA* be amended to grant the CCB jurisdiction over:

- Creating, varying and terminating guardianships;
- Terminating or suspending a power of attorney;
- Providing directions under powers of attorney and guardianships;
- Reviewing accounts of attorneys and guardians;
- Adjusting compensation taken by a guardian;
- Directing the PGT to apply for guardianship; and,
- Temporarily appointing the PGT or some other person as guardian.

This recommendation would delegate some of the jurisdiction of the Ontario Superior Court of Justice to the CCB. ACE supports this grant of jurisdiction, and proposes significant changes to the present CCB so that it could meet this new role and better fulfil its current role.

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[24] *SDA, supra,* note 3, ss. 15 and 16
[25] *Ibid.,* s. 46(3)

The courts are not the forum in which these types of cases can be dealt with most efficiently. In ACE's experience, guardianship applications brought through the courts can take many months, and, in contested applications, years. The costs can be significant and, where the assets of the incapable person are not similarly significant, it may not be practical, cost-effective or proportionate for a person of modest means to apply for guardianship over an incapable person.

ACE receives many calls from family member who are being denied access to an older adult by an attorney for personal care. ACE assists only the older adult in these circumstances. The only remedy available for these family members, if negotiation is not possible, is to take the attorney to court and seek directions on the power of attorney for personal care, or apply for guardianship. The legal fees involved place these options beyond the means of many people.

Most importantly, the allegedly incapable person does not have easy access to the courts. Where the dispute is regarding a guardian of property or an attorney for property, the funds necessary to bring an application on one's own behalf are likely in the control of the attorney or guardian. If the allegedly incapable person cannot access their own funds, they cannot hire a lawyer. Nor is it likely that this person would have the ability to represent themselves in a complicated guardianship matter.

An administrative tribunal offers accessibility and flexibility. Guardianship proceedings could be resolved in weeks rather than in months or years. Applications for directions need not be as prohibitively expensive as going to court. Further, at an administrative tribunal, a simple application made by telephone by the allegedly incapable person could trigger the appointment of counsel, thus ensuring representation for this person.

However, the protections of a court for allegedly incapable people, including the requirement for the party alleging incapacity to prove incapacity using credible and testable evidence, should not be removed merely because these issues are heard by an administrative tribunal.

Any such tribunal would have to be efficient, accessible and most importantly, committed to protecting the rights of the allegedly incapable person at the centre of the proceedings. To meet these needs, ACE suggests that the CCB be modified as follows:

- ***Jurisdiction:*** In addition to the areas identified in the recommendation above, ACE recommends that the CCB specifically be granted jurisdiction to determine the validity of powers of attorney, access to an allegedly incapable person and the legality of the detention of an allegedly incapable person. These issues may be raised by either the allegedly incapable person or another party.

  The administrative tribunal should also have the power to order the reassessment of an allegedly incapable person claiming to be capable by a qualified capacity assessor. The assessment would be paid for using the incapable person's funds. This power would ensure that people who have regained capacity do not languish under guardianship or powers of attorney, providing a method to prove that they had regained capacity to manage their own property or personal care.

- ***Expert members:*** The tribunal should consist of lawyer members who have years of experience in areas such as estates law – specifically in the areas of guardianship and powers of attorney disputes, consent and capacity law, or other similar areas.

  The CCB should not to require psychiatrists or public members to determine issues of capacity. ACE would argue that the current composition of the panels, with lawyer members, psychiatrist members and public members as is customary for CCB panels, is not suitable for determination of an application for guardianship or access to older adults. ACE would also suggest that the issues of consent to treatment and admission to long-term care involve a legal determination, with health care professionals being called in to provide evidence with respect to capacity to consent to treatment or from an evaluator with respect to admission to long-term care. The expertise of a psychiatrist or a public member, who presently sit on three- or five-member boards, is unnecessary in these contexts.

- ***Charter jurisdiction:*** Any tribunal that addresses issues that engage the security of the person, should have the jurisdiction to assess the constitutional validity of its enabling legislation under section 52 of the *Constitution Act, 1982,*[26] and provide remedies under section 24(1) of the *Constitution Act, 1982.*[27] Section 70.1 of the *HCCA* should be repealed and the statute that creates the "modified" CCB should ensure that it has the above-noted *Charter* jurisdiction.[28]

- ***Adherence to rules of evidence:*** Although these rules would be less stringent than at court, the CCB must be comfortable with making findings as to the weight of evidence, and be comfortable with excluding evidence if to allow it would be unjust to the other party. The members must also be comfortable with addressing a significant volume of affidavit evidence, as is common in guardianship applications. The reasons of the CCB should spell out how evidence was weighed.

- ***Standing:*** Recommendation 26 addresses who may commence certain applications. The administrative tribunal should be able to determine who can make an application. An attorney, guardian, substitute decision-maker, or

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[26] *Constitution Act,* being Schedule B to the Canada Act 1982 (UK), 1982, c 11, s. 52*;* The CCB in *Ontario (Attorney General) v. Patient*, 2005 CanLII 3982 (ON SCDC) was determined not to have this jurisdiction in the context of Community Treatment Orders because the legislation designed the CCB to determine issues of fact rather than law, evidenced by the strict statutory time limits and the potential majority of non-legal members of the tribunal. The *HCCA* was then amended to specifically preclude the CCB from determining the constitutional validity of its own legislation, see *HCCA*, supra, note 2, s. 70.1; see also Joaquin Zuckerberg, "Jurisdiction of Mental Health Tribunals to Provide Positive Remedies: Application, Challenges and Prospects", (2011) 57:2, *McGill Law Journal* 267, online:<http://lawjournal.mcgill.ca/userfiles/other/3380200-57.2.art1.Zuckerberg.pdf>

[27] *Charter, supra,* note 13, s. 24(1); In *R. v. Conway,* 2010 SCC 22, the Supreme Court held that a tribunal's jurisdiction to grant *Charter* remedies in the course of carrying out its statutory mandate would flow from whether the tribunal has the power to decide questions of law and *Charter* jurisdiction has not been excluded by statute.

[28] See *Ontario v. Patient, supra,* note 26.

allegedly incapable person should be able to bring an application as a matter of right. A monitor designated under a power of attorney should be able to bring applications for directions as a matter of right. However, "family or others in a trusting relationship," should not have automatic standing. All other interested parties should have to apply to the administrative tribunal for standing in order to bring an application with respect to an allegedly incapable person.

- ***Timelines:*** The CCB has presently had significant issues meeting its statutory timelines. Recently, in *Re JS*,[29] consent to go beyond seven days for scheduling a hearing was provided by the applicant. However, the applicant did not agree to a five-month postponement. The CCB determined that a delay of this duration was procedurally unfair to the applicant and rescinded the community treatment order.

  In *Re MG,*[30] a preliminary motion on the delay of the hearing was denied even though there was a four-month delay in setting up a hearing. Counsel for the applicant argued the delay prejudiced the applicant's rights. Even though the CCB agreed that "the process of arranging this hearing was clearly flawed," it found that the delay did not affect the community treatment order itself and denied the applicant's preliminary motion.

  In *re ND,* a delay in a hearing on incapacity to manage property of approximately 6.5 months meant that there was no recent evidence of incapacity before the Board. The CCB therefore found that the evidence at the hearing, which did not include evidence from the last six months, failed to establish incapacity.[31]

  In order to promote the timeliness of interventions, there should be strict statutory timelines for conducting hearings on certain types of applications. Timelines for different types of proceedings should reflect the need for a quick turn-around in scheduling hearings, the frequency of statute-mandated review, and the evidentiary requirements. The timelines for guardianship hearings, for example, should not be as short as timelines for hearing challenges to involuntary admission under the *Mental Health Act.*

- ***Structure, Infrastructure and Supports:*** ACE supports the recommendations of the MHLC in this regard.

- ***Mediation:*** The tribunal should offer mediation services, firstly, to parties who would like to avail themselves of this service, rather than attending at a hearing; and secondly, prior to a guardianship hearing in a mechanism similar to mandatory mediation under rule 75.1 in Estates Court in Toronto, Ottawa and in the County of Essex.[32]

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[29] *JS (Re),* 2015 CanLII 19554 (ON CCB)
[30] *MG (Re)*, 2015 CanLII 64013 (ON CCB)
[31] *ND (Re)*, 2013 CanLII 92293 (ON CCB)
[32] R.R.O. 1990, Reg. 194: *Rules of Civil Procedure*, r. 75.1

> Mediation should not be permitted with respect to determinations of capacity or assessing the legality of detention of an incapable person. The appointment of counsel for the allegedly incapable party would also be essential. As under recommendation 32, time limits should be amended where the parties wish to proceed with mediation.

ACE suggests that with the above-proposed changes, the CCB can function as an effective, rights-oriented administrative tribunal with the ability to hear all consent and capacity issues.

7. Section 3 Counsel under the *SDA*

ACE supports recommendation 28 to amend the *SDA* to make it an offence to interfere with Section 3 counsel, but would suggest that this recommendation be broadened to include access to counsel more generally. ACE has encountered numerous instances where a senior contacts ACE for legal help, but the person's attorney for property and/or personal care attempts to restrict our access to the senior, thus preventing us from providing effective counsel. In such instances, there has been no proceeding underway, and yet the allegedly incapable person's right to access counsel has been impeded. ACE proposes expanding the scope of this recommendation to make it an offence to interfere with counsel in any matter where a person's capacity is at issue. Where access has been impeded, counsel should be able to make a complaint to the PGT, who assist in bringing the offence before Provincial Court.

We also believe that in order to deter interference of this kind, more than one avenue of enforcement would be required. In addition to amending the *SDA*, ACE proposes that the Law Society of Upper Canada's *Rules of Professional Conduct* commentary include mention that such interference by legal counsel or paralegals would invite discipline.

8. Guardianship of an Incapable Person

i. Limiting guardianships

ACE strongly supports recommendations 36 to 40, which seek to create limited guardianships of incapable people where guardianships are:

(a) limited to issue areas or even a single issue;
(b) created for a limited period of time;
(c) subject to review;
(d) require periodic evaluations of capacity (for example, every six months); and,
(e) require attestations that no less restrictive alternatives exist.

While courts could always order limited guardianships, they are not commonly asked by parties to do so. ACE also supports the recommendation that guardians be required to assist the individual who has regained capacity in having the guardianship order rescinded.

These recommendations will assist those under guardianship greatly. ACE has received many calls from people who do not have the financial means to challenge their guardianship, or to obtain an assessment, as their property is being managed by their guardian. Even if they have regained capacity, the person has no way of challenging the guardianship. By compelling the guardian to attest to the continued incapacity of the person under guardianship, and to assist and/or cooperate with the completion of evaluations of capacity, the individual can more easily remove guardianship and return to managing his or her own finances or personal care.

The recommendations also ensure that those who have capacity in some areas of their lives, but not in other areas, do not have that their decision-making rights stripped away from them entirely. Guardianship as presently utilized is a blunt instrument. These recommendations offer a way to refine this tool.

ACE disagrees with recommendation 34, which would allow adjudicators who are determining whether guardianship should be granted to seek a report from a "relevant organization". Such reports, if they exist, should be requested by the parties and presented as evidence in support of a position. The opposing party could then challenge the evidence. Without the effective tool of cross-examination, these reports should not be permitted into the process. These reports risk supplanting the adjudicator's own expertise in determining whether there is a less restrictive alternative available to a person other than guardianship.

ii. Statutory Guardianships

ACE disagrees strongly with recommendation 35, that the statutory guardianship process under the *SDA* be repealed and replaced by applications to a new administrative board.

The *SDA* presently provides that the PGT automatically becomes someone's guardian of property when: (1) a certificate is issued under the *Mental Health Act* certifying that a person is incapable of managing property; or, (2) on a finding of incapacity to manage property by a capacity assessor under the *SDA*.[33] ACE recognizes that there will be a sacrifice of due process in order accommodate an "automatic" guardianship in certain instances, however, this sacrifice can be limited, as discussed below, and is necessary in the interest of protection of an incapable person's assets.

It is vital to retain the automatic triggering of guardianship to a neutral organization such as the PGT to ensure that the incapable person's property is managed in a timely and safe manner. The PGT is ideally placed and has the statutory powers to take over the management of a person's property.[34] This is necessary where a person's housing situation may be at risk, or the person may be in danger of someone depleting their assets. An application to an administrative tribunal, although quicker than a court, is not automatic. Even an application for interim guardianship will require some amassing of

[33] *SDA, supra,* note 3, ss. 15 and 16
[34] *Ibid,* s. 16

evidence, especially if contested. The allegedly incapable person's assets may be at grave risk in the interim.

Recommendation 6 rightly restricts the ability of physicians to assess capacity to manage property under the *Mental Health Act* to where, "there are reasonable grounds to believe that the person may lack legal capacity to manage property and the person may suffer negative consequences as a result." ACE believes that this recommendation would limit the present overuse of statutory guardianships to situations where they are truly required.

ACE agrees that it is not useful to have the PGT act as a guardian if another party is willing to act as guardian. However, a process presently exists by which a person can take over from the PGT.[35] The administrative tribunal could administer this process. However, it is important to ensure that the incapable person and the PGT are also parties to that process. ACE has found that the PGT often has useful information obtained through the guardianship-investigations process which would ensure, for example, that the same person who was placing the incapable person's assets at risk is not named as their guardian.

Furthermore, there are issues around the implementation of rights advice by capacity assessors in the context of statutory guardianships under section 16 of the *SDA*. People who are found incapable of managing property in this context are not always made aware that they can challenge this finding at the CCB, or that they may obtain legal representation in this regard. Confirming that people found incapable are notified of this review process, which is mandated under the *SDA*, and are assisted in accessing legal counsel will ensure that statutory guardianships are only in place where legally defensible.

It is important that the PGT continue to be the statutory guardian of first instance in order to ensure that the property of incapable people is managed in a safe and responsible manner where no valid and continuing power of attorney for property exists. This safeguard ensures the protection of the property and protects the vulnerable person from financial abuse.

9. Using Mediation in Consent and Capacity Disputes

ACE has discussed the use of mediation in combination with an administrative tribunal above. However, recommendations 31 and 33 discuss the use of mediation where a new administrative tribunal is not created. Many of the legal issues discussed in this report involve abuse and capacity.

It is not possible to mediate capacity. A person is either capable or not capable. A person should not, for example, be determined capable because a settlement is mediated in which they will "consent" to a treatment they may not understand in order to move forward.

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[35] *Ibid.* s. 17

Further, mediation is not appropriate where there are allegations of abuse. In these cases, the allegedly incapable person may be intimidated by the person who has perpetrated the abuse, and will be unlikely to oppose them.

However, in an adjudicative proceeding, mediation can be acceptable where the settlement would have to be approved by the court where there are parties under disability. Further, the incapable person would be required in those contexts to have legal representation at any mediation. ACE would argue that without the overarching protections available in an adjudicative proceeding, mediation can lead to unfair result.

ACE would support the recommendation if it was in the context of adjudicative proceeding, and includes expanding mandatory mediation in Estates proceedings outside of Toronto, Ottawa or the County of Essex, as mandated under Rule 75.1 of the *Rules of Civil Procedure.*[36]

If an administrative tribunal is not created to address consent and capacity issues broadly, the CCB would have very limited need for mediation as discussed in recommendations 32 and 33. ACE can envision that mediation may only be useful in Form G applications,[37] where the health care provider or evaluator may be able to negotiate an outcome with the substitute decision-maker and the incapable person has representation. In such scenarios, the parties should be able to agree to deviate from statutory timelines as outlined in recommendation 32.

10. Promoting Education in Consent and Capacity

Recommendations 11 to 13 and 45 to 54 discuss education in respect of consent and capacity in different contexts:

- Recommendation 11 supports Health Quality Ontario in producing educational materials for health care organizations related to the assessment of capacity and the accompanying procedural rights;
- Recommendation 12 supports the Ministry of Health and Long-Term Care in encouraging long-term care homes to include information related to consent, capacity and decision-making in information provided to residents and families in annual satisfaction surveys;
- Recommendation 13 seeks that the Local Health Integration Networks (LHINs) encourage health services to improve education and training to professionals carrying out assessments of capacity;
- Recommendations 45 to 49 empower a public clearinghouse to create and disseminate information regarding capacity and decision-making;
- Recommendation 50 states that the *HCCA* should be amended to specifically give health professionals a duty to provide information to SDMs in a standardized form;

[36] *Rules of Civil Procedure, supra,* note 32
[37] *HCCA, supra,* note 2, ss. 37 and 54

- Recommendation 51 provides that adjudicators be empowered to require guardians and attorneys to obtain education on their duties;
- Recommendation 52 encourages professional educational institutions to strengthen their curriculum on consent and capacity issues; and,
- Recommendation 53 and 54 encourage the regulatory colleges with support from the Ministry of Health and Long-term Care to strengthen their material on consent and capacity issues.

ACE believes that these recommendations are sound. However, it is highly important to ensure that the educational materials suggested in each of these recommendations be legally correct. In ACE's experience, materials differ widely in terms of their legal accuracy.

For example, staff in long-term care homes often require that residents or their substitute decision-makers complete "level of care" forms on admission to long-term care.[38] Examples of levels of care include "Comfort measures only" or "Transfer to hospital without CPR" or "Full Code." However, these forms do not constitute consent to treatment in most cases, as they are not related to the resident's current health condition.

Because of the existence of these documents, we have seen many cases where treatment was illegally delayed or withheld. For example, a person was not taken to hospital for treatment of a leg fracture because their "level of care form" had identified the level as including "Comfort measures only".[39] The resident was themselves incapable of making a decision, and the home did not contact the substitute decision-maker to inform them of the injury, nor did they seek consent to treatment. These forms purport to be consents related to future treatment, but they are not: they are, in fact, illegal, but are used broadly in the long-term care sector. Recommendation 12 may lead to long-term care homes propagating such incorrect ideas about consent. The Ministry of Health and Long-Term Care should be required to monitor these forms along with any other information provided about consent.

Similarly, in all of the contexts noted above, the educational materials used should be drafted by individuals with legal expertise in Ontario. The materials should be reviewed regularly to ensure consistency and legal accuracy. As such, ACE recommends that any materials provided under Recommendations 11 to 13, 50, 51 and 53 to 54 be created by the public clearinghouse provided for under Recommendations 45 to 49. Further, ACE recommends that these materials be subject to a vetting procedure that permits time for feedback from the public and interested organizations.

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[38] See "Papers! Papers! Papers! – Part II: The What's What Regarding Paperwork in Long-Term Care!", *ACE Newsletter,* Vol 12, Number 1 (Spring/Summer 2015), online:<http://www.advocacycentreelderly.org/appimages/file/Final%20Newsletter%20Spring%202015%201Jun2015.pdf>

[39] *Ibid.*

11. Minor Edits to Section II: Overview of the Ontario Systems for Legal Capacity, Decision-Making and Guardianship

In reviewing the Interim Report, ACE found a few areas in Section II: Overview of the Ontario Systems for Legal Capacity, Decision-Making and Guardianship that were likely misworded. However, if left as is, these may be misleading to readers.

ACE suggests the following:

- *At page 16*: Where the *HCCA* details capacity to consent to personal assistance services, it is important to note that the *HCCA* only applies to personal assistance services provided in long-term care.[40]

- *At page 16:* The Interim report states,"Where a decision is necessary and an individual has been found legally incapable with respect to that decision or that type of decision, a substitute decision-maker will be appointed to make that decision." This statement is inaccurate and confusing.

    - There may be some confusion in this report as "substitute decision-makers" are herein defined as a person making a substitute decision, including attorneys for property and guardians of property. Typically, the term "substitute decision-maker" only applies to decisions made under the *HCCA.*

    - Further, it is inaccurate to state that a substitute decision-maker will be "appointed" to make decisions. Under the *HCCA,* substitute decision-makers in the hierarchy are not "appointed", but determined by their relationship to the incapable person in accordance with the legal requirements.

- *At page 21:* The CCB also hears applications following a finding of incapacity to manage property under s. 54 of the *Mental Health Act*.[41]

- *At page 22:* It is important to note in the section that the *Advocacy Act* was repealed in 1996,[42] further, it was meant to act as a counterbalance to the *Consent to Treatment Act, 1992.* The *Consent to Treatment Act* was replaced by the *HCCA* in 1996.[43]

- *At page 23:* The Interim Report states that, "legislation makes provision for procedural rights whenever legal capacity is removed." This is not true in certain cases, including where a person is incapable of making personal care decisions not dealt with in the *HCCA,* such as nutrition, clothing or visitors.

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[40] *HCCA, supra,* note 2, s. 2 "recipient"
[41] *Mental Health Act, supra,* note 8, s. 54
[42] *Advocacy Act,* 1992, S.O. 1992, c. 26
[43] *Consent to Treatment Act*, 1992, S.O. 1992, c. 31

Conclusion

The Interim Report has made significant recommendations while still attempting to maintain the integrity of the legal regime in respect of consent and capacity in Ontario.

On reviewing the Interim report, ACE makes the following comments/recommendations:

1. *Retaining the cognitive and functional approach to legal capacity and issues with supported decision-making*
    - Supports recommendation 3, that Ontario retain the cognitive and functional approach to consent;
    - Supports recommendation 18, that the communication needs of the person whose capacity is being assessed are accommodated;
    - Disagrees with recommendation 19, that support authorizations should be permitted under Ontario law; and,
    - Disagrees with recommendation 20, that network decision-making should be explored in Ontario.

2. *Assessing incapacity*
    - Supports recommendation 5, limiting capacity assessments to where there is reason to believe a person is not capable of making decisions on their own behalf and a need for decisions to be made;
    - Further suggests that Form 4 under the *SDA* be amended to include particulars of the alleged incapacity;
    - Further suggests that a disclosure form accompany private opinions provided by designated capacity assessors under the SDA;
    - Supports recommendation 6, which limits circumstances where a physician would conduct a capacity assessment under section 54 of the *Mental Health Act*; and,
    - Supports recommendation 9, that a form be created to provide notice of a finding of incapacity under the *HCCA,* and suggests that a specific form be created for evaluators making findings of incapacity with respect to admission to long-term care.

3. *Detaining residents in long-term care and tenants in retirement homes*
    - Recommends that section 70 of the *Retirement Homes Act* which authorizes detention be repealed; and,
    - Supports recommendation 15 for proclamation of the detention provisions in the *LTCHA* and the *HCCA.* ACE further suggests that the detention provisions in the *LTCHA* be amended to include: an automatic application on detention; a right to periodic review, and a right of review for other forms of detention in addition to secure units; and, exclude “other prescribed persons” from making recommendations about confining residents to a secure unit.

4. *Holding attorneys and substitute decision-makers accountable*
    - Supports recommendation 21, that substitute decision-makers and attorneys for property and personal care would sign mandatory statements of commitment;
    - Supports recommendation 22, that an attorney for property or personal care provide a notice where they are acting;
    - Supports recommendation 23, that provides for monitors to powers of attorney, and suggests they be given standing to bring Form G applications under the *HCCA*;
    - Supports recommendation 41, allowing a person to remove certain individuals from the substitute decision-maker's hierarchy, and suggests that the threshold for capacity to make this decision be a low one; and,
    - Disagrees with recommendation 17, changing the terms "substitute decision-maker" and "guardian" to "decision-making representative."

5. *Restricting the use of professional decision-making representatives*
    - Disagrees with recommendations 43 and 44, that would assist in providing more access to professional decision-making representatives and allow community organizations to assist in making day-to-day decisions for a person.

6. *Supplementing the jurisdiction of the CCB*
    - Supports the modification of the CCB with jurisdiction to determine: the validity of powers of attorney; access to an allegedly incapable person; the legality of detention of an allegedly incapable person; jurisdiction to provide *Charter* remedies and to interpret the constitutional validity of its enabling legislation; with panelists who are lawyers. While the incapable person, attorneys, substitute decision-makers, guardians and monitors would have standing as of right, others should have to apply for standing. Mediation should be offered, but the allegedly incapable person should have counsel and timelines should accommodate this mediation.

7. *Assisting section 3 counsel appointed under the SDA*
    - Supports recommendation 28, that it be an offence to impede access to Section 3 counsel under the *SDA,* and supports enforcement through complaints to the PGT and commentary in the *Rules of Professional Conduct* that such interference would invite discipline.

8. *Guardianship of property and person*
    - Supports recommendations 36 to 40, which seek to limit guardianships and assist capable persons in removing themselves from guardianship;
    - Disagrees with recommendation 34, that the adjudicators determining whether guardianship should be granted may ask for a report from a relevant organization; and,
    - Disagrees with recommendation 35, that the statutory guardianship process under the *SDA* be repealed and replaced by applications to the new administrative board. ACE suggests that the application to take over as statutory guardian from the PGT be made simpler.

9. *Using mediation in consent and capacity disputes*
    - Supports recommendations 31 and 33, in so far as the mediation discussed is in the context of an adjudicative proceeding, such as an estates proceeding in Ontario Superior Court of Justice or an application to an administrative tribunal, if such a tribunal is created; and,
    - Disagrees with recommendation 32, unless the mediation before the CCB is with regard to Form G applications and the incapable person is represented by legal counsel.

10. *Promoting education in consent and capacity*
    - Supports recommendations 11 to 13 and 45 to 54, but cautions that this information be created by the public clearinghouse. ACE suggests that the educational information should be reviewed regularly and be subject to consultation to ensure that it is legally accurate.

We would like to thank the LCO for this opportunity to provide feedback on the Interim Report, and would be pleased to clarify or discuss any aspect of this commentary going forward.

Yours truly,

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