Court File No. CV-21-00077187-0000

ONTARIO SUPERIOR COURT OF JUSTICE

B E T W E E N:

KRISTEN HEEGSMA, DARRIN MARCHAND, GORD SMYTH, MARIO MUSCATO, SHAWN ARNOLD, CASSANDRA JORDAN, JULIA LAUZON, AMMY LEWIS, ASHLEY MACDONALD, COREY MONAHAN, MISTY MARSHALL, SHERRI OGDEN, JAHMAL PIERRE, and LINSLEY GREAVES

Applicants

-and-

CITY OF HAMILTON

Respondent

APPLICANTS' APPLICATION RECORD

VOLUME 4 - (TABS 64-82)

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VOLUME 4 INDEX – *HEEGSMA ET AL.* v. *CITY OF HAMILTON*

TAB (EXHIBIT LETTER)	Document
	APPLICATION RECORD VOLUME 4
APPLICANTS' FACT WITNESSES	
DR. CLAIRE BODKIN	
64.	*Affidavit of Dr. Claire Bodkin dated May 5, 2023*
a.	*Exhibit A – Ltr of Dr. Claire Bodkin re: Greaves dated April 27, 2023 P 4/5*
65.	*Transcript of the Cross Examination of Dr. Claire Bodkin dated September 6, 2024*
AUDREY DAVIS	
66.	*Affidavit of Audrey Davis dated July 19, 2023*
a.	*Exhibit A – Feb 16, 2021 Email from Paul Johnson (P 12/18)*
67.	*Transcript of Cross Examination of Audrey Davis dated August 29, 2024*
BENJAMIN HOGNESTAD	
68.	*Affidavit of Benjamin Hognestad dated June 7, 2024*
a.	*Exhibit A – relevant portions of MMIWG report (P 3/35)*
DR. RACHEL LAMONT	
69.	*Affidavit of Dr. Rachel Lamont dated June 7, 2024*
a.	*Exhibit A – Ltr of Dr. Lamont dated June 20, 2023 re: Heegsma (P 5/28)*
b.	*Exhibit B – Ltr of Dr. Lamont dated Dec 14, 2023 re: Marchand (P 7/28)*
c.	*Exhibit C – Intentionally Omitted per Nov 12, 2024 Endorsement*
d.	*Exhibit D – Intentionally Omitted per Nov 12, 2024 Endorsement*
e.	*Exhibit E – Ltr of Dr. Lamont dated Oct 5, 2023 re: Lewis (P 16/28)*
f.	*Exhibit F– Intentionally Omitted per Nov 12, 2024 Endorsement*
g.	*Exhibit G – Ltr of Dr. Lamont dated May 11, 2023 re: Pierre (P 23/28)*
h.	*Exhibit H – Intentionally Omitted per Nov 12, 2024 Endorsement (P 25/28)*
70.	*Transcript of Cross Examination of Dr. Lamont dated Oct 7, 2024*
a.	*Exhibit 1 - September 2, 2021 twitter thread*
b.	*Exhibit 2 - September 5, 2022 Twitter thread*
OLIVIA MANCINI	
71.	*Affidavit of Olivia Mancini dated October 4, 2021*
72.	*Affidavit of Olivia Mancini dated July 18, 2023*
73.	*Transcript of Cross Examination of Olivia Mancini dated Aug 20, 2024*
a.	*Exhibit A – Integrating Best Practices of Harm Reduction Aug 2, 2022*
DR. TIMOTHY O'SHEA	
74.	*Affidavit of Timothy O'Shea dated June 7, 2024*
a.	*Exhibit A – Ltr from Dr. O'Shea dated June 13, 2022 re: Heegsma (P 4/9)*

b.	*Exhibit B – Ltr from Dr. O'Shea re: Ammy Lewis (P 7/9)*
75.	*Affidavit of Tim O'Shea dated August 12, 2024*
76.	*Transcript of Cross Examination of Tim O'Shea dated Sept 6, 2024*
MEDORA UPPAL	
77.	*Affidavit of Medora Uppal dated July 17, 2023*
a.	*Exhibit A – Curriculum Vitae (P 13/77)*
b.	*Exhibit B – YWCA Hamilton 2019-2020 Impact Report (P 17/77)*
c.	*Exhibit C – Submission to Emergency and Community Services Committee – City of Hamilton Nov 7, 2019 (P 30/77)*
d.	*Exhibit D – 2021 Point in Time Connection Results 2021 (P 36/77)*
e.	*Exhibit E – Service Restriction Framework for Women, Trans, Gender-Diverse (P 66/77)*
f.	*Exhibit F – Invisible: Single Women's Experiences of Chronic Homelessness in Hamilton Aug 30, 2018 (P 71/77)*
78.	*Supplementary Affidavit of Medora Uppal dated June 4, 2024*
79.	*Transcript of the Cross Examination of Medora Uppal dated Aug 20, 2024*
DR. JILL WIWCHARUK	
80.	*Affidavit of Jill Wiwcharuk dated June 7, 2024*
a.	*Exhibit A - Letter of Dr. Wiwcharuk dated May 31, 2022 re: Cory Monahan (P 5/21)*
b.	*Exhibit B – Letter of Dr. Wiwcharuk dated June 1, 2022 re: Cassandra Jordan (P 7/21)*
c.	*Exhibit C – Letter of Dr. Wiwcharuk dated June 2, 2022 re: Sherri Ogden (P9/21)*
d.	*Exhibit D – Intentionally Omitted – Applicant Removed*
e.	*Exhibit E – June 8, 2022 re: Jammy Pierre (P13/21)*
f.	*Exhibit F – June 9, 2022 re: Mario Muscato (P 14/21)*
g.	*Exhibit G – dated June 9, 2022 re: Mysty Marshall (P 17/21)*
h.	*Exhibit H – dated June 10, 2022 re: Shawn Arnold (P 19/21)*
81.	*Transcript of Cross Examination of Dr. Wiwcharuk dated Aug 16, 2024*
82.	*Transcript of Continued Cross Examination of Dr. Wiwcharuk dated Sept 6, 2024*

Court File No. CV-21-00077817-0000

ONTARIO

SUPERIOR COURT OF JUSTICE

BETWEEN:

KRISTEN HEEGSMA, DARRIN MARCHAND, GORD SMYTH, MARIO MUSCATO, AND SHAWN ARNOLD, ET AL.

Applicants

-and-

CITY OF HAMILTON

Respondent

AFFIDAVIT OF CLAIRE BODKIN

SWORN MAY 5, 2023

I, Doctor Claire Bodkin, of the City of Hamilton in the Province of Ontario, do hereby AFFIRM:

1. I have personal knowledge with respect to the facts set out below, except where stated otherwise. Where the information is not based on my personal knowledge, it is based upon information provided by others which I believe to be credible and true.

2. I am a Physician and the Co-Medical Director of Hamilton Social Medicine Response Team (HAMSMaRT). HAMSMaRT is an organization of health providers and community organizers providing community-centred care to people experiencing homelessness, including encampment residents. I have worked with HAMSMaRT for three years.

3. I have known Mr. Greaves for approximately ten months, and have provided medical care to him on two occasions.

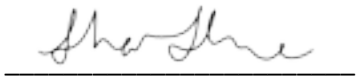
4. I authored the April 24, 2023 report attached hereto as Exhibit "A" and endorse the contents therein.

Sworn remotely by Claire Bodkin at the City of Hamilton in the Province of Ontario, before me on May 5, 2022 by "zoom" videoconference in accordance with O. Reg. 431/20, Administering Oath or Declaration Remotely.

Sharon Crowe
Commissioner for Taking Affidavits

Claire Bodkin

THIS IS EXHIBIT “A” TO THE
AFFIDAVIT OF CLAIRE BODKIN
AFFIRMED REMOTELY BEFORE ME AT
THE CITY OF TORONTO DURING A “ZOOM” VIDEOCONFERENCE
IN ACCORDANCE WITH O.REG. 431/20,
ADMINISTERING OATH OR DECLARATION REMOTELY
THIS 5TH DAY OF MAY, 2023



SHARON CROWE

Commissioner for Taking Affidavits, etc.

Dr. Claire Bodkin

HAMSMaRT

A5048

140 King St East, Suite 101
Hamilton, Ontario, L8N 1A5

Phone: 833-426-7678
Fax: 833-563-2210

Date: 2023/04/27

To:

Address:

Phone:

Fax:

Patient: GREAVES, LINSLEY

Address:

NFA, Hamilton, ON

Phone:

Birthdate: 1969/10/23

Health Card No:

A764

A5049

To Whom It May Concern

I assessed Linsley Greaves on December 15 2022 in my outpatient clinic. He was brought in my paramedics, and presented with 2 weeks of worsening left foot infection and worsening right soft tissue injury. He had been repeatedly evicted from his encampment locations by the City of Hamilton in the few weeks prior, and his belongings kept getting wet, while the weather was fluctuating above and below freezing. This had led to tissue injury and infection of both feet.

On examination of the left foot, there was extensive skin sloughing/desquamation of ankle and hindfoot on dorsal side with capillary bleeding across ulcerated area; skin more intact midfoot then more sloughing forefoot. The first toe was autoamputated, with ulceration in this area, then other toes insensate and gangrenous without signs of circulation. There was an intensely foul odour.

On examination of the right foot, there was edema and erythema over midfoot and forefoot, and gangrenous blackened toes with loss of sensation and no evidence of circulation.

I was concerned for osteomyelitis (bone infection), dry gangrene (dead or necrotic tissue), wet gangrene (dead or necrotic tissue with superimposed bacterial infection of the dead tissue), and cellulitis (skin infection). I sent him immediately to the emergency department, where he was admitted, and ultimately underwent amputation of his left leg below the knee.

~~It is my medical opinion that the repeated eviction of Mr. Greaves from his encampment during wet weather with temperatures around 0 degrees celsius resulted in repeated freezing and thawing of tissue, and this directly caused frostbite and subsequent wet gangrene requiring amputation of his left leg below the knee, leaving him permanently disabled.~~

Claire Bodkin MD CCFP

A765

COURT FILE NO. CV-21-77187

ONTARIO

SUPERIOR COURT OF JUSTICE

BETWEEN:

KRISTEN HEEGSMA, DARRIN MARCHAND, GORD SMYTH, MARIO MUSCATO, SHAWN ARNOLD, BRADLEY CALDWELL CHRISTINE DELOREY, GLEN GNATUK, TAYLOR GOGO-HORNER, CASSANDRA JORDAN, JULIA LAUZON, AMMY LEWIS, ASHLEY MACDONALD, COREY MONAHAN, MISTY MARSHALL, SHERRI OGDEN, JAHMAL PIERRE, LINSLEY GREAVES and PATRICK WARD

Applicants

-AND-

CITY OF HAMILTON

Respondent

The Cross-Examination of Dr. Claire Bodkin, on an Affidavit dated May 5, 2023 taken upon affirmation in the above action this, 6th of September, 2024, conducted via videoconference hosted by the offices of Nimigan Mihailovich Reporting Inc.

APPEARANCES:

For the Applicants:

For the Hamilton Community Legal Clinic:

SHARON CROWE

For the Community Legal Clinic of York Region:

MICHELLE SUTHERLAND

NONYE OKENWA

BENJAMIN HOGNESTAD

For the City of Hamilton:

JORDAN DIACUR

JOJO JOHNSON

Gowling WLG (Canada) LLP

I N D E X

PAGE

WITNESS: DR. CLAIRE BODKIN

Cross-Examination by MR. DIACUR 5

EXHIBITS

GUIDE TO UNDERTAKINGS, ADVISEMENTS, and REFUSALS:

This should be regarded as a guide and does not necessarily constitute a complete list:

UNDERTAKINGS:

(None noted).

UNDER ADVISEMENTS:

(None noted).

REFUSALS:

[1] 37/25.

--- Commencing at 12:21 p.m.

DR. CLAIRE BODKIN,

THE WITNESS HEREINBEFORE NAMED,

Having been duly sworn by me to testify to the truth,

testified on their oath as follows, to wit:

CROSS-EXAMINATION BY MR. DIACUR:

1 Q. So, ma'am, I have questions for you today principally about your affidavit that was sworn May 5th, 2023. I want to make sure that you have a copy of that available to you.

Do you have a copy, either a hard copy or an electronic copy?

A. I can open it up, yeah. Just give me a second.

2 Q. My plan would also be to put it on the screen so that everybody can see it so if we reference it, we'd all be looking at the same thing. But please feel free to either refer to that or a copy that you have.

But other than that, other than your affidavit or the documents that are put to you, you are not to refer to any other notes or documents.

Understood?

A. Understood.

3 Q. Okay. And actually, I'll do that now. I will share my screen and make sure that everybody can see

A5051

it. So can you see what's on the screen now, your affidavit sworn May 5th, 2023?

A. Yeah.

4 Q. Okay. And so you just so I understand correctly, you have not provided a copy of your CV or curriculum vitae in this matter; correct?

A. I have not.

5 Q. And you have not provided any studies or evidence regarding the capacity or the sufficiency of the shelter system in the City of Hamilton?

A. I have not.

6 Q. And you have not provided a signed document called either an Acknowledgement of Expert's Duty or a Form 53 in this matter; correct?

A. I have not.

7 Q. And so, Dr. Bodkin, what do you consider your role to be in this litigation?

A. I was Linsley's treating physician when he presented with the injury -- with the infection and injury that immediately preceded his amputation.

8 Q. Okay. And so you would be giving evidence specifically about that subject?

A. Yes.

9 Q. And do you consider yourself to be independent in this matter?

A. Yes.

10 Q. And by that I mean you do not favour one side or the other?

A. I mean, I think I have a duty to my medical responsibility, like my medical license, to provide truthful and honest, yeah, like assessment of the situation. So yeah, I think that in the matter specifically of just discussing Linsley's assessment, treatment and injury, I am required by my license to give my independent medical advice, which doesn't mean that I don't have an opinion about things, but it doesn't impact or affect my assessment and management of his medical condition, which is the only thing that I'm speaking to in this case.

11 Q. Understood. Thank you.

So you did reference Mr. Greaves. You are authored what is referred to in your affidavit at paragraph 4, I should say, as the April 24, 2023, report attached as Exhibit A to your affidavit, and you endorse the contents of that document; correct?

A. Yes.

12 Q. Okay. I'm going to go to that document. I will jump down to Exhibit A, and I will put it up on the screen. I can see on the first page of it that it is dated April 27, 2023, or at least the entry in the records

of what you referred to as HAMSMaRT is dated April 27 2023.

The document itself doesn't have a date on it. So one thing I wanted to clarify with you is it is referred to the April 24, 2023, report in your affidavit, but it's dated April 27 on the face of the document.

Do you recall which of the two dates the document was prepared on?

A. I don't. I would assume that I had probably drafted a first copy and then maybe I needed to print it again and that's why the new date is on it, but I actually don't remember.

13 Q. Okay. Understood. I just wanted to see if there was a clarification on that. But it was sometime around the end of April of 2023 that it was prepared; is that fair?

A. Yes, absolutely. And I provided care to him the previous December 2022.

14 Q. Understood. Okay. And the document itself, I put it on the screen here, it opens, "To whom it may concern."

Who was the intended recipient of this report?

A. So this was a request from the legal team to provide a report for this litigation on the medical

A767

care that I had provided to Linsley Greaves. And I know the formatting is odd, but it is all one document. It's just that our electronic medical record apparently cannot format things properly.

15 Q. Understood. Okay. You got provided the request or instructions that you received from the Applicants' lawyers in your affidavit or in this report; correct?

A. My instructions were just to write a report on the care that I provided.

16 Q. Is there any additional correspondence, emails, letters, or notes of any phone calls between you and the Applicants' lawyers regarding this matter?

A. There's no notes of any phone calls. There was communication just in the last day around a part that was in my original affidavit that you or your team wanted struck from the affidavit, but that's it.

And there was some communication before the affidavit around just trying to find Linsley to get him to sign a release of information so that I could write this with his consent. And it took us some time to actually find him and get him to sign that because of -- because he's living outside and moving around, but that was it.

17 Q. Okay. And I guess that was obtained?

A. Yeah.

A5052

18 Q. And was there any correspondence specifically about your instructions to provide this document?

A. I think it was truly just -- yeah, it was truly just can you comment on this medical care. I don't think there was anything besides that.

19 Q. Okay. And did you prepare this document on your own or did the Applicants' lawyers assist you?

A. No. I prepared it on my own.

20 Q. Did you review the Notice of Application in this matter prior to preparing this document at Exhibit A to your affidavit?

A. No.

21 Q. Did you speak with Linsley Greaves prior to preparing it?

A. Yes, because I needed to get the consent signed.

22 Q. Okay. So I had understood that the consent came after the fact. So the consent was actually obtained prior to the preparation of this document?

A. Yes.

23 Q. Okay. And did you review Mr. Greaves' affidavit dated June 2nd, 2022, prior to preparing this document at Exhibit A to your affidavit?

A. No, no. The timeline on that doesn't make

sense, does it?

24 Q. Well, this document --

A. I came on in April. Oh, 2023.

25 Q. Yeah. So his --

A. Okay.

26 Q. So his affidavit was prepared the previously year in June 2022.

A. No. No.

27 Q. Have you reviewed that affidavit prior to today?

A. No.

28 Q. Have you reviewed any of the evidence in this matter, any of the other affidavits from the Applicants?

A. I reviewed Dr. Rachel Lamont's affidavit, yes.

29 Q. Okay. And I understand that you did not provide any reply evidence to the affidavit of Dr. Koivu?

A. I don't know that that is so. I don't think so.

30 Q. Okay. Understood. That makes sense. If you are not even aware of it, then I can understand that response.

Okay. So my understanding is that you practice family medicine and have been in that practice

area since September of 2021; do I have that right?

A. Sort of, yeah. So I practice family medicine. I work both in an inner-city setting where I provide care that's focused to people who use drugs, and then I actually also work as a rural locum physician, so I'm a family doctor that provides emergency medicine, in-patient care, long-term care. I'm like an old-school general practitioner with a particular focus on the care of people who use drugs.

31 Q. Understood. Thank you for that. That's helpful. So I'm going to scroll back up quickly to your affidavit, paragraph 2.

You state here that -- it says that as well as being a physician, you are the Co-Medical Director of Hamilton Social Medicine Response Team or HAMSMaRT.

A. Yeah, I was at the time that I wrote this affidavit. I'm on parental leave right now.

32 Q. Okay. So you are away from HAMSMaRT, but will be returning once your parental leave is owner?

A. That's a good question. As of right now, yes.

33 Q. Okay. Well, I understand that can be somewhat up in the air for sure.

You understand that HAMSMaRT previously

sued the City of Hamilton, along with two of the current applicants in this matter, Mr. Caldwell and Ms. MacDonald; correct?

A. Yes.

34 Q. And that was in 2020?

A. Yes. I mean, it was a loosely affiliated group of people at that point in time. It was not like an incorporated organization, but, yes, I do understand that.

35 Q. And would you agree that HAMSMaRT is, among other things, an advocacy organization?

A. I would.

36 Q. All right. There is also one other document I would like to show you. It's an email in your name that is attached to an affidavit of a Lisa Nussey, N-U-S-S-E-Y.

I'm going to put it on the screen now. So this is -- and I should scroll up so that you can see it. This is Exhibit B to the affidavit.

MS. CROWE: Sorry, counsel. Before you continue, we have withdrawn this affidavit.

BY MR. DIACUR:

37 Q. I understand, but it is a document that was disclosed to us, and it's in the name of this witness, so I'd like to put it to her, and I have a couple of questions for her about it.

A5053

So this is listed as Exhibit B to the affidavit of Lisa Nussey. And it was sworn on July 13, 2023. And if I scroll down, there is on this page here, page 3 of 12 -- it's identified in the bottom left-hand corner -- an email from info@HAMSMaRT.ca, but the email itself is signed, it appears anyway, by you, Claire Bodkin, on behalf of HAMSMaRT; is that fair?

A. Yes.

38 Q. And the email is dated April 29 2020. We can see that in the top right-hand corner?

A. I actually can't see it. Let me see if I can --

39 Q. I can try to zoom in on it. I realize it is a bit small. Let's see if that's better. How is that?

A. Yeah.

40 Q. Top right-hand corner, April 29 2020, can you see that?

A. Yeah.

41 Q. And this email was sent by you in your name?

A. Yeah.

42 Q. And given that it was sent in April of, 2020, it was sent a couple of months before that previous lawsuit we were just discussing that included HAMSMaRT in 2020?

A. Yes.

43 Q. And this is copied to a number of people, including Jason Farr@Hamilton.ca; correct?

A. Yes.

44 Q. And Jason Farr was a city councillor at that time?

A. Yes.

45 Q. And the greeting in this email is to Councillor Farr only, "Hi, Councillor Farr," correct?

A. Yes.

46 Q. and you state in this email that -- in the third sentence:

"Dismantling encampments further destabilizes people."

This is you lobbying a city politician and advocating against dismantling encampments; correct?

A. Like -- so I'm -- can I just ask Sharon, like should we keep going here? Am I okay to answer things? Like what's the --

47 Q. It's a relevant question, so you are required to answer it.

MS. CROWE: I will object as needed, Dr. Bodkin. Thank you.

THE WITNESS: Okay. Yes.

BY MR. DIACUR:

48 Q. You would agree that you are at least in part an advocate who has engaged with the City of Hamilton specifically on the subject of encampments?

A. Yeah. Yes, I would.

49 Q. Okay. So I'm going to jump back to your affidavit now. It's just going to take me a second to do. I'll do that via the index to this document, pull it back up.

So we are back on the cover page of your affidavit sworn May 5th, 2023. In paragraph 3 of your affidavit you indicate that you have known, Mr. Greaves, so Linsley Greaves, for approximately 10 months and have provided medical care to him on two occasions.

A. Yeah.

50 Q. Now, in terms of the medical care provided, was that diagnostic care, was it medical treatment, or was it both?

A. So in both cases he needed a higher level of care than what I could provide as a community-based physician. So it was taking a history, doing a physical examination.

In one of those instances, it was actually my colleague that took over his care at that time, so I didn't even finish the assessment and plan part of it.

A769

In the December 2022 instance, I assessed him. I did provide treatment in the form of pain management and then calling the hospital to advocate for him to be seen by the emergency room doctor in a timely fashion and to give them handover on why I was sending him to the emergency room.

And then his treatment continued in the emergency room and then as an admitted inpatient at the Hamilton General Hospital.

51 Q. Okay. And you mentioned the time in December of 2022 that you saw Mr. Greaves. When was the other time that you provided medical care to him?

A. So -- and again -- like, I don't -- in terms of medical care -- so it was July 2022. I did see him. I did, like, take a look at his foot at that point in time. But then I immediately called over a colleague who took over his care.

So it was a very, like, brief, brief interaction. And yeah, you know, I was acting in my capacity as a physician in that I, like, saw him, assessed him, and then asked another colleague to come over and take over.

But it was a very brief interaction in July of 2022.

52 Q. Okay. Who was the colleague?

A5054

A. Dr. Lauren Cook-Chaimowitz.

53 Q. I will take you now back to that report, the April 24 or 27th, 2023 report, Exhibit A to your affidavit, and I will scroll down to it.

So you do say here that Mr. Greaves was brought to your outpatient clinic by paramedics.

A. Yeah.

54 Q. Is that common? I would think that they would take him to the hospital; right?

A. Yeah, that's a good question. So we have a program in Hamilton called Social Navigator.

55 Q. Mm-hmm.

A. And they are paramedics that specifically do a lot of work and outreach with people who face all sorts of social barriers, but a lot of them are people deprived of housing.

And so they often will bring people to our HAMSMaRT clinic because we offer drop-in care to people in a timely way where they don't need to wait hours and hours, say, at the emergency room. So if they can treat somebody in an out-patient setting, it's often better for the patient, and it's better for the healthcare system for that to happen.

In this case, they brought him to me and I assessed him and determined that, unfortunately, it was

not amenable to outpatient treatment, so than I referred him on to the emergency room. But actually that's quite common that Social Navigator would bring patients to us.

56 Q. Understood. That's helpful.

You indicate here that Mr. Greaves presented with two weeks of worsening left foot infection and worsening right soft tissue injury.

Based on what you've told me, you didn't see him in the two weeks previous; correct?

A. No. But as a physician, like, the very basis of my practice is taking a history, a detailed history. So I ask people about, you know, what's been happening, what's led up to this, what were things like. And I document that in contemporaneous notes as part of my -- then I move on to the physical examination and then the assessment is based on the combination of history and physical examination.

57 Q. Understood. But you would agree that the timeline, two weeks of worsening of foot infection, for example, that's based on Mr. Greaves' self-report?

A. That and also Social Navigator paramedics had been seeing him as well. So they also were able to corroborate that.

58 Q. Okay. That's helpful as well.

Would you agree that getting a baseline for

a patient is important in terms of being able to tell whether they are getting better or worse?

A. I mean, I work as an emergency room physician, so actually a lot of my job is assessing people in the moment who I haven't met before where I'm making an assessment on the basis of history and physical exam within, you know, a few minutes kind of thing.

So it's not that it doesn't have value, but actually no, I don't see it as a core part of the assessment in this particular instance.

I didn't need to see him before in order to make the assessment and diagnosis and plan that I made that day.

59 Q. Okay. And you indicate here that he was repeatedly evicted -- and when I say "he," I mean Mr. Greaves -- was repeatedly evicted from his encampment location in the two weeks previous by the City of Hamilton.

That's something that was reported to you. You didn't witness repeated evictions of Mr. Greaves from encampments; correct?

A. No. It was reported to me by Mr. Greaves and by the Social Navigator paramedics.

60 Q. Understood. Was the specific number of evictions reported to you?

A770

A. No. What was relevant to his medical care was just that he had lots of risk factors for non-freezing cold injury or trench foot and lots of risk factors for frostbite related to the -- like his belongings getting wet and then his tissue in his feet getting frozen and thawed.

So the number of evictions was not particularly important, only that it happened, you know, more than once and that the result of that was this particular exposure that led to this particular injury.

61 Q. Okay. Was it reported to you how long Mr. Greaves was able to stay at an encampment between any of the evictions?

A. No. I didn't ask him. No, I didn't.

62 Q. Was it reported to you whether Mr. Greaves was offered indoor shelter at the time of any encampment dismantlement?

A. It was not, no. It wasn't reported. I don't know if it was offered.

63 Q. Was it reported to you whether Mr. Greaves was offered any assistance in finding somewhere else to go?

A. It was not reported, no.

64 Q. Was it reported to you what kind of tent Mr. Greaves had in his encampments?

A5055

A. No, it was not reported.

65 Q. Was it reported to you whether Mr. Greaves had sufficient shelter in an encampment to protect him from the elements?

A. I mean, in the context of the repeated evictions, it was not sufficient. In terms of what it was like two weeks prior to this, like, getting moved around a lot and the temperatures changing -- yeah, you know what, I actually can't recall, and I didn't document it in my notes, so...

66 Q. Okay. And you do state in this document your medical opinion that it was what you call, quote:

"The repeated eviction of Mr. Greaves from his encampment that directly caused frostbite and subsequent wet gangrene, requiring amputation of his left leg below the knee."

A. Yes.

67 Q. That is accurate?

A. It is.

Sorry, Sharon. Can I just ask you? I thought that the affidavit was changing, although that is my medical opinion.

MS. CROWE: Yes. Can we go off record for a moment?

MR. DIACUR: Sure, but it is unusual for the witness to be asking counsel questions.

--OFF-THE-RECORD DISCUSSION

---RECESS TAKEN AT 12:45 p.m.

---UPON RESUMING AT 12:52 p.m.

BY MR. DIACUR:

68 Q. So, ma'am, I would like to take you through to an affidavit that was sworn by Linsley Greaves in this matter. It's dated June 2nd, 2022, as I said, previously.

And I'd like to take you particularly to paragraph 31 of his affidavit, the second-last paragraph. As you can see here from the jurat, it was sworn June 2nd, 2022, signed by Linsley Greaves.

He says in paragraph 31 of his affidavit that he ended up getting frostbite on his left foot and toes, quote, last winter. So that would be December of 2021 to March 2022, given when his June 2nd, 2022, affidavit was sworn; correct?

A. Yeah. Sometime in that winter, yeah.

69 Q. And that's about one year prior to when you saw him in December of 2022; right?

A. Yes.

70 Q. And he says in paragraph 32 of his affidavit that he saw Dr. Wiwcharuk on June 2nd, 2020, the same day that he swore this affidavit, for treatment of the frostbite.

That's roughly three to six months after he says the frostbite occurred in the first place; right?

A. Yes. Roughly, yes.

71 Q. And he says in paragraph 31 that his foot had been getting steadily worse and that Dr. Wiwcharuk told Mr. Greaves that day, June 2nd, 2022, he was going to lose his left big toe, that he was going to be an amputee. That's when Mr. Greaves' foot injury was diagnosed; correct?

A. So different foot injury. I agree that this is like a -- because he spent so much time outside he's had repeated injuries in terms of frostbite and then trench foot or non-freezing cold injury. So he's had recurrent injuries.

And once you get frostbite once and have damage to the vasculature in your foot once, you're going to be at further risk with further exposures. But they are not the same injury, no. Or it's like a much further escalation and evolution with a new injury, like new frostbite, new non-freezing cold injury.

Does that makes sense?

72 Q. I think so. And you are saying that --

A. He's had frostbite more than once.

73 Q. Frostbite can re-occur; is that what you are saying?

A. Yeah. And that when I saw him, it was a new injury. Like at that point in time, that left big toe had already auto amputated, which I think is in my affidavit, that the toe was gone. But he then had a new injury again, another episode of frostbite and non-freezing cold injury.

74 Q. Well, that's where I'm going with my questions. It does say here that Dr. Wiwcharuk indicated he was going to lose his left big toe and that amputation was indicated. You would agree with that?

A. Sorry. So amputation just means lost of a digit or a limb; right? And so he was an amputee from his left big toe, which is very different than losing your leg below the knee, which is the amputation he had like immediately after I saw him.

So yes, he would be an amputee of his left big toe. But that is not the same in terms of function or degree of injury or like, you know -- that we call it auto amputation, so it falls off on its own, you don't need a major surgery, versus a below knee amputation, which is a major orthopedic surgery.

75 Q. Certainly amputation of a toe is far better than amputation of a leg below the knee.

A5056

You would agree with that?

A. Yes.

76 Q. And he was told at this time, in June of 2022, that an amputation was indicated?

A. No, no, no. Of his left big toe, not of his leg.

77 Q. I understand. But he was told that an amputation was the indicated treatment for his injury in June of 2022.

A. It wasn't -- I disagree. It was not the indicated treatment. It was the inevitable outcome. He auto amputated that toe. He did not have surgery.

78 Q. I understand that it auto amputated, but Dr. Wiwcharuk is saying that his toe needed to be cut off and amputated.

A. No. She's not saying that. She's saying that is the inevitable outcome.

79 Q. What other treatment is there for this issue?

A. So in an immediate frostbite situation, there is hyperbaric treatment if it is caught early enough.

80 Q. Sorry. I want to be clear. I'm not talking about immediate treatment. I'm talking after three to six months, when a doctor is saying that this toe

needs to be amputated, it is going to be lost, what treatments other than amputation are available?

A. So she is not saying that it needs to. She is saying that that is the inevitable outcome, like that is just what will happen. That is the course of things, and there is nothing that can be done to reverse that.

81 Q. Sure. I heard your answer on that subject. But other than amputation, after three to six months of a progressive injury due to frostbite, what other treatments are there than amputating?

MS. CROWE: This has been asked and answered.

MR. DIACUR: No, it hasn't.

THE WITNESS: I did not see him and treat him at that time. I don't know why we're --

BY MR. DIACUR:

82 Q. But I'm asking you as a physician, other than amputation, after three to six months of a frostbite injury, what other treatments are there?

A. So I think that that question would actually be better directed at a vascular surgeon or somebody who specializes in thermal injuries. Like, that's not my area of expertise.

83 Q. So you are not able to answer the question?

A. If there's other things besides auto

amputation at that point in time? I mean, I didn't see him.

And in terms of speaking generally to the management of frostbite injuries after three to six months, no, that's not my area of expertise. No, I can't answer it.

84 Q. You would agree that on the basis of Mr. Greaves' own evidence, he presented to you in December of 2022 with a months' old frostbite injury?

A. No. That's not what I'm saying. He had a new frostbite injury and a new non-freezing cold injury that occurred during the two weeks prior to when I saw him in a further part of his foot.

85 Q. So he had the original injury, and you are saying that there was a further injury?

A. Yes.

86 Q. How did you determine that there was a further injury?

A. Sorry. So I did a history. I asked him what's been going on, what's changed about your foot, what's changed about your skin, what's changed about -- like, what is going on there.

I also got collateral from the Social Navigator paramedics that had been seeing him. Then I did a physical examination.

A772

And then I came to my assessment which is that, yes, in the two weeks prior -- I mean, you are right that he was, like, already vulnerable to this kind of injury because he had had frostbite before. He had had an auto amputation of the toe before. It had some impairment to his circulation before for sure. And those are also things when you are doing a history that you take into account.

But that is not the same as he had a new injury, indeed, in the two weeks prior to when I saw him.

87 Q. And how did you determine that? Was it solely from his self-reporting to the paramedics, Social Navigator?

A. And from seeing him. You cannot have a massive -- like, so I was concerned for osteomyelitis, bone infection. I was concerned for wet gangrene, which is infected gangrenous tissue. You can't have that untreated for months and months and months and months and not go into sepsis.

Like, it just -- that timeline does not -- it would be extraordinarily unusual to have the level of tissue damage that he had and for that to be possible for months at a time without having a full body infection.

88 Q. Right. And that's ultimately my point. I mean, untreated frostbite can lead to an infection,

A5057

gangrene, skin sloughing, desquamation, bleeding, ulceration, and eventually auto amputation, all of the things that you list in your report; right?

A. So auto amputation typically is just in digits. It's not typically what would happen with a limb.

89 Q. No, understood. But untreated frostbite can lead to infection, worsening infection, gangrene, skin sloughing, desquamation, bleeding, ulceration, and eventually auto amputation; you would agree with that?

A. Yes, it can.

90 Q. And that's actually what happened here in the case of Mr. Greaves; correct?

A. I think where we disagree is on the timeline, though. Like, I don't agree with you -- this was not brewing for a year. This was -- he had a prior injury. He kept having recurrent injuries, and then he had this one that was particularly bad.

91 Q. No. So I think I see what you are saying. So he did have untreated frostbite for months; you would agree with that?

A. No. No, no, I would not agree with that.

92 Q. Okay.

A. I do not agree with that.

93 Q. So he sees Dr. Wiwcharuk here?

A. Yeah.

94 Q. In his own words, June 2nd, 2022?

A. Yeah.

95 Q. And he's talking about frostbite that he got last winter?

A. Yes.

96 Q. So that's three to six months previously?

A. Sure, yes.

97 Q. He had untreated frostbite for months?

A. Okay. But frostbite is not a full body experience; right? Like a local area of tissue freezes and thaws.

98 Q. His left foot and toe, as he says. That was the area that was affected.

A. I don't know if it was his whole foot or, because I didn't see him then. I didn't assess him then. I didn't treat him then.

99 Q. I understand. I'm asking you about his evidence. He says his left foot and toes.

A. He doesn't say, "my whole foot." He doesn't say the entire foot. He says on his left foot. I don't know what part of the left foot that means.

100 Q. So you are saying that you can't say whether or not he had untreated frostbite for months, based on his own evidence?

A. I don't think -- so, frostbite itself is

just the process of freezing and thawing tissue; right? So that happens in a discrete amount of time.

And then there may be residual damage from the frostbite injury; right? So damage to the blood vessels, damage to the tissue. And then you have this dead or devitalized tissue with poor circulation that then becomes more -- more at risk of either future episodes of frostbite and non-freezing cold injury and becomes more vulnerable to things like infections, because we don't have as good blood supply there to help you fight infections.

But then he had another injury, right, like another episode of tissue either freezing and thawing, which is frostbite, or of non-freezing cold injury, which is where the tissue gets wet around cold. There's a lot of vasoconstriction that happens. There's, again, damage to the tissue which is not frozen all the way through.

And so what I am saying, and I feel like I said ten times now, is that he did have frostbite, yes. And then after that frostbite, he had tissue damage. That was the sequela or the outcome of the frostbite. And then he had the toe auto amputation. I agree. That is what's here.

Then he had months where I didn't see him as a doctor. And then I saw him and I did what I do as a

A773

physician who does primary care and does emergency medicine all the time, which is that I took a history, I did physical examination, and then I made an assessment and a diagnosis, and then I arranged for appropriate care, because it wasn't what I could provide in my outpatient clinic.

But I want to be really clear that this is not just one static injury that happened over the course of a year, that the frostbite episodes are the freezing and thawing of tissue, that the non-freezing cold injury or trench foot is the immersion in cold, like usually cold, wet environments and causing vasoconstriction and damage to the tissue.

And once that is damage damaged, like, the immediate treatment for frostbite is rewarming, but there is still this sequela of the damage itself in terms of tissue damage and in terms of susceptibility to infection.

And there was a new episode of that that happened in the two weeks prior to when I saw him.

101 Q. That's what I'm asking you to clarify. So we've established that untreated frostbite can lead to infection.

You would agree with that?

A. So what I would agree with is that untreated damage tissue after frostbite can lead to

A5058

infection.

102 Q. Okay. And an untreated infection can spread. You would agree with that?

A. Yes.

103 Q. So how did you determine that it was a new injury that was caused in the two weeks prior -- so you saw him in December of 2022 -- and not a worsening or spreading of the infection that went untreated that began in or around, based on his own evidence, in the winter of 2021-2022?

A. So respectfully, I'm here on my own time. I am unpaid. And I have already answered that question, which is that you cannot have the level of tissue damage that he had on his foot and for that -- sorry, cannot -- it is extremely unlikely. I won't say cannot, because in medicine nothing is 100 per cent.

It is extremely, extremely unlikely that you would have the level of tissue damage that he had when I saw him and for that to have been going on for longer than maybe two and a half weeks or three weeks. But, like, it would not have gone on for that long at that level without spreading.

That is extremely unlikely. And I've already answered that question.

104 Q. Well, in terms of spreading, I mean, we are

talking about an individual whose toe had auto amputated.

MS. CROWE: Mr. Diacur, I have to interject. The question has been asked and answered over and over. She's repeatedly explained that she feels that this is a distinct injury and was not connected to the original frostbite in the winter of 2021.

So I think it is time to move on.

BY MR. DIACUR:

105 Q. Well, I disagree, but I am prepared to move on.

Are you aware that Mr. Greaves has indicated that he is or was a user of crystal meth?

A. It actually wasn't the focus of my treatment for him, but I was aware of that, yeah.

106 Q. And you would agree that crystal meth, there are impurities In it that can cause neuropathy, particularly in the extremities?

A. So, I mean, it does act a vasoconstrictor, which can then in turn, in some people, lead to neuropathy.

107 Q. And neuropathy is nerve damage, in layman's terms?

A. Yeah.

108 Q. Neuropathy can lead to loss of sensation in the extremities?

A. It usually is painful first, but sometimes it can lead to loss of sensation.

109 Q. And when there is a loss of sensation, the patient's injuries to the extremities may not be treated properly as a result; would you agree with that?

A. This is really conjecture outside of -- maybe conjecture is a legal word I'm using wrong, but we are moving beyond what I actually know about Linsley and his specific condition and situation.

110 Q. I'm asking you in general about a user of crystal meth and somebody who suffered from neuropathy. They can lose sensation. It's possible that an injury might occur and not be treated properly as a result.

As a general proposition, would you agree with that?

MS. CROWE: Mr. Diacur, she's indicated that she can't speak to that in the context of Mr. Greaves, and she's here to give evidence with respect to his experience.

BY MR. DIACUR:

111 Q. No. That's not true at all. She's here to give relevant evidence that's applicable to this matter. It is not limited to Mr. Greaves whatsoever.

So the question is --

MS. CROWE: It should be limited to what is

in her affidavit and what her knowledge --

MR. DIACUR: Absolutely not. No. Not even close, counsel. No.

MS. CROWE: Okay, Mr. Diacur, I'm going to ask you --

MR. DIACUR: Any relevant question -- any relevant question --

MS. CROWE: I'm going to ask you again to, first of all, let me finish my questions and my comments and to use a respectful tone when we're speaking to each other.

MR. DIACUR: No, no. That is a ridiculous objection, counsel. It is not limited to the four corners of her affidavit.

MS. CROWE: I think your response is ridiculous.

MR. DIACUR: No. It is not limited in any way to the four corners of this witness's affidavit.

MS. CROWE: And her knowledge.

MR. DIACUR: She can answer relevant questions that.

MS. CROWE: Well, I guess that's where we disagree, then. I disagree that what you are asking is relevant, and so that's a refusal.

---REFUSAL

A5059

BY MR. DIACUR:

112 Q. Okay. Well, that is a completely different matter. But that refusal is -- again, it is ridiculous. It's a relevant question.

Was drug use neuropathy and untreated injury considered as a potential causative factor in terms of Mr. Greaves' foot issues?

A. I mean, I was mostly focused, honestly, on getting him to the right level of care. Like at that point in time, the focus was on the fact that he had this massive infection that needed timely treatment.

And so whether or not crystal methamphetamine contributed to it wasn't a primary driver in me referring him to the hospital.

Yeah. Yeah. And then in terms of whether it contributed to his injury --

113 Q. No. That's not the question.

A. No?

114 Q. Did you consider as a differential diagnosis the possibility that his injury was either caused or contributed to by his drug use, neuropathy, loss of sensation?

A. And, sorry. How does that apply to my assessment and treatment of him?

115 Q. I'm asking you if you did any sort of

differential diagnosis. Did you?

A. So, a different -- I mean, yes. I laid it out in my affidavit, which is the differential diagnosis is osteomyelitis, wet gangrene, dry gangrene.

Can we go back to my --

116 Q. I can put it back up on the screen for you. That's what I'm asking you --

A. I guess the thing --

117 Q. I'm not asking you about the possible knock on effects, let's call them, in layman's terms of the injury.

I'm asking you about the diagnosis of the cause. Did you consider any other potential causes, including Mr. Greaves' drug use, including neuropathy which may flow from it, and including --

A. So I think I see what you are saying. So rarely, almost never, would somebody's diagnosis be due to one thing. Right? If you have a heart attack, it's probably age, it's genetics, it's smoking, it's environmental. All of those sorts of things.

So in terms of considering what could have contributed, yes, I did consider that crystal methamphetamine could have contributed to things in a more distal way.

In terms of proximal issues, so then the

most immediate cause leading to his injury and presentation, no, I did not consider it as part of the most proximal causes, because I do not think, and still don't think that, you know, smoking crystal methamphetamine that day or that week or two weeks prior contributed.

However, I did think -- and it's not in my affidavit. I can appreciate that. I did think that, you know, months prior using crystal methamphetamine could have been, one, not the direct, just to be clear, very clear, not the direct reason, but could have been a contributing factor, along with other factors, to his overall presentation, yes.

118 Q. What other factors did you consider?

A. So the fact that he had a prior injury in terms of the frostbite before and tissue damage before.

119 Q. So having existing tissue damage is also a potential causative factor for new injury?

A. So causative is not the word I would use. It doesn't meet the causative criteria. It is a risk factor, for sure. That's a risk factor. Smoking anything is a risk factor, whether that's cigarettes or methamphetamine or whatever. That is a risk factor.

Age is a risk factor in terms of -- not getting frostbite, like, that doesn't have to do with it,

A775

but the ability of the body to, like, modulate its response to cold and exposure and the ability of -- like, also just in terms of atherosclerosis and other forms of peripheral vascular disease. So those would be the main things that would be potential risk factors.

However -- and like the main reason, just to be clear, of me thinking of what are the main contributing factors to him having this infection have nothing to do with litigation. They have to do with what can we actually do to prevent worsening of this and prevent this from happening again. They're for his health.

And the main factor in that was getting cold and getting wet. Those were the main factors. Those were the main preventable things that we could -- I reviewed my clinic notes immediately prior to this, and it says, like, there's no way that he's going to be able to recover from an infection if he's constantly on the move and can't get his antibiotics and he's constantly getting wet. He really needs to be admitted to hospital so that he can be in one place and be dry so that he can get treatment for this, because at that point in time I worried that he would need an amputation, but I didn't know that that was what was going to happen.

And sometimes the treatment for these

A5060

infections is intravenous antibiotics, and they are able to salvage the tissue. So at that point in time, that was my thinking.

120 Q. Okay. Well, I think that was actually in answer to my earlier question.

You mentioned medical notes or records that have not been produced in this matter. Why didn't you include these other contributing factors that you just mentioned in your report prepared for purposes of this litigation?

A. Because I was focusing on the most proximal factors that led to the situation.

121 Q. Your report doesn't say the most proximal factors. It says it's the direct cause.

A. I guess we interpret proximal differently. I would interpret direct as this is the thing that happened right before the thing -- the other thing that happened. That's direct, rather than indirect causes.

122 Q. And you don't mention any other contributing factors, including the ones that you now say that you did consider?

A. Yeah, fair enough. Again, I was looking at direct causes. Yeah. And -- yeah, anyway. We won't go there.

MR. DIACUR: Okay. Well, thank you very

much, Doctor. I appreciate you attending and answering. Those are all my questions.

MS. CROWE: Thank you, Dr. Bodkin. If you can just give me a moment to look at my notes and see if there's any thing further that I'd like to ask you about.

---OFF THE RECORD AT 1:15 p.m.

MS. CROWE: Thank you very much for your time, Dr. Bodkin. I don't have any other questions for you.

--- The examination concluded at 1:16 p.m.

I hereby certify the foregoing is a full, true, and correct transcription of all of my oral stenographic notes to the best of my ability so taken at the Cross-Examination of DR. CLAIRE BODKIN, given under oath before me on the 6th of September, 2024.

Amy Armstrong, CVR-RVR

Certified Realtime Verbatim Reporter #7305

Certified Commissioner of Oaths

Certified this 7th of September,2024

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Court File No. CV-21-00077817-0000

ONTARIO

SUPERIOR COURT OF JUSTICE

BETWEEN:

KRISTEN HEEGSMA, DARRIN MARCHAND, GORD SMYTH, MARIO MUSCATO, SHAWN ARNOLD, BRADLEY CALDWELL, CHRISTINE DELOREY, GLENN GNATUK , TAYLOR GOGO-HORNER, CASSANDRA JORDAN, JULIA LAUZON, AMMY LEWIS, ASHLEY MACDONALD, COREY MONAHAN, MISTY MARSHALL, SHERRI OGDEN, JAHMAL PIERRE, LINSLEY GREAVES AND PATRICK WARD

Applicants

-and-

CITY OF HAMILTON

Respondent

AFFIDAVIT OF AUDREY DAVIS
(sworn July 19, 2023)

1. I, AUDREY DAVIS, of the City of Buffalo in the State of New York, MAKE OATH AND STATE AS FOLLOWS:

Overview of Position

2. I am the Director of the Hamilton Regional Indian Centre (HRIC). As per HRIC's mission statement, our goal is to provide the Urban Indigenous People with the tools to achieve a balanced and holistic lifestyle by providing programs that encompass the entire life cycle and meet the needs of individuals through the Healing Continuum. HRIC

delivers 30+ programs and has more than 60 staff members supporting the programs and services offered through the Centre.

3. In Ontario, more than 84 percent of the Indigenous population lives in urban communities. Our Centre is here to promote and deliver culturally appropriate programs which encourage Urban Indigenous people to reconnect to, retain, and/or gain their culture and provide a safe community gathering space to do so. We offer programs and initiatives for Hamilton's diverse and quickly-growing Indigenous populations which provide access to justice, health, housing and homelessness supports, family support, long-term care, healing and wellness, employment and training, education, justice, cultural and language programs, as well HRIC provides cultural capacity (competence) training to non-Indigenous agencies and organizations in the Greater Hamilton area.
4. In my role, I sit at a number of committees within Hamilton to advocate for access to services and supports, funding and build relationships. The goal is to meet our mandate of improving outcomes for the Indigenous people residing in Hamilton and share awareness of the impacts of colonialism and its ongoing impacts on Indigenous people. Of the committee participation there are key tables with a focus on homelessness and housing. Since the onset of the pandemic, HRIC recognized that homelessness and housing need would intensify. We responded by growing our supports for the homeless and precariously housed supports from three staff to more than 20 staff.

Historical Displacement of Indigenous Peoples in Canada-A Brief Overview

5. Indigenous people have been removed from their traditional territories from every direction in Canada for centuries. Many times these removals have been through the use of violent force. Indigenous homes have uprooted, moved or demolished without

consent, consultation and/or approval from Indigenous peoples. This has happened during times of road/highway expansions, resource extractions or land seizures for development of subdivisions and parks.

6. Displacement also took place in the form of lndian Residential Schools, Federal Indian Day Schools, and the Sixties Scoop, where the government removed Indigenous children from their homes in order to assimilate them into Canadian culture.

7. Often, tools of violence, oppression, racism and discrimination were used to take control of Indigenous lands.

Relationship to the Land and Water

8. Indigenous people have a spiritual relationship with land and water. With this relationship comes roles and responsibilities to the land and water such as to protect both from harm. Many Indigenous people believe that when you are simply present on the land or in the water, you are in ceremony - ceremony that is deeply rooted in spiritual ways of being from their ancient societies.

Hamilton's Indigenous Population

9. Hamilton has one of the largest population of off-reserve Indigenous peoples in Ontario.

10. There are different reasons that contribute to the larger Indigenous population in Hamilton.

11. Hamilton is located beside Six Nations. Six Nations is the only First Nation community that includes all six Haudenosaunee nations. Located along the banks of the Grand River, the Six Nations of the Grand River is the most populous First Nation in Canada.

12. Hamilton has seen an increase in people, including Indigenous peoples moving from other jurisdictions due to affordability issues.

13. Like many people during the pandemic, some Indigenous people come to Hamilton due to unaffordability in other communities.

14. Some Indigenous people come to Hamilton in order to stay with family/friends. Once their temporary stay is over, they sometimes end up homeless and in a position where they have difficulty leaving the city. Individuals then request assistance from HRIC to leave the city and/or access food banks and shelters until such a time as they can find housing and sometimes employment. HRIC has an employee who recently moved his family to the city from a northern community. Due to inability to find housing, the family ended up living in a shelter for five months before the family was able to secure appropriate housing. There are many more Indigenous people with experiences like this.

Over-representation of Indigenous Peoples in Homeless Population

15. It is well known that Indigenous people are over-represented in the homeless population. The City of Hamilton completed a "Point in Time Count" of homelessness in Hamilton from the Indigenous perspective in 2021.

16. HRIC's Housing and Homelessness Supports Team is currently servicing about 155 either homeless or at imminent of homelessness, with an additional 55 people waiting for services. The waitlist is the result of the caseloads of all our caseworkers exceeding their capacity.

17. We have long advocated to the City for additional resources in the community, such as Indigenous shelters and drop in centres. In late December 2021, the City advised HRIC that there was some funding available for an Indigenous drop in centre. However, we had to use the funding by March 31, 2022, or risk losing it.

18. This meant that we had to find a space, negotiate a lease, hire new staff, and figure out a way to have it up and running on time so as to not jeopardize the funding or undermine the need.

19. Although we were thankful for the funding, it almost felt like we were being set up to fail: it was not a reasonable amount of time to establish operations, and there was no commitment to ongoing funding beyond the initial amount. This meant that we also had to secure alternate sources of ongoing funding while trying to get the centre running.

20. In March 2022, HRIC opened up an Indigenous daytime drop in centre for the homeless where we see up to 30 people a day. For the month of April, we saw 130 different people, the majority being homeless.

21. Given that we have only been open for just over a year and awareness of the centre is still growing, the number of people we see is increasing weekly. We also anticipate that the numbers will continue to climb until there is resolution to the housing crisis.

22. Finding housing for Indigenous people is difficult for many reasons, including affordability, discrimination, and other systemic factors.

23. It is particularly hard to house people considered to be "street entrenched". This refers to people who have deeply established patterns that inhibit their ability to establish trust and maintain connections with support services, including housing supports. Often times, the combination of factors such as insufficient income, lack of access to services, unresolved trauma, mental health and substance use disorders, relationship breakdowns make it extremely challenging to connect individuals with housing.

24. The acts of racism and discrimination in housing against Indigenous people makes it difficult for Indigenous people to secure a safe home environment. Racism and discrimination in housing is often the determinant that leads many Indigenous people homelessness and without the security and safety of a home.

In the aforementioned "Point In Time" survey, discrimination in housing was listed as the fourth most common challenged for Indigenous people experiencing homeless in finding new housing.

25. HRIC staff often receive and responded to reports of racism and discrimination in housing. We have had clients face eviction for performing smudging ceremonies in their homes. Having too many people residing at the unit. Other clients have been called derogatory terms by their landlord. Others faced racial profiling in the form of being denied housing based on their race. Landlords will recognize Indigenous names, i.e. Longboat or Henhawk, on applications and refuse the application.

26. Not only do Indigenous people face racism and discrimination once there are housed, Indigeneity can also act as a barrier to finding new housing. We have had clients be inexplicably refused housing after attending to view a unit. Others have had their rental applications after they disclose a history of incarceration. It is not something that is vocalized by landlords, but our staff believe that racism factored into the refusal.

27. Other times people are screened out after a HRIC worker identifies themselves to a prospective landlord. Again, this is not something that is expressly stated, but there is often no other explanation as to why the individual could not obtain the unit.

Hamilton's Shelter System

28. Inasmuch House is a Hamilton shelter for homeless women and is supposed to prioritize Indigenous women. It is exclusively for women and their children fleeing domestic violence, and is consistently full. Native Women's Centre is also a VAW shelter, that also service homeless women. They are also full most of the time. There is a need for more Indigenous specific shelters across demographics.

29. There are no Indigenous shelters for men, couples, families, or youth. There are also no

Indigenous shelters for Two Spirit people. Two Spirit people are Indigenous Queer members of lndigenous Communities. The absence of shelters for Two Spirit is a substantial gap in Hamilton's shelter system.

30. Many Indigenous women experiencing homelessness in Hamilton have described being denied access to shelter, the absence of culturally-appropriate supports, and the inability to remain connected with supports when they are continually displaced. Each of these gaps increases their vulnerability.

31. When an Indigenous woman is evicted from an encampment without an established plan for shelter, she is at heightened risk of violence.

32. The lack of lndigenous shelters, or shelters that offer culturally appropriate supports, has a profound negative impact on Indigenous people experiencing homelessness.

33. There are many traditional elements of Indigenous culture that cannot be practiced, or are not accessible, in a non-Indigenous shelter environment. People cannot perform healing ceremonies or have access to traditional medicines. This is significant because our ceremonies and medicines help with healing from the intergenerational trauma of the loss of cultural identity and systemic discrimination.

34. Many shelter staff are not aware of local Indigenous supports or agencies with which to connect shelter residents.

35. Many shelter staff have not received appropriate or sufficient training on important service elements such as intergenerational trauma and cultural sensitivity.

36. Like many institutions, shelters often knowingly or unknowingly perpetuate systemic discrimination. We have received multiple reports from clients who are discriminated against, harassed, demeaned, falsely accused and summarily banned from shelters. Mental health issues have led to people being removed and banned from shelters due this factor.

37. In the case of service restrictions, we have encountered clients who face extremely long shelter bans. In some cases, people are banned for years or even decades. Some of our clients are banned from all shelters, meaning that there is no way for them to access indoor overnight spaces.

38. On New Year's Day 2021, an Indigenous man was left on streets in the middle of winter and the pandemic after being banned from every shelter. Some of the bans lasted for years, with the longest going until 2025. The man's doctor had unsuccessfully tried to advocate to the City for him to get into shelter, explaining that she believed that the service bans may be related to his mental health. Hamilton Community Legal Clinic intervened and implored the City to come up with a shelter plan for the individual. In response, the City explained that the shelters could not accept the individual because of safety concerns. The City did not offer any type of accommodation. In the end, Hamilton Community Legal Clinic advised HRIC of this man's predicament, and we stepped in to provide a temporary hotel room until we secured housing for this man. A copy of the email exchange between Hamilton Community Legal Clinic and the City is attached hereto as Exhibit "A".

39. In another instance, an Indigenous man asked a shelter worker for a referral to HRIC. The worker told the man that he could not access services from both the shelter and HRIC, and if he chose to work with HRIC, he would be discharged from the shelter. To be clear, HRIC does not offer shelter beds so there would be no duplication of services. It is just another example of how non-Indigenous shelters cannot properly support Indigenous people.

Encampments and Indigenous People

40. As stated, HRIC provides outreach services to individuals living in encampments. Many Indigenous homeless that live on the street state the shelters are not safe and choose the streets as the safer option. We at HRIC have worked with people who have been robbed, experienced racism and discrimination in the form of verbal and physical assaults while

at shelters.

41. It takes time for outreach services to establish trust with people in encampments. The homeless population is highly marginalized and disconnected from services. There is a deep distrust of institutional supports due to intergenerational trauma.

42. When encampments are established, we are able to: 1) locate homeless individuals, and 2) over time, we can establish relationships in order to encourage people to access services. We can remain connected with people to offer ongoing support, food and basic need items such as tents and sleeping bags. These actions are all part of establishing relationships, always with the goal of at some point in time being able to connect to the appropriate services that will move them along their healing journey.

43. Over time, we can also design and implement healing ceremonies and medicines with individuals based on their unique circumstances. Our mobile street outreach team carries traditional medicines and performs healing ceremonies at encampments. We embrace our brothers and sisters when they are at their lowest. As Indigenous, it is our responsibility to care for our most harmed brothers and sisters.

44. Individuals who receive sustained support over time tend to have better social outcomes rather than situations where a person is moved from an encampment and disconnected from services then, we have to start relationship building all over again once we locate these people. People often don't keep the same cell phone, if they have a phone at all. It can be very difficult to reconnect with people once they are displaced.

45. As encampments are dismantled, people are going deeper into wooded areas where we cannot connect. This is happening with each encampment destruction, and will get worse if they continue displacing Indigenous from their land and home.

Sworn remotely by Audrey Davis in the City of St. Catharine's, before me on July 19, 2023 in accordance with O. Reg. 431/20, Administering Oath or Declaration Remotely.

Commissioner for Taking Affidavits
Sharon Crowe

Audrey Davis

THIS IS EXHIBIT “A” TO THE
AFFIDAVIT OF AUDREY DAVIS
AFFIRMED REMOTELY BEFORE ME AT
THE CITY OF HAMILTON DURING A “ZOOM” VIDEOCONFERENCE
IN ACCORDANCE WITH O.REG. 431/20,
ADMINISTERING OATH OR DECLARATION REMOTELY
THIS 19th DAY of JULY, 2023

Sharon Crowe

Sharon Crowe
LSO NO. 47108R
Commissioner for Taking Affidavits, etc

Sharon Crowe (HCLC)

From: Johnson, Paul <Paul.Johnson@hamilton.ca>
Sent: February 16, 2021 3:29 PM
To: Jill Wiwcharuk; Sharon Crowe (HCLC)
Subject: RE: URGENT - Service Restriction for [redacted]

This message was sent from outside of Legal Aid Ontario. Please do not click links or open attachments unless you recognize the source of this email and know the content is safe.

Yes...this individual was unique in that his restriction was widespread for behaviours that are well noted. The general rule is not to restrict from hotels as well but there are cases where behaviour in all settings has led to restrictions.

These are difficult cases and need to be discussed so there is another path. Thankfully they are minimal in numbers given the nearly 4,000 different people that access shelters each year.

Paul

From: Jill Wiwcharuk <jillwiwcharuk@gmail.com>
Sent: February 16, 2021 3:27 PM
To: Johnson, Paul <Paul.Johnson@hamilton.ca>; Sharon Crowe (HCLC) <crowes@lao.on.ca>
Subject: Fwd: URGENT - Service Restriction for [redacted]

Hi Paul,
Nice to see you in the meeting this morning. I sure share your sense of dread wrt what happens after all this money is done!! Wow.

In following up to the discussion about things happening on the ground vs things happening in policy and the disconnect that we are so often seeing, I thought this email chain would be helpful for you to see. In particular the top email from Rob and a few emails down where he states that the service restriction in effect at Mission Services was in effect at the hotel for him as well.

No need to respond, just wanted to send it along. We are all working hard on this, I know.
Take care,
Jill

---------- Forwarded message ---------
From: **Mastroianni, Rob** <Rob.Mastroianni@hamilton.ca>
Date: Fri, Jan 1, 2021 at 7:58 PM
Subject: Re: URGENT - Service Restriction for [redacted]
To: Sharon Crowe (HCLC) <crowes@lao.on.ca>
Cc: Jill Wiwcharuk <jillwiwcharuk@gmail.com>

Hello,

I unfortunately do not have access to another hotel that would accommodate [redacted] We have contracts at multiple hotels that are being utilised based on demographic and contracts with the vendors. I can attempt to push an alternate

hotel location further, however it would require that [redacted] is provided with 24/7 on site support. If that is something that HCLC or SHN have an option to provide, please let me know and I will see what else can be done.

A5073

In response to your other email re:RCF as an option, that is definitely something we can explore and look at ways of supporting as a longer term solution if [redacted] fits the mandate of an RCF. However they are not emergency response and therefore do not do immediate or 24/7 admission. As well, the medical opinion would need to be submitted to the Operator to approve admission.

Please let me be clear that I can appreciate this is a difficult situation and we work diligently to ensure people have access to space. This unfortunately seems to be a time where I do not have an immediate solution.

Thanks,

Rob Mastroianni;
Manager, RCF Subsidy Program & Emergency Shelter Services;
Housing Services Division

-------- Original message --------
From: "Sharon Crowe (HCLC)" <crowes@lao.on.ca>
Date: 2021-01-01 5:51 PM (GMT-05:00)
To: "Mastroianni, Rob" <Rob.Mastroianni@hamilton.ca>
Cc: 'Jill Wiwcharuk' <jillwiwcharuk@gmail.com>
Subject: RE: URGENT - Service Restriction fo[redacted]

Hello again,

Can the City pay for Mr. [redacted] to stay in a hotel other than the hotel managed by Mission Services?

Sharon Crowe, Staff Lawyer

Hamilton Community Legal Clinic

T: (905) 527-4572 ext. 39

F: (905) 523-7282

www.hamiltonjustice.ca

From: Mastroianni, Rob [mailto:Rob.Mastroianni@hamilton.ca]
Sent: January-01-21 5:08 PM
To: Sharon Crowe (HCLC) <crowes@lao.on.ca>
Subject: Re: URGENT - Service Restriction for [redacted]

This message was sent from outside of Legal Aid Ontario. Please do not click links or open attachments unless you recognize the source of this email and know the content is safe.

Hi Sharon,

The Service Restriction unfortunately is in effect at the hotel that would serve men as it is operated by an existing shelter provider. I am unfortunately not able to provide a hotel stay given the service restrictions.

Thank you,

Rob Mastroianni;

Manager, RCF Subsidy Program & Emergency Shelter Services;

Housing Services Division

-------- Original message --------

From: "Sharon Crowe (HCLC)" <crowes@lao.on.ca>

Date: 2021-01-01 4:21 PM (GMT-05:00)

To: "Mastroianni, Rob" <Rob.Mastroianni@hamilton.ca>

Subject: RE: URGENT - Service Restriction for [redacted]

Thank you for the response. I am not aware, and have not been informed, of any alternate locations available to [redacted] What is the City's position on a hotel room? I understand that the program normally prioritizes women and families. However, given the exceptional circumstances at play, I am hoping that an exception would be made. Please clarify the position on a hotel room.

A5075

Sharon Crowe, Staff Lawyer

Hamilton Community Legal Clinic

T: (905) 527-4572 ext. 39

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www.hamiltonjustice.ca

Hamilton Community Legal Clinic
Clinique juridique communautaire de Hamilton

From: Mastroianni, Rob [mailto:Rob.Mastroianni@hamilton.ca]
Sent: January-01-21 4:07 PM
To: Sharon Crowe (HCLC) <crowes@lao.on.ca>
Subject: Re: URGENT - Service Restriction for [redacted]

This message was sent from outside of Legal Aid Ontario. Please do not click links or open attachments unless you recognize the source of this email and know the content is safe.

Hi Sharon,

As I committed to Jill, I have been following up on [redacted] as well as another situation that Jill raised and I understand you have also been consulted.

A791

In [redacted] situation, I have connected with the men's shelter providers to obtain additional information. Based on the discussions and due to the situations that occurred while he was in shelter, the providers are not in a position to admit him to shelter at this time. They have concerns for the safety of their staff as well as other residents and have to balance the difficult task of operating this congregate setting.

A5076

I can appreciate that the issues that resulted in the service restriction may be related to his mental health. I see that Jill has offered to help monitor his situation. Perhaps there other supports or locations that health care system may be able to suggest or offer as an appropriate alternative location.

As you noted, the City acts as Service Manager for this system and partially funds agencies to operate emergency shelters in our community. I will always advocate for accommodation of clients as I have done in this case, however I am not able to impose that an agency admit someone.

I would be happy to set up a time to discuss your comments regarding service restrictions in general.

I have not had a chance to respond ti Jill's last email and assume you will be in contact with her as a follow up to this email. I trust you will provide her with this update.

Thank you,

Rob Mastroianni;

Manager, RCF Subsidy Program & Emergency Shelter Services;

Housing Services Division

-------- Original message --------

From: "Sharon Crowe (HCLC)" <crowes@lao.on.ca>

Date: 2021-01-01 3:05 PM (GMT-05:00)

A792

To: "Mastroianni, Rob" <Rob.Mastroianni@hamilton.ca>

A5077

Subject: URGENT - Service Restriction for [redacted]

Good afternoon,

We have serious concerns over the dangerously precarious situation of [redacted], an Indigenous man with a mental health disability who is homeless and service restricted from every homeless shelter in Hamilton (for as long as the end of 2021 and 2025). As mentioned by Dr. Jill, there are reasonable grounds to believe that the service restrictions are related to [redacted] mental health. As service providers, shelters are required to accommodate [redacted] disability to the point of "undue hardship". As the manager and partial funder of shelter services, the City is also required to engage in the accommodation process.

We are therefore writing to request immediate accommodation of [redacted] disability by ensuring that he has a roof over his head starting tonight, and continuing while he remains homeless. Under normal circumstances, we would reach out to each individual shelter to discuss the specific concerns that lead to the service restriction, and canvas opportunities for an accommodation plan. However, given the urgency of the situation and the fact that this is New Year's Day, there is insufficient time to engage in that process. As such, as an immediate and interim measure, we request that the City discuss the possibility of [redacted] accessing any isolation spaces available at the shelters. In the alternative, we request that the City place [redacted] in a hotel starting tonight and until such time that an agreement can be reached to rescind the service restrictions. Dr. Jill has advised that she will work with [redacted] to help monitor his medication, and look into the availability of additional mental health supports.

We cannot overstate the simple fact that [redacted] cannot be simply left on the streets. It would be unimaginable in the best of circumstances, but given that we are at the height of a pandemic,
the need is that much more paramount.

Apart from the urgency of [redacted] situation, we would also like to discuss concerns regarding the overuse and severity of service restrictions. We appreciate the complexity of the problem and hope that we can work collaboratively with the City and community agencies to establish fair practices.

Please provide confirmation of a shelter plan for [redacted] as soon as possible. Thank you.

Sharon Crowe, Staff Lawyer

Hamilton Community Legal Clinic

A793

T: (905) 527-4572 ext. 39

F: (905) 523-7282

www.hamiltonjustice.ca

Hamilton Community Legal Clinic
Clinique juridique communautaire de Hamilton

Court File No. CV-21-77187

ONTARIO SUPERIOR COURT OF JUSTICE

B E T W E E N:

KRISTEN HEEGSMA, DARRIN MARCHAND, GORD SMYTH, MARIO MUSCATO, SHAWN ARNOLD, BRADLEY CALDWELL, CHRISTINE DELOREY, GLEN GNATUK, TAYLOR GOGO-HORNER, CASSANDRA JORDAN, JULIA LAUZON, AMMY LEWIS, ASHLEY MACDONALD, COREY MONAHAN, MISTY MARSHALL, SHERRI OGDEN, JAHMAL PIERRE, LINSLEY GREAVES, and PATRICK WARD

Applicants

- and -

CITY OF HAMILTON

Respondent

The Cross-Examination of Audrey Davis, taken upon affirmation in the above action this 29th day of August, 2024, conducted via Zoom videoconference hosted by the offices of Nimigan Mihailovich Reporting Inc.

INDEX OF PROCEEDINGS

A5079

AFFIRMED: Audrey Davis

EXAMINATION BY: PAGE NO.

Mr. Diacur.....4

GUIDE TO UNDERTAKINGS, UNDER ADVISEMENTS AND REFUSALS

This should be regarded as merely a guide and does not necessarily constitute a full and complete list.

Undertakings are found on the following pages:

None entered

Under advisements are found on the following pages:

None entered

Refusals are found on the following pages:

None entered

EXHIBITS

Exhibit No.	Description	Page

None entered

APPEARANCES:

Sharon Crowe For the Applicants
Community Legal Clinic

Jordan Diacur For the Respondent
Gowing WLG

Also Present:
Michelle Sutherland - Community Legal Clinic
Liz Marr - student with Gowling WLG

---UPON COMMENCING AT 1:00 p.m.

Audrey Davis,
having been duly affirmed,
was examined and testified as follows:

BY MR. DIACUR:

1 **Q.** So ma'am, I'm going to have some questions for you today, principally about your Affidavit, which is dated July 19th, 2023. Before turning to that, I just want to confirm that you have that available to you. Do you have a copy of that?

A. Yeah, I got it in front of me.

2 **Q.** Okay. And I also want to confirm that you don't have any other notes or documents because you're only to refer to your Affidavit. Is that understood?

A. Oh, okay. Yeah, I do have other ones but I won't reference them.

3 **Q.** Okay, thank you.

A. I'll separate them.

4 **Q.** Thank you.

A. No worries.

5 **Q.** So to begin with, I'd like to start at Exhibit A to your Affidavit, and what I propose to do is to put it up on the screen as well as tell

A795

you where I'm looking so you can either reference what's on the screen or what you have in hard copy there in front of you.

A. Mm-hmm.

6 **Q.** I'll do that now. Can you see on the screen, this is Exhibit A to your Affidavit?

A. Yes.

7 **Q.** July 19th, 2023?

A. Mm-hmm.

8 **Q.** And so as I understand it, Exhibit A to your Affidavit is a series of e-mails and so if I scroll through it, it's several pages long but it's a series of e-mails sent and then responded to. I believe it's seven pages, based on this. So I understand that the earliest of them dates to New Year's Day, January 1st, 2021?

A. Mm-hmm.

9 **Q.** And they're largely e-mails exchanged by Sharon Crowe and Rob Mastroianni at the City?

A. Mm-hmm.

10 **Q.** So we have an e-mail from Sharon to Mr. Mastroianni and Mr. Mastroianni's response on the same date and then we have a further exchange of e-mails between Sharon Crowe and Rob

Mastroianni, same date of Rob's response just after 5:00 p.m. on January 1st, 2021. And then there are, again, a couple of additional e-mails sent on that same date closer to 6:00 p.m. on January 1st, 2021, one from Sharon Crowe to Rob Mastroianni now copying in Jill Wiwcharuk and then Mr. Mastroianni's response still copying in Jill Wiwcharuk. This has all been on January 1st. This last e-mail is just before 8:00 p.m.; do I have all that correct?

A. Mm-hmm.

11 **Q.** Sorry, just for the record, I need you to say either yes or no. I get what you're saying and indicating but it has to be a yes or no to be clear.

A. No problem. Yes.

12 **Q.** Okay, thank you. And then at the very top of the chain, there are a couple of e-mails that are later. So you see that there's a forwarded message, January 1st, 2021, as I said, just before 8:00 p.m. with its chain and then we have e-mails exchanged on February 16th, 2021 between Dr. Wiwcharuk and a man named Paul Johnson at the City with Sharon Crowe also receiving a copy. Do you see that e-mail?

A. Yes.

A5080

13 **Q.** And then the last e-mail in the chain is just Mr. Johnson's response to Jill Wiwcharuk and Sharon Crowe also on February 16th, 2021, and this last e-mail is at 3:29 p.m.; is that correct?

A. Yes.

14 **Q.** Okay. So as I scroll through this, you didn't write any of these e-mails; right?

A. No.

15 **Q.** And you're not copied on any of these e-mails; right?

A. No.

16 **Q.** And you can't confirm for me whether these e-mails are authentic?

A. No.

17 **Q.** And I see that throughout, and in fact in this e-mail that's at the top of the chain, there are redactions made. So it looks like there's a name that's redacted. "Service Restriction for" redacted. And the e-mail that Mr. Johnson was responding to, the subject line includes "Service Restriction for" redacted. And that is flowed through the entire document. It looks to me like it's a name that's redacted. Do

you know if that is the case?

A. Yes.

18 **Q.** Okay. Who made those redactions?

A. I don't know. I'm not a part of this e-mail.

19 **Q.** Understood. Well, no, it's part of your Affidavit so I have to ask you.

A. Oh, okay.

20 **Q.** But you don't know who redacted it?

A. It was probably legal counsel just for the privacy of the individual.

21 **Q.** Okay. All right. And again, if I look at Paul Johnson's e-mail at the very top of this chain, February 16th, 2021, he indicates yes, this individual was unique in that his restriction was widespread for behaviours that are well-noted. He does also indicate these are difficult cases and need to be discussed so there's another path. Thankfully, they are minimal in numbers given the nearly 4,000 different people that access shelters each year.

To your knowledge, was the restriction that's being referenced in this e-mail behaviour-related?

A. To my understanding, yes.

A796

22 **Q.** Did you have any direct involvement in the Service Restriction or the response to it?

A. The response following when the City didn't support this gentleman or client I was able to, through my organization, provide some shelter space for him, temporary shelter space and then house him at a later date.

23 **Q.** Okay, thank you. I will come to that because I believe there is a further description of how that all happened in your Affidavit.

A. Mm-hmm.

24 **Q.** But what I'm really getting at, at this point, is that we're talking about a single individual throughout these e-mails and not more than one; is that correct?

A. That's my understanding, yes.

25 **Q.** And where Mr. Johnson in this e-mail says that this individual was unique, would you agree that this was a unique case?

A. With some -- yeah, some things it was unique. It was what, New Year's Eve, everything was shut down but when you're talking about Indigenous people's experiences in shelters, that's, you know, as this fellow states in this e-mail,

difficult cases. So it's not unique in the case that it's the only situation.

26 **Q.** Okay.

A. So yeah, it's unique in that sense.

27 **Q.** And so the individual whose name is redacted is an Indigenous person?

A. Mm-hmm.

28 **Q.** You can confirm that for me?

A. Mm-hmm.

29 **Q.** Sorry, again, it's got to be a yes or no.

A. Sorry, yes, yes.

30 **Q.** That's okay. I'll remind you. It's okay. I know how it happens. It's okay.

A. Mm-hmm.

31 **Q.** Okay. So that's helpful. Thank you. And I want to scroll down to one of Mr. Mastroianni's e-mails. They're all dated January 1st, 2021 but the e-mail that I'm interested in is on page five of the exhibit. And so the e-mail from Mr. Mastroianni, the timestamp is 4:07 p.m. and he indicates that, here in paragraph four, "I will always advocate for accommodation of clients as I have done in this case, however, I am not able to impose that an

agency admit someone."

A. Mm-hmm.

A5081

32 **Q.** That's correct in your experience, right? The City can't dictate who is admitted into shelter?

A. Yes, yes, it is. You know, there's nothing wrong with an agency being able to identify who they admit. There's bigger challenges, bigger systemic barriers that need to be addressed, right.

33 **Q.** Well, and I understand that --

THE REPORTER: Sorry. I'm sorry, Jordan. Ms. Davis, you kind of trailed off at the end of your answer there. If you could just keep your voice up for me, that would be appreciated.

THE WITNESS: Sure.

THE REPORTER: Thank you.

THE WITNESS: Mm-hmm.

BY MR. DIACUR:

34 **Q.** Yeah. The point of this is to ultimately have a transcript so yes, I appreciate that comment. Thank you. So I understand that there is an obligation to accommodate within a shelter to the point of undue hardship?

A. Mm-hmm. Yes.

35 **Q.** And what is that, in your

experience? What does -- what is the point of undue hardship?

A. Well, I think, you know, to the -- of letting them access the facility --

MS. CROWE: Sorry. Excuse me. Sorry, I was on mute there. I think you're asking for her opinion and for something that was beyond the scope of her Affidavit.

MR. DIACUR: No, I specifically asked in her experience, what constitutes undue hardship? So I'm not asking for her opinion, I'm asking for her experience.

MS. CROWE: Okay. Keeping in mind that she's not a lawyer.

THE WITNESS: Not a lawyer. I am not a lawyer.

BY MR. DIACUR:

36 **Q.** No, no, that's understood, but this is a test that is applied to individuals constantly by non-lawyers and so I'm asking for her experience.

A. Okay. So in my experience, and with homelessness and shelters, I've never run a shelter, I'll state that, but I do run the organization that provides many social services support to Indigenous

A797

individuals and we don't just turn people away without alternative resources, and when you're talking about December or January 1st, the weather, I know what the weather was like that day. I believe there is a responsibility not to leave people in situations. You're a shelter, you have an obligation to shelter people whether it's on site or off site. We have people we work with who we cannot support them directly ourselves but we connect them to and provide them as many resources we can to ensure that their safety and wellbeing is taken care of in the moment.

So despite the fact that, you know, we learned a lot -- I learned a lot about the shelter systems and their obligations in working with Indigenous social service agencies specifically a lot in Hamilton, and one of the obligations is if they don't have space, they need to provide accommodations or ensure that there's accommodations be it a hotel, referral to another agency. And I gained this understanding just through working with -- having to work directly with caseworkers in trying to secure shelter, immediate shelter for people in situations.

So, so yeah, they don't have to

admit someone but they have to make all efforts to ensure that person is safe.

37 **Q.** Well, let me ask it this way, what did the redacted individual do in this case to be Service Restricted?

A. I don't know the exact details.

38 **Q.** Did you ask?

A. No.

39 **Q.** I understand in this e-mail chain, it's stated that this individual would require 24/7 supports in order to operate in either a shelter or a hotel environment?

A. Right. Right, and that's where I was speaking to about the gaps and the barriers that are in place. One of those gaps is supportive housing for people who have those barriers. Mental health, addictions, whatever it might be, but it doesn't, it doesn't get rid of the obligation of the community or society to support these people. Just because he can't be put in a shelter doesn't mean he deserves to be outside in the cold left to fend for himself when all services, that was a holiday, you know, all the social service agencies are closed. So he had nowhere to go.

40 **Q.** In your experience, would providing

24/7 on site support be a form of undue hardship for an emergency shelter?

A5082

A. I don't know. I can't speak to the shelter service provider itself from a firsthand basis and understanding the complexities and how they operate --

41 **Q.** Okay.

A. -- on a day-to-day basis.

42 **Q.** All right. So I'd like to turn to your Affidavit. I have some questions for you about the content. I'm just going to click through via the index in this document that you compiled so I'll put it up on the screen. Can you see your Affidavit sworn July 19th, 2023 there?

A. Yes.

43 **Q.** So I'd like to start with paragraphs two and three. So you do identify yourself as Director of the Hamilton Regional Indian Centre, HRIC?

A. Mm-hmm.

44 **Q.** Sorry, it's got to be a yes or no.

A. Sorry, yes.

45 **Q.** Just for the record. Thank you. And if I refer to the Hamilton Regional Indian Centre as HRIC, you'll understand what I'm doing?

I don't have to say it out loud every single time, I can use the acronym, is that okay?

A. Yes, you can.

46 **Q.** Okay, thank you. All right. Is that still your position? I know it was in July of 2023 but do you remain the Director of the HRIC?

A. Yes, I am, but I do want to -- in statement one it says the City of Buffalo. I don't know how that got overlooked. It's actually the Town of Niagara is where I reside.

47 **Q.** Okay. But is that still in the State of New York?

A. Yes.

48 **Q.** Okay. Understood. And that's where the university is located right by the river there, Town of Niagara?

A. Niagara University, yeah.

49 **Q.** I just want to make sure I know what we're talking about so that's good. Thank you. Okay. And you do indicate in paragraph two that the HRIC delivers 30 plus programs. I understand that some of those are related to housing and homelessness supports; right?

A. Yes.

50 **Q.** Okay. And those programs in

A798

particular, the housing and homelessness supports programs, what do they include?

A. We have housing support caseworkers, intensive caseworkers, we have a couple of landlord liaison positions, shelter intervention worker, one position. Let's see. What else. We have the Indigenous drop-in which is staff who, you know, program support staff there. What else is in the housing and homelessness team? There's about 30 positions. We've just secured a housing stability position, worker position. There's a manager, supervisor, assistant. I wasn't prepared to list all of those staff. Yeah, but there is approximately 30 staff that provide supports.

51 **Q.** Specifically in that area?

A. Specifically in housing, yes.

52 **Q.** Okay, thank you. All right. So I'd like to jump forward a bit to paragraph 17 of your Affidavit. I'll scroll to that now. You indicate that we have long advocated for the City -- or to the City for additional resources in the community, such as Indigenous shelters and drop-in centres.

Just to be clear, though, Indigenous individuals are able to access existing shelters in the City of Hamilton; correct?

A. They are able to access existing shelters.

53 **Q.** And they do so? You know for a fact that Indigenous individuals do that?

A. Some do.

54 **Q.** Okay.

A. There are barriers within the shelters for Indigenous people, though.

55 **Q.** No, I understand that. I'm just asking for confirmation that that is something, in your experience, does happen?

A. Mm-hmm.

56 **Q.** Okay. And at paragraph 16, you mention the wait list, the HRIC's waiting list and so again, to be clear, the individuals on the HRIC's waiting list are free to access housing supports through other providers in the City of Hamilton while on that list; correct?

A. Yes.

57 **Q.** And you're aware of that happening as well?

A. Mm-hmm.

58 **Q.** And so at paragraph 19 of your Affidavit, you indicate that there was funding provided and this actually goes back to paragraph

17 being referenced an Indigenous drop-in centre in late December 2021. The City had advised the HRIC that there was some funding available for an Indigenous drop-in centre, however, it had to be used by March 31st, 2022 or it might be lost.

A5083

A. Mm-hmm.

59 **Q.** And you indicate in paragraph 19, "Although we were thankful for the funding, it almost felt like we were being set up to fail." So I understand that the City offered this funding and it was time-limited for use within three months?

A. Mm-hmm.

60 **Q.** The HRIC accepted the funding on those terms?

A. Mm-hmm. Yes, we did.

61 **Q.** Okay. And why was the funding time-limited? Do you know that?

A. What their funding cycle is, I believe.

62 **Q.** And was the funding coming from some other government body?

A. I didn't ask the City --

63 **Q.** Okay.

A. -- about where the funding came from, but they obviously operated on a fiscal year.

64 **Q.** Okay. And so that March 31st, 2022 is, that deadline is the end of the fiscal year?

A. Yes.

65 **Q.** Okay. Is it possible that it was COVID funding coming from a different level of government?

A. It could have been possible. I can't, you know -- I don't know. I didn't ask at the time.

66 **Q.** No, understood. That's --

A. I believe it was just a surplus funded that wasn't expended through the year.

67 **Q.** Okay. Understood. If I scroll through to paragraph 20, you indicate that in March 2022, the HRIC did open up an Indigenous daytime drop-in centre and that was using the City's funding?

A. Yes.

68 **Q.** So I would suggest to you that that's a success and not a failure?

A. We had to secure funding from other sources, divert funding, use existing staff to help support there because it was a very limited amount of --

69 **Q.** No, understood, but I would suggest

A799

that that's a success and not a failure?

A. A success, yeah. I suppose you could call it a success, yeah.

70 **Q.** And if I scroll down to paragraph 22, you mention that housing is difficult to obtain for Indigenous people including due to discrimination. Are we talking about discrimination by landlords?

A. Yeah, you get discrimination by landlords, yes.

71 **Q.** Is it discrimination by anyone else?

A. Discriminatory practices. The whole systems are set up, hence the reason for the TRC, right. Canada's systems are set up in opposition to Indigenous ways of being and knowing. So the discrimination, the racism is systemic as well as within society.

72 **Q.** But specifically when it comes to a barrier to housing, are we talking about discrimination amongst the landlords who would be offering that housing in the market?

A. It could be discrimination from the landlords, could be discrimination ongoing, systemic discrimination that had put Indigenous people and those who are homeless or at risk of homelessness in

a position where they can't afford housing, adequate or appropriate housing. They don't have jobs, they have addictions, they have mental health issues. There could be all kinds of different barriers and impacts of colonization impacting these people.

So when I speak about discrimination there, it's very, you know, vast where this goes. It goes back to colonization. It goes back to the residential school, the day schools, the Sixties Scoop, the disconnect from cultural impacts not only that Indigenous person but, again, it ties back to the systems. The government systems, the societal systems and individuals including landlords. Employers, people who have these -- who have been taught all these stereotypes about Indigenous people where, where discrimination against Indigenous people is just part of the culture.

73 **Q.** Got it. Okay. And so in terms of what you mentioned there, would that also include what you refer to here as other systemic factors?

A. Yes.

74 **Q.** Okay. You also mention affordability. Would you agree that affordability is not a factor that's limited to Indigenous people, it's a broader issue?

A. Currently, yes. Since COVID, yes.

75 **Q.** Okay. And in paragraph 23, you mention, you used the term "street entrenched".

A. Mm-hmm.

76 **Q.** You indicate that that makes it harder to obtain housing. Now, I understand what you're saying here in terms of street entrenchment. It's individuals who have a deeply established pattern that inhibits their ability to establish trust and connections.

A. Mm-hmm.

77 **Q.** Now, I just want to ensure, again, would you agree that that is also something that is possible outside of the Indigenous community as well as within it?

A. Yes. Yes, the difference being is that Indigenous people, again, are overrepresented in homelessness and any other social ill due to colonization and then back to the discrimination being systemic in our society.

78 **Q.** Right. And you do mention at paragraph 24 a Point in Time survey and you indicate that discrimination in housing was listed as, well, the fourth most common challenge for Indigenous people in that Point in Time survey.

That Point in Time survey isn't included as an exhibit to your Affidavit; correct?

A. No, it's not.

79 **Q.** It's a document that you referenced at some point in the past?

A. Is it included, Sharon?

80 **Q.** Well, there's only one exhibit to your Affidavit and --

A. Oh, okay.

81 **Q.** -- it was the e-mails that we just referenced.

A. Yeah, so the Point in Time count is something completed by, you know, within each community that receives funding through the region --

82 **Q.** Okay.

A. -- other funding from the Federal Government. It's a requirement and it just gives a snapshot, they call it a snapshot of homelessness within a community.

83 **Q.** Okay, so --

A. To be able to tell, you know, what are the needs and the gaps in each community.

84 **Q.** So other than that, other than that Point in Time survey that you reference, the

comments that you make here in paragraph 24, and you are free to review that, what are these comments based on?

A. Let me just read it real quick.

85 **Q.** Yes, please.

A. Okay, so those comments are based on, again, the Point in Time count which wasn't included.

86 **Q.** Yeah, no, I'm not asking -- other than that.

A. Okay.

87 **Q.** Is there anything other than that that that's based on?

A. Yeah.

88 **Q.** Okay. Let me know.

A. Let me finish.

89 **Q.** Yeah.

A. So I worked for, prior to working at Hamilton Regional Indian Centre I worked for the Ontario Federation of Indigenous Friendship Centres supporting programs across Ontario in Indigenous agencies, primarily friendship centres with the Reaching Home. At that time it was called the Homelessness Partnering Strategy funding pots.

THE REPORTER: Sorry, I didn't hear

what it was called.

THE WITNESS: Homelessness Partnering Strategy.

THE REPORTER: Thank you.

THE WITNESS: HPS. And then it changed to Reaching Home. Same pot of funding, just a different title. So I was in many communities. I regularly visited these communities to provide supports through that funding pot and help identify gaps and barriers in the communities. The communities were Ottawa, Niagara area, Moosonee, Timmins, Barrie or not Barrie, sorry, Midland. There was nine communities in total. Thunder Bay was one of the programs as well.

So a lot of it is based on experience and all the information gathering I did in that work as well. When you talk about, you know, discrimination in housing, you know, I can tell you stories of workers going with a community member to view a housing unit and the landlord walked out on the porch seeing the person was Indigenous and told them to basically screw up. Get out of here. I'm not renting to an Indigenous person.

So yeah, that's common and there

A5085

were other stories that I could add to but, you know, so this comes from my past work experience, my own lived experience being an Indigenous woman and growing up in Canada and having to find housing. You know, having -- being discriminated against, you know. Making sure I took my non-Indigenous housing or husband with me to appointments to better my chances of getting into an appropriate unit.

So that's what it's based on. You know, let's say -- yeah. And, you know, in the past, I myself, and I know people who do, you end up renting inferior housing because you're viewed, you're Indigenous and they hold those stereotypes against you.

BY MR. DIACUR:

90 **Q.** When that occurs, discrimination in terms of obtaining housing or in respect of occupancy of housing, does the HRIC's housing and the housing assistance programs assist individuals, Indigenous individuals with taking steps to rectify that?

A. We will try. We will refer them over to the, over to the legal clinic. We aren't -- we are very much a lot of peer support, caseworkers. We don't have the expertise, professionals or

clinicians that we employ so our scope is limited. We do have the resources where we will refer them to. We do have the landlord liaisons who will help and work with, with landlords to try and navigate situations. The reason we have landlord liaisons, primarily, is to build for the staff members, for HRIC to build relationships with the local landlords to help reduce those barriers faced by Indigenous people and then we just rely on the same landlords to word of mouth, share with other landlords and we support. We continue with ongoing support of the tenants to help and try and ensure that they remain housed because it is a big challenge to find new housing.

91 **Q.** Thank you. So scrolling down to paragraph 28 of your Affidavit, this is under a subheading "Hamilton's Shelter System". You mention two locations, Inasmuch House and the Native Women's Centre. You do indicate that Inasmuch House is consistently full and you indicate that the Native Women's Centre is also full most of the time.

A. Mm-hmm.

92 **Q.** You agree with me that Inasmuch House sometimes has available spaces?

A801

A. Yes, they do.

93 **Q.** And the Native Women's Centre does sometimes have available spaces?

A. Yes.

94 **Q.** Okay. And in paragraph 29, you do indicate that there are no Indigenous shelters for men, couples, family or youth and there you're referring to in Hamilton; right?

A. Mm-hmm.

95 **Q.** Sorry, it's got to be yes or no.

A. Yes.

96 **Q.** Yes. Okay. But again, Indigenous men, couples, family, youth, Two Spirit individuals can access the existing shelters in Hamilton?

A. Yes.

97 **Q.** And you indicate that the absence of shelters for Two Spirit individuals in particular is a substantial gap in Hamilton's shelter system?

A. Mm-hmm. Yes.

98 **Q.** Well, I would suggest to you that you would personally prefer to see such a separate, dedicated facility for Two Spirit individuals but the fact that a dedicated facility has not been set aside for Two Spirit individuals is not a gap in the system since they can access the existing

system. Would you agree with that?

A. Somewhat. They can go there. Are they safe there? Not all the time, no. And then --

99 **Q.** So it's a security issue? Is that what you would say?

A. Pardon?

100 **Q.** It's a security issue? Is that what you would say?

A. It's a safety issue. It's providing safe shelter for people. The shelters do not provide safe shelter for Indigenous people and it's not unusual to hear people say I'll sleep on the street before I go to the shelter because I feel safer out there.

101 **Q.** Yeah. And you do make a comment like that later in your Affidavit so I'll have a question for you about that statement. So we'll come to that. Paragraph 30 of your Affidavit you do indicate that there's an --

A. Before you go on --

102 **Q.** Yes.

A. -- I want to speak to the families and couples shelter. When you're talking about access, yes, they can access shelters, right, but they have to be separated. So when you're talking

about families who are already displaced, you know, if there's a 16-year-old boy, 17-year-old boy within that family, he cannot go to the family shelter with the mother and the father can't go to the shelter with the mother. They have to be separated.

A5086

So there's already that historic trauma of separation issue. You know, back to the residential schools, Sixties Scoop where children and parents are separated causing trauma and that can be very triggering for those because many of the Indigenous homeless people are survivors of residential school and/or the foster care system.

103 **Q.** Understood. So in paragraph 30 of your Affidavit you indicate that there's an absence of culturally appropriate supports?

A. Mm-hmm.

104 **Q.** And that's specifically with reference to Indigenous women experiencing homelessness in Hamilton. What are you referencing there?

A. I'd have to think about if I was speaking specifically because this was written a couple years ago. Had turnover with staff, new consultation with managers on things, you know, to add in and staff to add in information. We do have,

you know -- I can speak to an experience back in 2018 where there was a woman who came to the centre one afternoon, and of course it was on a Friday afternoon looking, you know, she couldn't access a shelter. Looking to get shelter access. We called every shelter and this was due to -- this one was due to no shelter spaces that we ended up with her until 11:00 o'clock at night. We called as far as Toronto and couldn't get a space. Ended up she left with a tent and a sleeping bag to sleep in the streets, right.

So, and when you're talking about the vulnerability, how vulnerable that woman is already being female out on the streets and add to it being Indigenous, you know, when predators are looking to find a victim, they look for the most vulnerable. And when you're talking about women, yes, vulnerable, add Indigenous to that because the perception is, and we know this, that Indigenous women are very disposable and when they go missing or murdered, you know, the same efforts don't go into them that -- to locating them or finding justice for them that goes to non-Indigenous. So being denied access to a shelter, there's also other women who are denied access based on, you know,

A802

again, it goes back to the behaviours, you know, mental health, addictions and it speaks to the gaps.

Again, I understand safety concerns for others and, you know, staff but at the same time, there is a need to provide alternative shelter. You can't just, you know, having shelter is a human right, right. You know, that's the belief, the principles that we operate on that we don't leave people out in the streets and especially vulnerable and very vulnerable people such as Indigenous women who may have mental health and addictions challenges so yeah.

You know, when they talk about being denied access to shelters, yeah, it happens. It happens and culturally appropriate doesn't mean they can just smudge there. It means there's somebody there who understands their plight, who understands why they're in the situation and who can -- sorry about that. My Roomba is talking to me.

105 **Q.** That's no problem.

A. You know, who they can connect with, have trust with, have rapport with because historically speaking, the Canadian system has not been supported or trusted for Indigenous people.

106 **Q.** Okay. Well, I want to make sure

that I understand that. So you mentioned smudging in particular. There are traditional elements of Indigenous culture that can be practiced in shelters in Hamilton; right?

A. That's my understanding now that it's becoming more, you know -- through our work, I believe I speak to this, too, HRIC has cultural capacity trainers. We have our managers who go out and advocate and bring cultural awareness and understanding and push for training and how they can better support Indigenous people or at least give them the things they need to do the smudging or carry on with their ceremonies. But again, it's not limited to smudge, it's -- when you're talking about culturally appropriate, providing opportunity or space for them, smudge is great. It's a step in the right direction but there's so much more to it than just being able to smudge.

107 **Q.** Understood. So the other part of that is I understand the HRIC does go out into the community and go to the shelters and provide that training. Do you see that as part of the HRIC's role?

A. That's part of our mission to support Indigenous people and bringing back

empowerment. You know, they can't -- you know, that's why there's the TRC because Indigenous people did not put ourselves in this situation, it's the system around us. The system needs to change. The attitudes of individuals need to change because we can empower ourselves as much as we can. If we're denied access to society and the means to improve ourselves, you know, it's not a one-sided thing. Again, it ties back to the TRC and the obligation of the Canadian society to work on reconciliation side-by-side.

A5087

108 **Q.** Understood. Just for the record, I just want to clarify, TRC, you're referencing the Truth and Reconciliation Commission?

A. Yes, the calls to action, yes.

109 **Q.** Just want to make sure because if it's an acronym on the record --

A. Oh, okay. Yeah. Mm-hmm.

110 **Q.** Thank you. So again, I would say that this is a success story for the HRIC going out into the community and taking those steps. The fact that it exists in Hamilton is a good thing. You'd agree with that?

A. Yes, yes.

111 **Q.** And so I'd like to move to paragraph

34 of your Affidavit. You indicate here many shelter staff are not aware of local Indigenous supports or agencies with which to connect shelter residents and I have a question for you about this in terms of your knowledge of what many shelter staff are unaware of. Is that based on the HRIC's work of going out and educating shelter staff?

A. That's based on experiences. Again, this was written two years ago. We were, we were only a couple years into providing training. The training component at HRIC, cultural training program is fairly new. It only goes back to 2018 and it was funded by the Ontario Federation of Indigenous Friendship Centres. It is something that is currently not funded. It's an unfunded initiative that HRIC does to, you know, for the work that we do.

112 **Q.** Okay.

A. But -- oh, I was going to go somewhere else. When we talk about their lack of awareness, yeah, so we go in and, you know, we might have been to, say, Inasmuch House, I don't know if we have even trained that shelter. Just as an example, we go into a shelter, provide training and bring awareness and knowledge of working with

A803

Indigenous people but they have staff turnover just like we do. So the training might have been two years ago. You might have one or two, maybe three or four of the people, you know, certain percentage has left and moved on and has new staff. And again, you don't check a box when you say oh, Inasmuch House is trained, we're good with them to try and perfect (indiscernible) until this is resolved. You know, Indigenous discrimination and homelessness, which isn't anywhere in our future, our foreseeable future. But it's a moving target. It's individuals. You have to educate people. People have to become educated and have change of hearts, change of minds, change of ideas and perceptions about Indigenous people.

113 **Q.** Understood. So -- no, and that's helpful. I appreciate the clarification. Paragraph 36 you indicate that there have been multiple reports from clients who have, among other things, been falsely accused and summarily banned from shelters. My question for you about that is have you ever received a report of someone admitting to being appropriately or fairly accused of something?

A. Yes, they acknowledge that. You

know, yes, I have mental health, I have addictions issues. Yes, I've screwed up, but doesn't mean you throw them away.

114 **Q.** No, it goes back to the discussion we were having earlier about Service Restrictions and behaviour so I appreciate the clarification. I just want to make sure that we're clear on what your evidence is.

A. Mm-hmm. Yeah.

115 **Q.** When you say these are based on multiple reports of clients, what you're doing is passing along those second-hand reports. It's not like there's investigation done to confirm what you're being told; correct?

A. We don't -- we're not in that legal capacity. We support people to get them out of situations. They get banned, yes, we know that happens. They get accused of doing something they didn't do, yeah, we know that happens. You know, when it comes to a he said, she said, they're going to believe the non-Indigenous before the Indigenous for the most part. That's accepting -- yeah, you know, if they report that, yes, we believe that because we're Indigenous. We understand that that does happen.

So do we doubt them, yes, everybody is not honest all the time but at the same time, it goes back to that discrimination, the systemic discrimination. All of that, that continues to keep those who are most harmed and those who need the most support on the street, you know, and in precarious situations. So they might be banned from shelters and, you know, we understand that, we try to support them, we put them up in hotels, we try to house them and we do have access with the majority that we work with and move on to somebody else but then they come back because there's bigger issues with mental health and addictions. Putting a roof over somebody's head doesn't fix them, you know. It provides them human right, a right to be in shelter but then they go off into, you know, they can't get into the shelters, you know, the encampments, you know, provide those safety for those people, too, right.

So we just try to support as best we can and, and we take people for the most part. You know, we know the community. We know the people who are coming to us. You know, there's only so many Indigenous people's families and we do connect as much as possible so we get to know them and we know

when people are unfairly treated. We know -- they come and tell us when the shelter says you either work with us or you work with them so, you know, it's, again, that ongoing racism and discrimination that keeps getting in the way.

116 **Q.** You mentioned in paragraph 37, in some cases, people are banned, and this is, again, on the basis of Service Restriction. "In some cases, people are banned for years or even decades." Who has been banned or Service Restricted from a shelter for decades, in your experience?

A. We do have one fellow back -- hm, what year. I think it was pre-pandemic who could not access -- no, it wasn't pre-pandemic because we had caseworkers. Throughout the pandemic he would never be able to access the shelters. I can't go back to the shelters, I've been banned. Permanently banned.

117 **Q.** He was permanently banned?

A. He's permanently banned from the shelters, yeah. Yeah, and we've had people who we've shipped out of the community. You know, sent them, you know, taken them to Toronto, taken them to other communities where, you know, I believe we sent

one up to Timmins to a shelter. The hope is, you know, we try to send them home, to their home community but that's not always possible if they're not connected to their home community anymore nor were they ever.

118 **Q.** Okay, thank you. That's helpful. Paragraph 38, this is back to New Year's Day 2021. You reference an Indigenous man being banned from every shelter. Is that the same individual that we were talking about when we looked at Exhibit A and the e-mails?

A. Yes.

119 **Q.** And I understand that the HRIC did step in and shelter was obtained for that individual?

A. Yes.

120 **Q.** And that was done by, at least my understanding any way, it was done by January 20th, 2021; is that correct?

A. No, I believe we put him in a hotel the same night.

121 **Q.** Okay, so the hotel for temporary shelter and then there was permanent shelter obtained later that month?

A. If that's what it -- I can't recall

exactly when we secured his permanent housing.

122 **Q.** Okay. But to your recollection, was it within that same month?

A. He went right from hotel to a residence, yes. Permanent residence, yes.

123 **Q.** All right. Well, again, I suggest to you that that, obtaining a hotel space and obtaining shelter for an individual in that circumstance is the role of an organization like the HRIC that provides shelter supports. Would you agree with that?

A. It's our job to help, to put people in hotels. We don't have any funding no more to do that. At the time we were able to divert some funding. This was before, I believe before we had the agreement even with the City to put -- have funds available to put people in hotels, which we did eventually get throughout the pandemic but yeah, we weren't in the habit of putting people in hotels. We had in the past because we can't leave them on the street and as Indigenous people, yeah, it's our responsibility to take care of each other. But again, the reality is we have limited resources. We are not a shelter. Shelters --

124 **Q.** No, understood, and I'm not

suggesting that. I'm just saying that shelter supports are provided by the HRIC. You'd agree with that being part of the role of the HRIC?

A5089

A. No, it's what we do beyond. HRIC provides supports and services to individuals to help them secure housing, to help them maintain their housing amongst, you know -- help them connect them to mental health, connect them to addictions professionals. We are not a shelter nor are we a shelter provider.

125 **Q.** Okay. Again, there were resources available to resolve the predicament that this particular individual found himself in on New Year's Day. You'd agree with that?

A. Yes, there were. And I know that the shelter had resources available to do it, too, but they chose not to.

126 **Q.** Well, in general, I would put it to you that the system, the homelessness serving system including the HRIC worked to provide shelter to this man in need that same day. Would you agree with that?

A. No, the system didn't work. The HRIC --

127 **Q.** The HRIC is not part of the system?

A. HRIC is separate from the colonial system. We do things differently. We're not part of the system.

128 **Q.** Well, I'm not saying that it's part of the colonial system. I'm saying that it provides services to individuals who are homeless. It is homeless serving, at least in part. You'd agree with that?

A. We do provide services to homeless people.

129 **Q.** So the homelessness serving system in the City of Hamilton worked to provide shelter to this individual in need the same day?

A. No, Hamilton system didn't work. That's why I was called. We were closed. We were on a --

130 **Q.** I'm saying in the City of Hamilton. I'm not saying the City's system. HRIC is located in the City of Hamilton, yes?

A. Yes. I'll make it very clear so it's easy so we can move on. The City of Hamilton, the shelter system failed this man. HRIC was able to shelter him until we were able to house him.

131 **Q.** On the same day that he found himself in need he was sheltered?

A805

A. He was sheltered in a hotel room by HRIC, not by -- the system wasn't -- shelter system nor the City of Hamilton system wasn't successful. They failed.

132 **Q.** Yes, no, I understand your evidence. I appreciate that clarification. Paragraph 39, if I follow this paragraph, you're reporting what an Indigenous man told you he had been told by an unnamed shelter worker. Do I follow that correctly?

A. Yes. Yes, and like I said, at the time of the writing of this Affidavit, there were 155 clients. I don't know who the client was. I get the information, I'm the executive director. I don't work directly with the homeless people or the caseworkers. There's a manager and it was reported to me by one of the managers.

133 **Q.** Okay. So just to be clear, then, so this statement in paragraph 39 is what you were told by an HRIC manager that they were told by an Indigenous man that they were told by an unnamed shelter worker; do I have that right?

A. Yes.

134 **Q.** Okay.

A. Yes.

135 **Q.** And at the end of that --

A. It doesn't invalidate it.

136 **Q.** I'm sorry?

A. I said it doesn't invalidate it. It's still, again, this is --

137 **Q.** I'm just trying to establish the source of the information. It's valid or not is for the Court.

So paragraph 39 ends with the statement, "It is just another example of how non-Indigenous shelters cannot properly support Indigenous people."

A. Yes.

138 **Q.** And so just to be clear, the example you are giving is based on that chain of communication that we just described?

A. Just another example. It's a piece of the -- it's a part of the whole --

139 **Q.** Understood.

A. Just a piece of it. Another piece of it.

140 **Q.** And in paragraph 40, there is, again, a statement about Indigenous homeless individuals. You say, "Many Indigenous homeless that live on the street state the shelters are not

safe and choose the streets as a safer option." I believe this is what you were referencing earlier --

A5090

A. Mm-hmm.

141 **Q.** -- (indiscernible) something similar; is that right?

A. Yes.

142 **Q.** And again, just to be clear in terms of where the information is coming from, these are reports from Indigenous individuals to managers at HRIC that they then communicate to you?

A. It's usually the individual will communicate once they build rapport and relationship with their caseworker and then the caseworker will share this with managers.

143 **Q.** And then they share that information with you which is what you're reporting in your Affidavit?

A. Mm-hmm.

144 **Q.** Okay.

A. They don't always -- it's not like people run and share stuff. When I'm doing work and doing advocacy work, I will reach out to my managers and tell me, you know, tell me about your barriers and challenges that, you know, that the staff have

been experiencing with their community, with the clients.

145 **Q.** Okay.

A. And that's how it works.

146 **Q.** And you do reference that in paragraph 41 so I appreciate that. I understand your evidence and just for the record, those are all of my questions for you. I appreciate you attending to answer.

A. Mm-hmm. You're welcome.

BY MS. CROWE:

147 **Q.** Thank you, Ms. Davis. I just have a couple very quick re-direct questions, okay?

A. Okay.

148 **Q.** So the first one was when we were referring to that individual that's in the exhibit with the e-mail exchange, the New Year's Eve and New Year's Day incident, you explained that HRIC provided a hotel space for this man?

A. Mm-hmm.

149 **Q.** Do you remember how long he was in hotel?

A. No, no. If you would have given me a heads up that this was going to come up, I would have talked to one of my staff to look at the

A806

records and look at his case file and see how long he was in, but I know he was in a hotel until we housed him.

150 **Q.** Do you know how it went when he was in the hotel?

A. There were issues, yes. Yes, he has mental health and addictions issues. Again, speaking to the gaps, right.

151 **Q.** Did he receive 24/7 support while he was in a hotel?

A. No.

152 **Q.** Okay, thank you.

A. We don't have the resources to do that --

153 **Q.** Thank you.

A. -- and still looking for the issues.

154 **Q.** Thank you. And then with respect to the Point in Time survey that you reference, have you ever been involved in completing a Point in Time survey?

A. I've been involved in completing a number of Point in Time surveys. Again, speaking back to my previous experience with the Reaching Home, it's part of the Reaching Home mandate that communities do Point in Time counts so I worked with

a few communities to support the Point in Time counts. I was participated in one in Brantford and also participated in the Point in Time count here in Hamilton in 2018 I believe was the first one I participated in.

155 **Q.** What was the last one?

A. The first -- the last Point in Time count was 2021. I think it was put off for a year due to the pandemic. I think it was supposed to happen in 2020. I believe that's when it was supposed to happen and due to the pandemic, it was pushed back.

156 **Q.** Okay. Thank you very much, Ms. Davis, those are my questions.

A. Okay. You're welcome.

---WHEREUPON THE EXAMINATION CONCLUDED AT 2:08 p.m.

A5091

I hereby certify the foregoing to be the evidence of Audrey Davis, given under oath before me on the 29th day of August, 2024, recorded stenographically and later transcribed by me.

Rachel Thompson
Court Reporter
Commissioner of Oaths (expiring November 2024)

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Court File No. CV-21-00077817-0000

ONTARIO

SUPERIOR COURT OF JUSTICE

BETWEEN:

KRISTEN HEEGSMA, DARRIN MARCHAND, GORD SMYTH, MARIO MUSCATO, SHAWN ARNOLD, BRADLEY CALDWELL, CHRISTINE DELOREY, GLENN GNATUK, TAYLOR GOGO-HORNER, CASSANDRA JORDAN, JULIA LAUZON, AMMY LEWIS, ASHLEY MACDONALD, COREY MONAHAN, MISTY MARSHALL, SHERRI OGDEN, JAHMAL PIERRE, LINSLEY GREAVES and PATRICK WARD

Applicants

and

CITY OF HAMILTON

Respondent

AFFIDAVIT OF BENJAMIN HOGNESTAD

I, Benjamin Hognestad of the City of Toronto, in the Province of Ontario, MAKE OATH AND SWEAR AS FOLLOW:

1. I am a Staff Lawyer for the Community Legal Clinic of York Region. As such, I have knowledge of the matters hereinafter deposed to, except where stated to be based on information and belief. As to those matters, I verily believe them to be true.

2. On or about June 3, 2019, the federal government National Inquiry into Missing and Murdered Indigenous Woman and Girls (MMIWG) released its final report titled "Reclaiming Power and Place".

3. As part of my work as a lawyer in the Clinic, I have reviewed the relevant portions of the report, "Reclaiming Power and Place: The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls." A print-out of the said relevant portions is attached hereto and marked as **Exhibit "A"** to this affidavit.

4. The relevant portions include:

   - Volume 1a – a portion of Chapter 7 and Chapter 8, the cover and table of contents; and
   - Volume 1b – a portion of chapter 11 and a page containing some of the Calls to Justice.

5. I make this affidavit to provide background context for the matters considered in this application and for no further or other purpose.

Sworn before me at the City of Richmond Hill in the Province of Ontario this 7th day of June, 2024.

Sharon Crowe
A Commissioner for Taking Oaths, etc.

Benjamin Hognestad

A5094

National Inquiry into
Missing and Murdered
Indigenous Women and Girls

This is Exhibit "A" referred to in the affidavit of Benjamin Hagnestad sworn before me, this 7 day of June 2024

Sharon Cowie
COMMISSIONER, ETC.

RECLAIMING POWER AND PLACE

THE FINAL REPORT
OF THE NATIONAL INQUIRY
INTO MISSING AND
MURDERED INDIGENOUS
WOMEN AND GIRLS

Volume 1a

A810

Reclaiming Power and Place: The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls, Volume 1a

Cette publication est également disponible en français :

Réclamer notre pouvoir et notre place : le rapport final de l'enquête sur les femmes et les filles autochtones disparues et assassinées, volume 1a

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The Saa-Ust Centre, for the star blanket community art piece

Christi Belcourt, for *This Painting is a Mirror*

Table of Contents

Preface

Acknowledgements 1

Foreword by Chief Commissioner Marion Buller 5

Foreword by Commissioner Michèle Audette 7

Foreword by Commissioner Qajaq Robinson 9

Foreword by Commissioner Brian Eyolfson 11

Messages from the Directors 13

Reflections from the National Family Advisory Circle (NFAC) 15

Our Women and Girls Are Sacred: Reflections from the National Inquiry Elders and Grandmothers Circle 33

Introduction to the Final Report: Understanding Violence against Indigenous Women, Girls, and 2SLGBTQQIA People 49

Introduction to Section 1: Establishing a New Framework 89

CHAPTER 1: Centring Relationships to End Violence 93

- Introduction: Building a Solid Foundation 93
- Why Start with Relationships? 95
- Encounters That Make a Difference 98
- An Intersectional Approach to Encounters 102
- Four Pathways That Maintain Colonial Violence 111
- Indigenous Women, Girls, and 2SLGBTQQIA People as Rights Holders 117
- Promoting and Maintaining Healthy Encounters 122
- Conclusion: Bringing It All Together 124

CHAPTER 2: Indigenous Recognitions of Power and Place 129

Introduction: Women Are the Heart of Their Communities 129

Two-Eyed Seeing: Diverse Legal Orders and Inherent Indigenous Laws 132

Understanding How Laws Are Lived, in Community 137

Stories as Rights, Stories as Medicine 140

Indigenous Expressions of the Right to Culture, Health, Safety, and Justice 145

Existing Systems of Relationship, Governance, and Identity 162

Conclusion: Finding Solutions through New Relationships 173

CHAPTER 3: Emphasizing Accountability through Human Rights Tools 181

Introduction: Why Human Rights? 181

The International Human Rights Context 183

Applying International Human Rights Instruments to Ensure Accountability 199

Domestic Rights Instruments in Canada 202

Indigenous Rights and Human Rights: A Complicated Relationship 218

Conclusion: Understanding the Need for Self-Determined Solutions 221

CHAPTER 4: Colonization as Gendered Oppression 229

Introduction: The Context of Colonization for Indigenous Women, Girls, and 2SLGBTQQIA People 229

Understanding Colonization as a Structure 231

The Logic of Discovery: Early European Exploration among First Nations and Impacts on Gender Relations 234

A Religious Enterprise: Early Colonization among First Nations and Métis 236

The Early Colonial Context of Violence against Gender-Diverse People 239

Complex Relationships in Fur Trade Country 241

For Queen and Country: Shifting First Nations Experiences within the Context of Canada 244

Colonial Encounter: Distinctive Métis Experiences 283

Colonial Encounter: Distinctive Inuit Experiences 294

Conclusion: A Crisis Centuries in the Making 312

Introduction to Section 2: Encountering Oppression 321

CHAPTER 5: Confronting Oppression – Right to Culture 327

Introduction: Identity and Culture 327

Defining "Culture" 329

Pathway to Violence: Intergenerational and Multigenerational Trauma 331

Deeper Dive: The Need for a Systems-Level Approach to Transforming Child Welfare 339

Pathway to Violence: Social and Economic Marginalization 379

Pathway to Violence: Lack of Will and Insufficient Institutional Responses 381

Deeper Dive: Media and Representation 385

Pathway to Violence: Denying Agency and Expertise in Restoring Culture 397

Self-Determined and Decolonized Systems 399

Linking Culture to International Human Rights Instruments 402

Conclusion: "Stop making an industry out of me" 406

Findings: Right to Culture 408

CHAPTER 6: Confronting Oppression – Right to Health 413

Introduction: Connecting Health and Safety 413

Defining "Health" 414

Current Approaches to Health in Canada 418

Pathway to Violence: Intergenerational and Multigenerational Trauma 420

Pathway to Violence: Social and Economic Marginalization 442

Deeper Dive: Understanding Distinctive Experiences of Danger in the Lives of 2SLGBTQQIA People 447

Pathway to Violence: Lack of Will and Insufficient Institutional Responses 461

Deeper Dive: Issues Specific to Inuit and Remote Communities 472

Pathway to Violence: Denying Agency and Expertise in Restoring Health 488

Connecting to International Human Rights 493

Conclusion: Creating a New Normal 497

Findings: Right to Health 498

CHAPTER 7: Confronting Oppression – Right to Security 503
Introduction: "We're not safe. Nobody is safe." 503
Defining "Human Security" 504
Pathway to Violence: Intergenerational Trauma and Interpersonal Violence 508
Pathway to Violence: Social and Economic Marginalization 519
Deeper Dive: Understanding Intersectional Métis Experiences 526
Deeper Dive: Enhancing Interjurisdictional Cooperation to Promote Safety 561
Pathway to Violence: Lack of Will and Insufficient Institutional Responses 575
Deeper Dive: Resource Extraction Projects and Violence Against Indigenous Women 584
Pathway to Violence: Denying Agency and Expertise in Restoring Safety 595
International Human Rights Instruments and Human Security 608
Conclusion: Challenging "the way it is" 612
Findings: Right to Security 614

CHAPTER 8: Confronting Oppression – Right to Justice 621
Introduction: "Safety and justice and peace are just words to us" 621
Defining "Justice" 623
Pathway to Violence: Intergenerational and Multigenerational Trauma 627
Pathway to Violence: Social and Economic Marginalization 631
Deeper Dive: Criminalizing and Incarcerating Indigenous Women 635
Pathway to Violence: Lack of Will and Insufficient Institutional Responses 648
Deeper Dive: The Sex Industry, Sexual Exploitation, and Human Trafficking 656
Deeper Dive: The Need to Reform Law Enforcement to Increase Safety 674
Pathway to Violence: Denying Agency and Expertise in Restoring Justice 703
International Human Rights Instruments and Principles of Justice 711
Conclusion: Reinventing the Relationship 715
Findings: Right to Justice 717

A5100

CHAPTER 7

Confronting Oppression – Right to Security

Introduction: "We're not safe. Nobody is safe."

Across the country, the right to security held by Indigenous women, girls, and 2SLGBTQQIA people is routinely compromised. As families, survivors, and others shared their truths with the National Inquiry, it became clear that, for the majority of Indigenous women, girls, and 2SLGBTQQIA people living in all settings and regions, security is a key area where violence against Indigenous women and girls can and should be addressed. As we heard, Indigenous women, girls, and 2SLGBTQQIA people live with an almost constant threat to their physical, emotional, economic, social, and cultural security. As Bernice C., who spoke in Winnipeg, observed when speaking about her daughter, who went missing on her 18th birthday in 2008: "We're not safe. Our women are not safe anymore. Nobody is safe."[1]

This chapter examines the right to security with reference to the four pathways that maintain colonial violence. We examine the ways that the security of Indigenous women and girls is compromised by interpersonal violence, and how the risk of interpersonal violence is heightened by such factors as intergenerational trauma, poverty, homelessness, addictions, and barriers to education, training, and employment, as well as a lack of anti-violence services and supports. In addition, we explore how the absence of basic economic, social, and political rights that can guarantee security contributes to the targeting of Indigenous women and girls. We then explore how an unwillingness on the part of institutions to address these issues maintains a status quo that ensures that the crisis continues, and how, ultimately, the solutions required to restore security, as understood in a holistic way, lie within the experiences and the knowledge of Indigenous women, girls, and 2SLGBTQQIA people themselves.

Like many of the witnesses who shared their story of a lost loved one, Cee-Jai J. talked about her sister, Norma, who went missing from Vancouver's Downtown Eastside on September 28, 1992, and was found deceased a few days later. Twenty-five years later, to the day of her sister's death, Cee-Jai's daughter Shayla J. died after a car accident on September 28, 2017, when police took her home, rather than taking her to a hospital. As in the lives of so many of the other families and support people who shared their truths, the violent act that took the life of their loved one was only one of many incidents of violence in their lives. When Cee-Jai spoke about her sister's murder, she contextualized this act of violence as part of her own story of violent encounters and relationships she had experienced and witnessed, beginning from when, as she puts it, "I was just a baby in the crib."[2]

Like many of the witnesses, Cee-Jai experienced repeated acts of physical, sexual, and psychological violence throughout her entire life. From witnessing her father stab her mother when she was very young, to witnessing her mother being physically beaten and abused by men as a young girl, to repeated sexual and physical abuse and neglect in various foster homes, to the sexual assault and physical violence she experienced as a teenager and adult, violence permeates Cee-Jai's life story, and her relationships reflect a truth that is unfortunately not uncommon. She shared, "I feel like my spirit knows violence," summarizing what many Indigenous women, girls, and 2SLGBTQQIA people experience as the almost constant presence of violence that contributes to an overall absence of basic human security.[3]

Defining "Human Security"

In many of the Indigenous world views presented within the context of the Truth-Gathering Process, the right to security includes both a physical right and a social right. International covenants and conventions also take a broad look at the concept of "security" as being both physical and social.

This broad sense of human security draws from an approach that places well-being at its very centre, and that recognizes complex economic and social interactions – encounters – that work to shape security, or a lack of security, in a person's life.[4] It moves human security beyond the agenda of the state alone, and instead considers other factors or "non-traditional" threats such as poverty, disease, and the roots of issues such as the crisis of missing and murdered Indigenous women, girls, and 2SLGBTQQIA people.

"I FEEL LIKE MY SPIRIT KNOWS VIOLENCE."

Cee-Jai J.

STATE SECURITY VS. HUMAN SECURITY

State Security

- Protects the state and its boundaries, as well as its institutions.
- Defends the state from external aggression; ability to defeat an attack.
- The state works to ensure its own survival.
- State security relies on military strategies and defense, including armament, alliances, and other state-level structures and processes.

- People-centred and focused on security of individuals and of groups within the state.
- Expanded definition of threats, which can include things like environmental threats, as well as economic and social threats, food insecurity, and more.
- Involves not only governments but also internal organizations, including government organizations, community groups and other organizations.
- Based on the idea of going beyond protection to empower people as participants in ensuring security; in this model, people affected are direct contributors to solutions.

Human Security

The concept of human security was redefined in the 1990s, after a focus on military or traditional state security that went hand-in-hand with the Cold War period. As researcher Taylor Owen explains, the fall of the Berlin Wall made it clear that the biggest threats to human security might not come from militarized states anymore. Instead, citizens in the post-Cold War period "were being killed by the remnants of proxy wars, environmental disaster, poverty, disease, hunger, violence and human rights abuses."[5] In this context, the focus on the state as the only means for human security actually served to mask many of the ongoing human security crises targeting people all over the world.

In 1994, the United Nations Development Programme's (UNDP) "Human Development Report" (HDR) laid out four primary characteristics of human security, including that it is universal, that its components are interdependent, that it is best ensured through prevention, and that it is people-centred.[6] Importantly, it is *not* focused on militarized or state security apparatus, but on the safety of persons living in states, as conceived broadly and within the context of human rights. More specifically, the 1994 HDR listed seven "essential dimensions" of human security:

- economic security threatened by poverty;
- health security threatened by injury and disease;
- personal security threatened by various forms of violence;
- political security threatened by political repression;
- food security threatened by hunger and famine;
- environmental security threatened by pollution, environmental degradation, and resource depletion; and
- community security threatened by social unrest and instability.[7]

These elements are not comprehensive, as the HDR pointed out, but are dynamic and could be analyzed to understand the "particular threats experienced by particular groups of people, as well as the participation of those people in the analysis process."[8] They are also all interconnected, in that the threat to economic security is also linked, for instance, to threats to personal and political security, as well as to health. As Secretary-General of the United Nations Kofi Annan explained in 2000:

> Security can no longer be narrowly defined as the absence of armed conflict, be it between or within states. Gross abuses of human rights, the large-scale displacement of civilian populations, international terrorism, the AIDS pandemic, drug and arms trafficking and environmental disasters present a direct threat to human security, forcing us to adopt a much more coordinated approach to a range of issues.[9]

As it is commonly understood today, and as adopted by UN Resolution in 2012, the common understanding of human security now includes:

- the right of people to live freely and with dignity, free from poverty and despair, including freedom from fear and freedom from want;
- a people-centred and comprehensive approach that understands context-specific threats and that contributes to the empowerment of people;
- an approach that recognizes the connections among peace, development, and human rights, and that considers civil, political, economic, social, and cultural rights as interdependent and indivisible;

- an approach that does not include the threat or use of force or coercion, and that does not replace state security;
- national ownership, or, in other words, programs and policies that consider the distinctions among nations, and that work to strengthen national solutions that "are compatible with local realities";
- a primary responsibility for government to ensure the "survival, livelihood and dignity of their citizens"; and
- a full implementation of human security with respect for the UN Charter and the sovereignty of nation-states.[10]

As UN Deputy Secretary-General Asha-Rose Migiro remarked in 2012,

> Let us remember that human security is more than an abstract concept. For a hungry family, human security means dinner on the table. For a refugee, human security is shelter and safe haven from the storms of conflict or disaster. For a woman caught in conflict, human security is protection from harm. For a child living in poverty, human security is the chance to go to school.[11]

DEFINING HUMAN SECURITY

For Indigenous women, as the testimonies showed, threats to human security and to their basic human rights occur on a daily basis. For them, human security means the ability to live in the world without being under a constant threat of violence or harm; the ability to say goodbye to children going out with their friends, and not wonder if they will ever return; and, among other issues, the ability to start a family, to raise children, without worrying about their being targeted by racism and discrimination, or being apprehended unfairly. Witnesses discussed security in a physical sense, as the right to life, liberty, and personal safety, including control over one's own physical and mental health. They also identified the need for protection and social assistance through essential services in areas of health, housing, access to water, food, and education, and, most notably, the overall reduction of poverty, as it impacts levels of violence. In this context, safety and security are guaranteed through the pursuit and maintenance of relationships that are respectful, equal, and safe. Security is more than a physical condition; it is also a deeply felt experience of belonging, purpose, trust, connection, and harmony with the broader human, natural, and spiritual world.

Looking to what families and survivors told us about violence and the lack of safety in their daily lives challenges attitudes and beliefs that often blame Indigenous women themselves for the lack of safety in their lives, because it becomes clear that the source of that lack of safety is in the colonial structures within which Indigenous women live, rather than in the women themselves.[12] This way of thinking about security also makes clear that restoring security – as we will discuss in the upcoming chapter – requires much more than band-aid solutions, and requires creating substantive and systemic change in areas this report has identified and that are at the root of violence against Indigenous women, girls, and 2SLGBTQQIA people. As we heard from the voices of families and survivors, restoring security requires collective, Indigenous-led solutions that start by addressing the root causes of violence that so pervasively deny this basic human right.

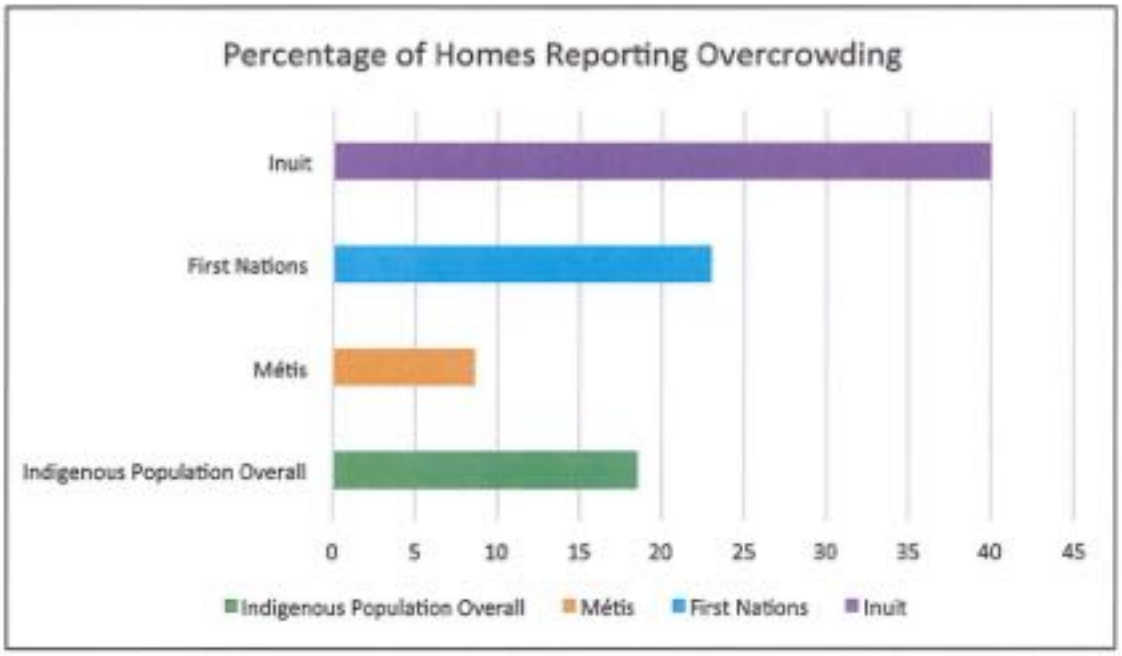
Pathway to Violence: Intergenerational Trauma and Interpersonal Violence

As Cee-Jai's story demonstrates, the security of Indigenous women and girls is threatened in ways that include, but go far beyond, a single act of physical violence. Addressing the violence that has caused the disappearance or death of Indigenous women, girls, and 2SLGBTQQIA people must consider how these specific acts of violence are the outcome of the long-term, multi-faceted denial of measures that foster and protect the security of Indigenous women throughout their lives.

Drawing on her many years of experience working with Indigenous women and their families whose lives have been impacted by violence, Expert Witness Josie Nepinak, executive director of Awo Taan Healing Lodge Society, an Indigenous women's emergency shelter in Alberta,

Housing

For First Nations, Métis, and Inuit women, one of the ways poverty impedes them in seeking safety is in their search for safe, affordable, and accessible housing. Across the country, family members, survivors, Knowledge Keepers, and others drew attention to the link between the lack of access to safe housing and violence. The lack of availability of safe and affordable housing in many First Nations, Métis, and Inuit communities is well documented. In 2016, according to Statistics Canada, close to one-fifth (18.5%) of the Indigenous population lived in housing that was considered not suitable for the number of people who lived there.[64] Specifically, of those living in crowded housing, 8.6% of Métis, 23% of First Nations, and 40% of the Inuit population lived in these conditions.[65]



For Indigenous women, girls, and 2SLGBTQQIA people living in poverty, access to housing, especially within remote or isolated communities, is especially difficult. Violence may be compounded by both crowded living arrangements, as well as the difficulty in accessing housing at all for a variety of different reasons including economic capacity and availability of housing. For instance, according to Statistics Canada data for 2016, Inuit living in Nunangat were more likely to live in crowded housing than those who lived elsewhere in Canada, and within Inuit Nunangat, half (51.7%) of the Inuit population lived in crowded housing.[66] Inuit families of loved ones who died from intimate partner violence often mentioned the shortage of housing in Inuit Nunangat, the overcrowding, the incidence of infectious diseases, and the violence that inevitably follows overcrowded homes. According to ITK, "Crowded housing is associated with high rates of communicable disease (such as tuberculosis), stressors that can lead to friction and violence

between family members, poor conditions in which children must learn and study, and other challenges."[67] The 52% of Inuit in Inuit Nunangat who live in crowded homes do so at a rate about six times greater than the rate for non-Indigenous People in Canada, and nearly a third of Inuit live in homes in desparate need of repair. As ITK points out, "This clearly shows the inequity between Inuit and others with regard to housing suitability and gives concrete evidence to what most Inuit already know anecdotally: that Inuit face a housing crisis which needs to be addressed."[68] This echoes testimonies heard by the National Inquiry where, repeatedly, families referred to the lack of housing and shelters for Inuit women seeking refuge from abuse and violence at home.

The report of the Standing Senate Committee on Aboriginal Affairs, *We Can Do Better: Housing in Inuit Nunangat*, documented the threat to the health and safety of Inuit families due to the housing crisis in 2017. The housing crisis in Inuit Nunangat has been of deep concern for Inuit families for many years. Within the communities, the lived experiences of Inuit men, women, and children stem from the reality of overcrowded housing: the lack of affordable homes, hidden homelessness, infectious diseases such as tuberculosis, respiratory infections, mental illness, vulnerability of children in experiencing or witnessing violence and abuse, and high rates of domestic violence. The issue of safe housing came up over and over again among Inuit who told their truths about themselves or their loved ones to the National Inquiry in Inuit Nunangat.

While the issue of safe housing in Inuit Nunangat was prominent, First Nations and Métis Peoples also face their own challenges. First Nations people were also more likely to live in a crowded dwelling on-reserve than off-reserve: 36.8% living on-reserve and 18.5% living off-reserve lived in crowded housing.[69]

In his testimony, Lance S. spoke about the condition of housing on reserves in Saskatchewan and how these conditions impact the health and well-being of community members.

> The poverty line that's out there, you know, the housing that's out on the reserves, the water that's out there – you know, there's a lot of things that us First Nations people on reserves, we still live like that today, that we lived 30 to 40 years ago, we still live that today. We still live in those old houses. Those old houses that are on these reserves are still being used. People, the Elders are getting sick from all that stuff.[70]

Minnie K. echoed these same concerns about safety and overcrowding in her description of housing in her community.

> Yes. Well, I did kind of look around at things like the families that are living in homes today. The homes they're living in today are not suitable for them.They're living in these homes that – well, their homes are crowded.Their homes are built, and so many families are in homes today that there's no room. And, also, that they built places they shouldn't be built and in rock piles and things and whatever. There's no spaces for kids to play even or anything like that.[71]

During the Heiltsuk Women Community Perspective Panel, Mavis Windsor spoke about how overcrowded and otherwise unsafe housing put First Nations women and girls in her community of Bella Bella, British Columbia, at an increased risk for violence.

> More often than not we have homes in our community where there are three or four families living together in very crowded circumstances and that affects the health and well-being of – of not only you know, the women in the family, but the men and the children, it can create situations where there's tension and you know, just it's not a very healthy situation.[72]

In her testimony, Rebecca M. talked about the housing-related challenges faced by Indigenous women living in Halifax, and how these challenges create a sense of insecurity.

> Housing security is a big issue for a lot of the Indigenous women that I know back home. So, like, for me and my family, we're always sort of, like teetering on whatever.
>
> Yeah, so I think that housing security – well, I can only speak of Halifax really, but that's a reoccurring issue that I always see our women struggle with. And it's for all kinds of different reasons, you know. It's not always just financial, you know. Like, a lot of the times I have a full-time job, or I'll have the money, but it's just either difficult to get one, find one.... Yeah. Or – or you have to leave one that you're at for whatever reason. Like, it could be, like I said, domestic, or it could be – it could be unsafe in some way, or – or it could have like, problems, but housing is – is a big issue.[73]

As scholars Ian Peach and Kiera Ladner point out, such conditions of vulnerability are direct corollaries to the urban migration of women, which, in turn, creates the conditions for women to go missing and be murdered, therefore perpetuating marginalization, rather than addressing it.[74]

"THE POVERTY LINE THAT'S OUT THERE, YOU KNOW, THE HOUSING THAT'S OUT ON THE RESERVES, THE WATER THAT'S OUT THERE – YOU KNOW, THERE'S A LOT OF THINGS THAT US FIRST NATIONS PEOPLE ON RESERVES, WE STILL LIVE LIKE THAT TODAY, THAT WE LIVED 30-40 YEARS AGO, WE STILL LIVE THAT TODAY. WE STILL LIVE IN THOSE OLD HOUSES. THOSE OLD HOUSES THAT ARE ON THESE RESERVES ARE STILL BEING USED. PEOPLE, THE ELDERS ARE GETTING SICK FROM ALL THAT STUFF."

Lance S.

Speaking about housing in the Northwest Territories, Pertice Merritt provided an example of the way the loss of even one residential structure can create significant challenges for the population, especially for women experiencing violence.

> And, I want to particularly mention transitional housing because that's what came to my mind to draw me back to this, because you may have heard in the news recently that [transitional housing apartments] in Yellowknife burned to the ground. This is where the

YWCA was housed. This was where transitional housing occurs. This has displaced 33 families. And, as I was preparing my – for the conference and to resolve the emergency protection orders, I said to ... the executive director, "This is an emergency protection order waiting to happen." And she said, "Pertice, it's already happened. They've moved people into other housing across Yellowknife, not with a security guard, and one woman has recently had her door kicked in and does not feel secure."

So, what they were providing in 2017–18, the YWCA provided transitional housing up to one year to 57 families and 94 children, and there were 21 youth in Hope's Haven, as we said, and the Yellowknife's Women's Society opened eight semi-independent units for single women.

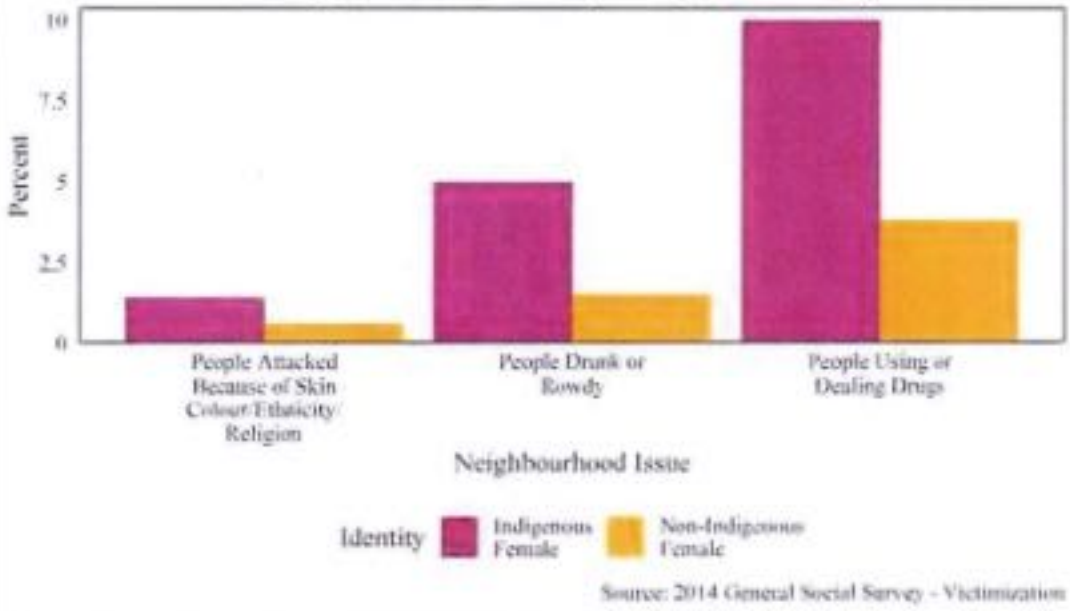
So, I think we have a further crisis brewing for our small population. And the numbers may not seem large to you, but we're a small population really spread across the North, and as an Elder said to me once in the community, "I count as a person."[75]

In other testimony, we heard how women whose relationships break down because of violence are then faced with challenges related to housing because of community policies or practices. Michele G. described how, because of band policy, she was not allowed access to her marital home.

Soon we decided to separate and divorce and it became a fight for who would get the marital home on the reserve that was in both our names. Because you can't sell the land on reserve – it's Crown land – you have to revert to band policy. I remained living in the house with my three kids and I became subjected to violence by some members of his family who didn't want me in there. One day I had 100 rotten fish dumped on my yard and a bicycle thrown through the front window. I wasn't home but my six kids were and they phoned 911 and hid in an upstairs closet terrified, but the police didn't attend. When I got home I was livid. Talked to some sergeant in [a police department] who apologized and said they thought it was a prank. I went to Chief in Council about the lack of policy to protect women from being shoved out of homes on the reserve to go live in poverty in the east end. They had no answer for me. I left the reserve at that time.[76]

For Indigenous women living in urban settings, or for the many Indigenous women, girls, and 2SLGBTQQIA people who decide to leave their community, access to safe and affordable housing continues to be a problem that puts them at additional risk for violence. For example, Jennisha Wilson, programs manager with Tungasuvvingat Inuit, talked about how, for Inuit women who resettle in the South, the only options for affordable housing are often in neighbourhoods where there are higher levels of violence and police presence: "Within Ottawa, Vanier tends to be one of the hubs where a lot of Inuit live. It also tends to be the number one spot that has the highest rates of sexual assault within the province. It also happens to be a place where surveillance and policing happens constantly." For Wilson, again, it is important to position these challenges in accessing safe and affordable housing within a colonial context that continues to jeopardize

women's security and safety. For her, the high number of First Nations, Métis, and Inuit women living in low-income, high-crime neighbourhoods is an example of "how violence is rearticulated through geography."[77]



Indigenous women were 3.3 times more likely to report people being drunk or rowdy in their neighbourhood, 2.3 times more likely to report someone being attacked due to skin colour or ethnicity or religion, and 2.6 times more likely to report people using or dealing drugs than non-Indigenous women.

In her testimony, survivor Rebecca M. talked extensively about the difficulties she faced as a low-income First Nations woman seeking housing in Halifax. She spoke about how she perceived a connection between living in an unsecure public housing unit in Halifax and the increased likelihood of violence.

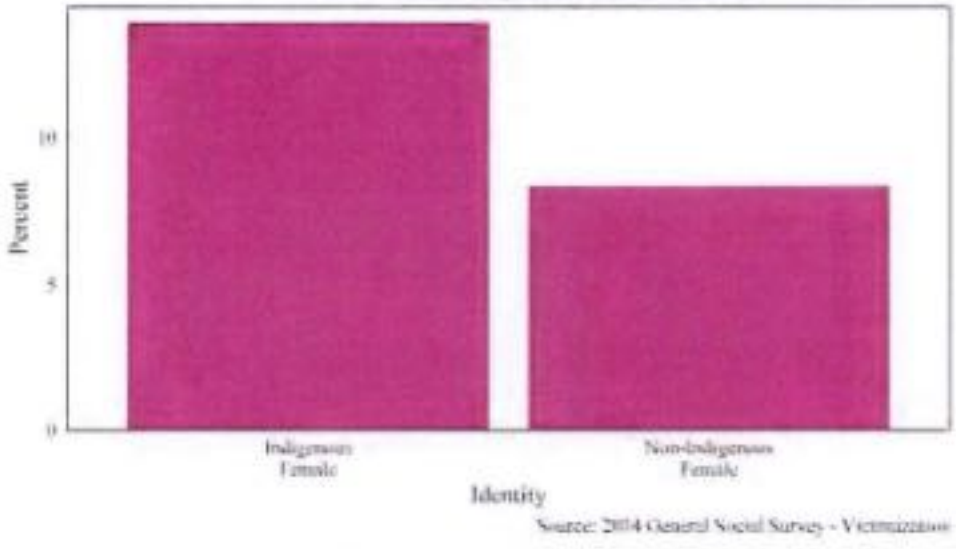
> [T.] Housing, that's Native housing in Halifax, so it's like public housing for Native people. And – and they're really slummy. They're like slum lords, so they have a lot of problems. The apartment – me and [my sister] lived there, we lived there for five years. The back door … was insecure, so like the wind could blow it in, and stuff, and it was like that the whole five years.
>
> From before we moved in to after, and it eventually led – so it was insecure the whole time, and even though I stressed to them, "You know, it's – it's me and my sister, my younger sister, like, we're young women and we live on our own, and you know, it's really unsafe," they never fixed it.

There was one time when I caught – we caught somebody trying to break into our place, and – like, I chased him down the road and everything. And then I called [T.] Housing, flipping out, because our back door wasn't secure. And they sent someone in and they just – I said they put an Indian lock on it, because they cut a two by four and then they put it between the back stair and the back door and they left it like that.

They said that they were going to order another door and – and it never came, never showed up. They never did anything about it, so needless to say they didn't really give a – a crap about me and my sister's safety at all.[78]

For Rebecca, unsafe housing was even more troubling because of other violence she faced in her life from a partner who was violent and who had previously breached orders to stay away from her. Not surprisingly, Rebecca's sense of a lack of physical and emotional security was compromised because of the threat of violence compounded by unsafe housing. As she described:

And so I kept on having nightmares of that person breaking in to my house because they knew where I lived. And so I couldn't really sleep well there, so when they were – they were in jail for a month, until their court date. And during that time, because I was really worried about what this person might do when they got out, I ended up … moving to the other end of the country. So I moved to Vancouver.[79]



14% of Indigenous women were victims of stalking in the last five years compared to 8.3% of non-Indigenous women; Indigenous women are 1.7 times more likely to be victims of stalking overall.

When Rebecca – like so many other Indigenous women – is forced to move in an attempt to restore safety, she is placed in additional danger.

For 2SLGBTQQIA people, access to safe housing within their territory or community may be complicated by sexism, transphobia, homophobia, and other discriminatory beliefs about gender identity, expression, and sexual orientation. Marge H. described how, as a lesbian, she was pressured to leave her community.

> I was outed from my community because I was a lesbian. I'd – there was no room … it was suggested by various family members for me to take a vacation. So I was working in the cannery at the time. And I was – saved up a couple of cheques. And I got on the – the ferry boat to Vancouver. And it really hurt because [of] the way I was treated. I had no – I lost friends really quick. And there was, of course, rumours and gossip, and stuff like that. And – so I left.[80]

Viola Thomas also commented on the lack of safety faced by 2SLGBTQQIA people in their communities and the pressures this puts on them to move.

> For many Two-Spirited people, they end up being displaced from their territory and from their communities because they're – they don't feel safe and they don't feel welcome because of their uniqueness. And so you have a large population of Two-Spirited peoples across the country that end up moving to urban areas, so that they have a space where they can feel a likeness to other folks and feel welcome for who they are.[81]

For many who are pressured or forced to move, these same problems exist within the city. For Jamie L. H., these concerns about finding safe, affordable housing are also complicated as she gets older and realizes the lack of housing options for aging transwomen and Two-Spirit people.

> I've been studying a model down in Mexico for Indigenous, retired women and they – and they have this home and it's a place that they live together in community. And I would like to see places like that for our LGBTQ+ communities. And, you know, we need that because I think right until you exit physically this earth, you need that sense of love and belonging. And so I fear the most that, you know, if I get really ill, where am I going to be put? And you know, so I think we need to address that.[82]

Homelessness and Exploitation

For many Indigenous women, girls, and 2SLGBTQQIA people, poverty makes access to any form of housing impossible, and they are forced to live in shelters, on the street, or in other forms of precarious housing. In sharing the circumstances leading up to the disappearance or death of their loved one, many family members described how their loved one was homeless or precariously housed at the time of her disappearance or death. For example, Cee-Jai explained that it was when

her sister was living on the street that she was murdered. Despite Cee-Jai's efforts to protect her sister, the vulnerability she faced as an Indigenous woman living on the street was too great.

Monique F. H., who now works as an advocate with an AIDS organization, drew on her own memories of her life as a young homeless girl living on the streets and the fear she lived in as a result of the almost constant threat to her security and safety.

> The violence that I experienced in my life has made me I think, more understanding to the women that I work with. A lot of them don't realize when I hear their stories, I hear myself, so when I was – when I was younger and on the street it was very – very difficult.
>
> I remember seeing girls getting beaten up all the time. Shooting up. Living that lifestyle. Always fearful of what was going to happen next. And I was scared even though I may not have acted scared, I was scared.[83]

In sharing her experiences of living on the streets, Marlene J. talked about how violence becomes a way of life – and often something she endured to meet her basic needs for housing and food.

> I would say I was raped three sometimes four times a week.... I was just trying to survive. I was drinking a lot to not have the pain. I was always drunk. I drank pop to kill the pain of hunger. I'd steal. Go in the liquor store and steal bottles of booze. I'd be drunk and then I ended up with these men. They figured oh yeah we're going to have a party and then end up being raped. How many parks I had to crawl out of. I was always alone.[84]

Poverty can also contribute to violence because of the way people may use drugs and alcohol to cope with the challenges associated with having no money or home. As Marlene explained, alcohol allowed her to survive the violence, hunger, and emotional pain she endured on the streets, even though it increased the risk that others would target her for violence.

> These people that had raped me, they pretended to be my friend. They said, "We can just sit and talk." Because I was homeless they decided that they would take advantage of the situation. Sometimes I'm drunk I don't remember, but I do know – I don't know. Like I said, being in residential school what they tell you every day that you'll amount to nothing sort of sticks with you and then you just don't care about yourself the way you should.[85]

Mealia Sheutiapik, an Inuk woman who shared her experience of homelessness on the streets of Ottawa, talked about how drug use became a way of surviving not only the harsh living conditions but also the trauma she carried with her as a result of the violence she had witnessed and the separation she felt from her family and culture.

> I was smoking hash. I didn't know any other drug that time. He got me into smoking hash. So, I tried to kill that pain when I was a witness to that murder. So, I just ended up

> carrying on and smoking hash, and it escalated to other drugs just to kill the pain and just to get numb, just to forget about that thought and what happened before. And, thinking about my grandma and my siblings, leaving them behind, I ended up using more hard drugs. And that also escalated me to go on the street and try and get more money to get high.[86]

Hearing from witnesses about the challenges poverty poses for First Nations, Métis, and Inuit women, girls, and 2SLGBTQQIA people demonstrated how the violation of their right to social security directly contributes to, and underlines, the many stories of violence, disappearance, and death shared by families and survivors.

Barriers to Education and Training

In the same way that poverty denies Indigenous women, girls, and 2SLGBTQQIA people access to housing, so, too, does it create barriers to education, training, and employment – the very tools that might stop the cycle of poverty in many Indigenous families and communities, and are known protective factors against violence.[87]

Access to education and to training and meaningful employment is a factor known to decrease the likelihood of perpetrating and being victimized by violence. In her testimony, Robyn Bourgeois, a Cree professor at Brock University and a survivor of trafficking, talked about how, for her, education empowered her and became a way of understanding her culture and the ways she might challenge colonial violence.

> I grew up feeling really empowered with school. I know that sounds funny, because for so many Indigenous Peoples, school isn't empowering. But, for me, it had always been. And I saw an opportunity.... I remember reading scholarly work by Indigenous thinkers and thinking, "This is amazing." Like, just how they can use the words of the government in particular, because I'm always obsessed with the government of Canada, and I've been struggling, you know, how to make sense of what goes on in this country in relation to Indigenous Peoples. And so, I remember thinking, "I can do that. I could do that." And so I went back to university.[88]

Likewise, in describing her experience growing up in foster care, Cheylene Moon, who participated on the Youth Panel in Vancouver, talked about how school offered a sense of security: "I loved school growing up, because it was like my safe place away from my foster homes."[89]

Security through education will become more and more important in Inuit Nunangat, as the Inuit population increases at a greater rate than in southern Canada. This makes for a very young society: Inuit children under 14 years of age comprise about 33% of the Inuit population.[90] One of the consequences of such a young population is a greater number of young Inuit mothers, and they are often single mothers. Sometimes these young mothers stop going to high school because of pregnancy. The financial strain on young single mothers makes life difficult for them and even

Findings: Right to Security

- Indigenous women, girls, and 2SLGBTQQIA people continue to experience social and economic marginalization and exclusion as a direct result of colonialism and of racist and sexist government policies. This marginalization and exclusion is the objective of the colonial policies of the Canadian state. Colonial policies violate the social, economic, and political rights of Indigenous women, girls, and 2SLGBTQQIA people, and jeopardize their rights to human security and, in turn, safety. These colonial policies are tools of genocide.
- The Canadian state has caused Indigenous women, girls, and 2SLGBTQQIA people to be removed from their homelands and territories and from their families and communities. They experience disproportionately high rates of poverty and insurmountable barriers to obtaining secure housing, food, education, employment, transportation, and other basic needs. Indigenous children and the elderly are especially vulnerable under these circumstances. Marginalization and exclusion decrease safety and increase the risk of violence, and often force Indigenous women, girls, and 2SLGBTQQIA people to remain in violent and unsafe situations or to end up in violent and unsafe circumstances in an attempt to have their basic needs met.
- The social and economic marginalization, compounded by complex and intergenerational trauma, also forces many Indigenous women, girls, and 2SLGBTQQIA people to resist the marginalization and to meet their basic survival needs by resorting to the sex industry, remaining in violent relationships, and joining gangs. This further marginalizes and endangers them. Marginalization and trauma are pervasive reasons for the institutionalization of Indigenous women, girls, and 2SLGBTQQIA people within the criminal justice system and in the child welfare system.
- The safety of Indigenous women, girls, and 2SLGBTQQIA people cannot be realized without upholding and implementing social, economic, and political rights, alongside cultural, health and wellness, and justice rights. A reliable and consistent livable income for all Indigenous women, girls, and 2SLGBTQQIA people is necessary to address the state of crisis related to their well-being and to their socio-economic and safety needs.
- Indigenous women, girls, and 2SLGBTQQIA people experience extreme rates of overcrowding and homelessness. The lack of safe housing, transition homes, and shelter impacts the health, wellness, and safety of Indigenous women, girls, and 2SLGBTQQIA people. The housing crisis is a significant contributor to violence.
- Existing social and economic services for Indigenous women, girls, and 2SLGBTQQIA people are often plagued by huge gaps in resources and infrastructure. Further, such services are often placed in unsafe areas, and are not culturally appropriate, thereby perpetuating a lack of safety and security.
- Indigenous women, girls, and 2SLGBTQQIA people continue to experience disproportionately low rates of educational achievement and high rates of unemployment. Employment opportunities and services, as well as resources to promote educational and employment success, are urgently needed as a way to combat social and economic marginalization and violence and to support community and individual safety.

The National Inquiry heard several stories from northern or more remote communities, as well, where the absence of services and poor services chronicled elsewhere in this report forced people to head south, where they were subsequently trafficked. Traffickers were cited as targeting group homes, medical travel homes, bus stations, and buses coming from remote communities, as Alaya's story also revealed. In this way, the lack of infrastructure and services in northern and remote communities feeds the sex industry and further exploitation. As the National Inquiry heard, those who exploit women, girls, and 2SLGBTQQIA people are well aware of how to target these people; they go so far as to station themselves outside of group homes or places where they know these potential victims might be, in order to bring them into human trafficking rings. In addition, studies have pointed to key recruitment areas including airports, and in particular the Montreal.[BB] Other key recruitment zones include schools, the boyfriend method (where a trafficker approaches a woman as a suitor, rather than as a trafficker),[CC] other girls or women, hitchhiking, and virtually any place that is away from home where victims can be isolated.[DD]

For many young Indigenous girls who are forced to, or choose to, leave abusive families or foster homes or want to seek out a better life for themselves, early experiences of sexual exploitation and trafficking continue into adulthood, during which engaging in survival or street-level sex work becomes a way of making ends meet. Mary Fearon explained how poverty and addiction are factors that make it necessary for Indigenous women to exchange or trade sex to meet their basic needs.

> One of the things that we see with a lot of our participants, particularly our younger participants, is survival sex. And, that idea that if they need to get a place to stay, if they're homeless, then they will often trade sex as a means to get some other need met, whether it be housing or food. Food security is a big issue. So, yes, there was – it was out of the need, that people are living in poverty in our province and across our country was certainly a big driving factor.[EE]

She continued, "One [factor] is that we recognize that 95% identify as living in poverty when they come into our program, so poverty is clearly a big indicator; that 79% have had some kind of addiction, or currently are dealing with addictions, or recovered from addictions."[FF]

Many survivors who shared their experience of poverty, homelessness, and violence talked about exchanging sex in order to meet their basic needs for food, housing, clothing, transportation, or other basic items – a practice often referred to as "survival sex work."

As Monique F. H. explained: "I slept, you know, with people for a place to live, for a place to stay, for food. But that is what survival does, that's survival for you, right? You – you do what you need to do in order to continue to live and to continue to survive."[GG]

Doris G. talked about how she turned to sex work in order to pay for housing for herself and her child.

> I needed help with [the] damage deposit, and no one would help me. It was hard being a single Native mother on welfare with an infant, so I went and found my friend, and she introduced me to her friends, otherwise known as johns, who would help me with cash. I could raise money for housing or for me and my child, for food. I remember stopping before I started to pray to Creator to keep me safe: I've got to make it home to my son.[HH]

In her testimony, Lanna Moon Perrin offered a slightly different perspective and explained that for some Indigenous, trans, and 2SLGBTQQIA people, sex work offers an empowering and financially rewarding way to support oneself and one's family.

> You know, I started with street-level sex work at 16 so that I could buy things for myself, a winter jacket, winter boots, decent food to eat. In my life, when I was young, I did experience violence on a lot of different levels, but I don't want to, in any way, frame it that it was my choice of getting into sex work that led me to be victimized.[II]

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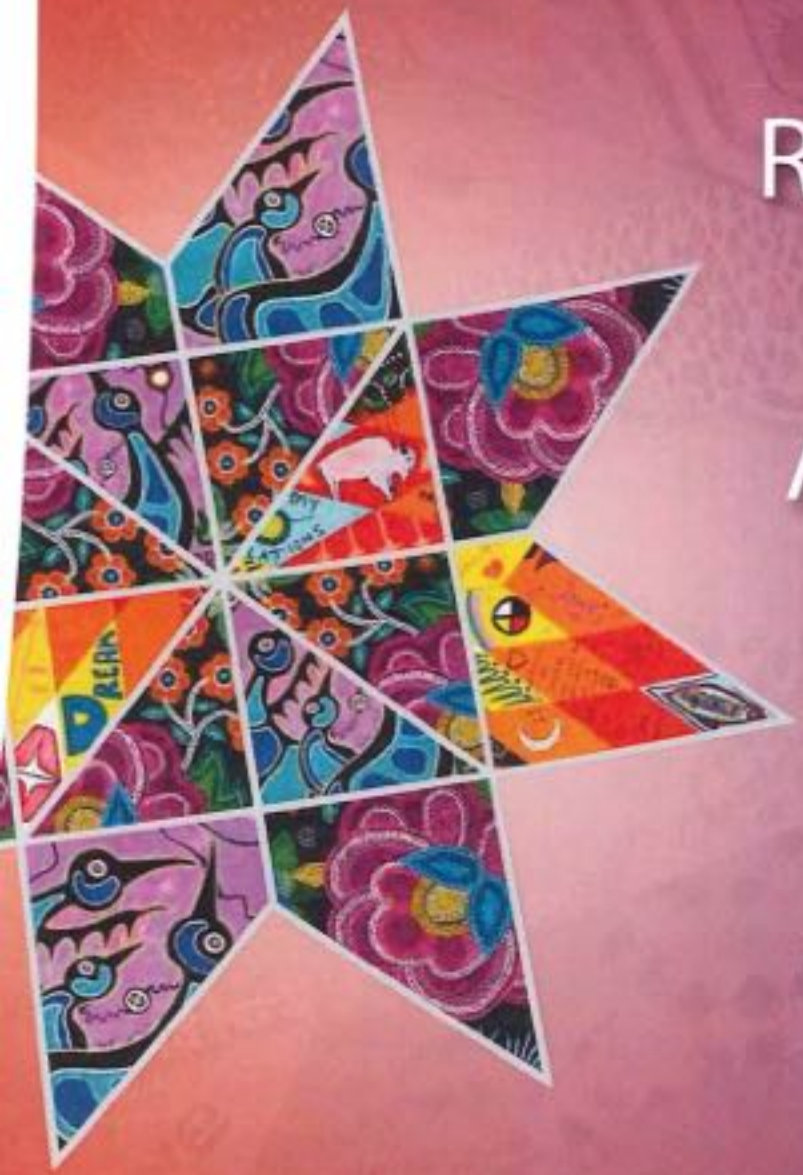
National Inquiry into
Missing and Murdered
Indigenous Women and Girls



RECLAIMING POWER AND PLACE

THE FINAL REPORT
OF THE NATIONAL INQUIRY
INTO MISSING AND
MURDERED INDIGENOUS
WOMEN AND GIRLS

Volume 1b

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Reclaiming Power and Place: The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls, Volume 1b

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Christi Belcourt, for *This Painting is a Mirror*

Table of Contents

Introduction to Section 3: Healing Families, Communities, and Nations 1

Chapter 9: Wellness and Healing 5

Introduction: Safety, Healing, and Strength 5

Healing Self and Family: Beginning the Journey 6

Families of the Heart 14

Ceremonial and Traditional Knowledge 19

"It's just a work in progress": Finding Other Outlets for Healing 27

Healing for Future Generations: Engaging Youth in Wellness 32

"We can't have only the women heal": Healing Men and Boys 37

A Lifetime of Healing 38

The Importance of Access to Healing 40

Finding Strength 41

The National Inquiry's Aftercare Program, and Lessons Learned 47

Conclusion: Respect and Connection 49

Chapter 10: "I am here for justice, and I am here for change": Commemoration and Calling Forth 53

Introduction: Beyond Commemoration 53

Commemoration and Calling Forth from the Perspectives of Families 55

The Legacy Archive 58

The Complicated Nature of Archives 60

Artistic Expressions from the Legacy Archive 63

Student and Youth Engagement Guide 75

Reclaim(ing) Power and Place: A Pilot Project 75

Conclusion: Art Actions for the Future 80

Chapter 11: Valuing Lived and Front-Line Experiences 83
Introduction: Four Guided Dialogues and the Distinctions-Based Approach 83
Promoting Empowering Research and Representation 85
Core Principles and Values for Safety 91
Exploring Safety through Four Key Themes 106
Culture as a Critical Source for Safety 107
Health and Wellness 131
Human Security Issues 141
Justice 153
Conclusion: Making Connections 165

Calls for Justice 167
Principles for Change 169
Overarching Findings 174
Calls for Justice for All Governments 176
Calls for Justice: Industries, Institutions, Services, and Partnerships 187
Calls for Justice for All Canadians 199
Calls for Justice: Distinctions-Based Calls 201
Inuit-Specific Calls for Justice 201
Métis-Specific Calls for Justice 210
2SLGBTQQIA-Specific Calls for Justice 214

An Acknowledgement of All Those Who Shared Their Truth 219

Annex 1: Summary of Forensic Document Review Project 233

Bibliography 277

List of Exhibits: Knowledge Keeper, Expert and Institutional Hearings 323

Access to Housing or Shelter

Several participants echoed the notion that access to shelter is a basic human right, and that a lack of safe and affordable housing or shelter increases risks of violence and harm, presents a barrier to fleeing unsafe situations, or forces individuals in rural, remote, or northern communities to migrate to urban centres.

> "What is it that will keep you safe? Housing – a place to go back to at night." (2SLGBTQQIA Perspectives)

> "The base [should be] that everyone have a roof over their heads. [Priority] number two is food. You can put more effort into your challenges, once you have a roof and food." (Inuit Perspectives)

Barriers to accessing housing and shelter include:

- **insufficient capacity in shelters**, including warming shelters and emergency shelters for individuals fleeing violence, as well as **lack of shelters**;
- **shortage of subsidized housing**, creating long wait-lists;
- **deferred maintenance challenges** that limit available housing or shelter space, adding financial burdens to shelter and housing organizations. This creates poor living conditions, which negatively impact the sense of self-worth of individuals in need of shelter and housing;

  > "It's very expensive to build houses, and utilities need to be upgraded. It's very hard to catch up. Maintenance services are also a big issue, especially for infrastructure. Small communities have a hard time getting things done to maintain housing." (Inuit Perspectives)

  > "[The] homeless shelter has been shut down, because of bedbug infestation. Takes a long time to get someone to clean it. It's run by an NGO [non-governmental organization], which can't afford to bring it up to code." (Inuit Perspectives)

  > "Non-profit housing is built in sub-par standards, making it seem like [clients] are not appreciated, [because] they are living in … subsidized housing." (2SLGBTQQIA Perspectives)

- **risks of discrimination in shelters**, including racism, homophobia, and transphobia;
- **lack of transitional housing** for individuals returning to communities from correctional facilities or from substance use treatment programs, or aging out of care. Participants noted that individuals at these transition points are particularly vulnerable to violence or harm, and that the lack of shelter funding from justice, health, or child welfare sectors increases the burden on shelter spaces;

"Judges are releasing men to the 'care' of a shelter, but there is not [enough] funding to house these men through the justice system, and they expect the shelter to absorb or find space for them.... [There are] men sleeping on [the] floor and in [the] kitchen." (Inuit Perspectives)

- **strict policies against substance use in shelters**, which create barriers for individuals struggling with addictions. One participant from Inuvik described her experience on the board for a men's shelter where other members lacked an understanding of addictions, espousing the belief that "if [someone] wants the shelter enough, they will stay sober." She said there was little support for "wet" shelters that allow substance use due to complications of insurance and risk management. Another participant described how substance use policies "further marginalize the already marginalized";

  "It sends the message that you're not welcome here, because you use drugs and alcohol. Some women were murdered because they used drugs. They will use drugs to stay awake and stay safe. This stigma around drug use and alcoholism makes people feel unwelcome, unsafe, and puts them on the street and at risk." (2SLGBTQQIA Perspectives)

  "The rules [for substance use] for [2SLGBTQQIA] clients in facilities cannot be so stringent. These people are at the facilities in crisis." (2SLGBTQQIA Perspectives)

  "Men in the system are in crisis. [It is] unrealistic to expect them to avail themselves of services. These men are not choosing to use. One should not have to choose using or housing." (Inuit Perspectives)

- **gender-based shelters and prioritization of women with children in housing**. This supports the safety of women and girls, but also creates complications and barriers for families, men, and 2SLGBTQQIA individuals. For instance, some participants described how policies against teenage boys in shelter spaces force women to have to choose whether to leave their sons behind when seeking emergency shelter spaces. Other women may feel safer staying with their partners on the streets instead of seeking shelter space. The prioritization of women with children limits available shelter and housing space for 2SLGBTQQIA individuals (particularly those without children) and for men, who have to leave their home during situations of family violence;

  "I wouldn't have been able to take my son with me to the shelter if I had needed to do it. Daughter, yes. That's what mothers have to think about." (Inuit Perspectives)

  "Often women on the street want to stay with their boyfriend for security reasons." (Inuit Perspectives)

  "A lot of 2S don't have housing because there are requirements to have children ... and a lot of 2S folks don't have children. That doesn't make sense. They're not included in the list." (2SLGBTQQIA Perspectives)

> "There is no transitional housing for the abuser, for these mainly men, to go, to live." (Inuit Perspectives)

- **financial barriers to public housing** for individuals who are marginally above the low-income threshold, or are receiving limited income support; and
- **inequitable access to housing**, where individuals with connections to influential people may receive preferential treatment.

Recommendations and Best Practices: Addressing the Crisis of Housing and Shelter

There was a strong call for increased and well-maintained shelters and subsidized housing in all communities, with sufficient capacity to meet current and projected demands. While many participants discussed the need for priority shelter spaces for women fleeing violence, groups also recommended establishing a variety of housing and shelter alternatives in communities, in order to meet the needs of different populations, including:

- ☑ **mixed-gender shelter and housing**, accommodating couples and families with teenage boys;
- ☑ **wet shelters** accommodating individuals struggling with substance use;
- ☑ **dedicated 2SLGBTQQIA housing and shelters**, or dedicated beds in shelters for trans and non-gender binary individuals; and

> "Establish 2S treatment centres and shelters with practitioners who are 2S themselves or [who] 'get' it." (2SLGBTQQIA Perspectives)

- ☑ **transitional housing with relevant support services** for individuals fleeing family violence, youth aging out of care, or individuals returning to communities from correctional institutions or substance use treatment programs.

Participants spoke of housing and shelter as a critical first step that establishes the security, stability, and trusting relationships needed to address more complex risk factors. Many described housing and shelter models that integrate support services, such as substance use treatment programs, employment services, cultural supports, and mental health services.

> "First, you house the person. You give them a place to live and be safe. Then you start focusing on the other issues that lead to homelessness and addictions." (Inuit Perspectives)

> "We need a place that's not like a conventional shelter, but a living space; not necessarily a permanent space, but you need space where you have access to a phone, Internet, a

> place to study, a place to get training.... You need these things to get a job. We need supports for employment. I wouldn't see it like a shelter, where there are bunk beds. We need dignity and privacy. Maybe you moved from the reserve to the city, and you don't have your supports there. Transitional housing that helps you and mentors ... you could hire 2S people to do that." (2SLGBTQQIA Perspectives)

Some participants described the importance of providing long-term housing options for individuals and families, with recommendations to increase transitions from shelter spaces to subsidized housing.

> "Shelters [are] such a dehumanizing experience.... The place you belong [to] is constantly stripped away. There's never any place you belong." (Inuit Perspectives)

> "[The] assumption was that sending men out in the cold, even in extreme cold weather, would motivate them. These men were being turned out in the morning. At 7:00 or 8:00 a.m. these Inuit men are being turned out into the cold, with harmful impacts, [including] on their self-esteem." (Inuit Perspectives)

> "Not just shelters and safe houses, but stable, reliable housing, where they can live long-term. It's not temporary, it's permanent. So, if they have children, they can go to school. Stable home.... They don't have that grounding space, to shut the door and go to bed, and then get ready for the day to go to work or school." (Inuit Perspectives)

As with other support services, participants emphasized the importance of providing culturally specific support services in shelters and housing, adapted to the identities of local clientele: for instance, including Inuit- and/or Métis-specific support services in urban shelters, and housing for those arriving from rural, remote, or northern communities.

> "For people who are not in their home communities, which are very far away, it gets really hard when they can't find a stable and safe place to rest their head. There needs to be more subsidized housing for women and families.... First Nations-specific, Métis-specific, Inuit-specific; even though we are all Indigenous, we need specific services. When you are in a vulnerable place, it is most comfortable to be with your community." (Inuit Perspectives)

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resource community-based supports and solutions designed to improve social and economic security, led by Indigenous women, girls, and 2SLGBTQQIA people. This support must come with long-term, sustainable funding designed to meet the needs and objectives as defined by Indigenous Peoples and communities.

4.3 We call upon all governments to support programs and services for Indigenous women, girls, and 2SLGBTQQIA people in the sex industry to promote their safety and security. These programs must be designed and delivered in partnership with people who have lived experience in the sex industry. We call for stable and long-term funding for these programs and services.

4.4 We call upon all governments to provide supports and resources for educational, training, and employment opportunities for all Indigenous women, girls, and 2SLGBTQQIA people. These programs must be available within all Indigenous communities.

4.5 We call upon all governments to establish a guaranteed annual livable income for all Canadians, including Indigenous Peoples, to meet all their social and economic needs. This income must take into account diverse needs, realities, and geographic locations.

4.6 We call upon all governments to immediately commence the construction of new housing and the provision of repairs for existing housing to meet the housing needs of Indigenous women, girls, and 2SLGBTQQIA people. This construction and provision of repairs must ensure that Indigenous women, girls, and 2SLGBTQQIA people have access to housing that is safe, appropriate to geographic and cultural needs, and available wherever they reside, whether in urban, rural, remote, or Indigenous communities.

4.7 We call upon all governments to support the establishment and long-term sustainable funding of Indigenous-led low-barrier shelters, safe spaces, transition homes, second-stage housing, and services for Indigenous women, girls, and 2SLGBTQQIA people who are homeless, near homeless, dealing with food insecurity, or in poverty, and who are fleeing violence or have been subjected to sexualized violence and exploitation. All governments must ensure that shelters, transitional housing, second-stage housing, and services are appropriate to cultural needs, and available wherever Indigenous women, girls, and 2SLGBTQQIA people reside.

4.8 We call upon all governments to ensure that adequate plans and funding are put into place for safe and affordable transit and transportation services and infrastructure for Indigenous women, girls, and 2SLGBTQQIA people living in remote or rural communities. Transportation should be sufficient and readily available to Indigenous communities, and in towns and cities located in all of the provinces and territories in Canada. These plans and funding should take into consideration:

- ways to increase safe public transit;
- ways to address the lack of commercial transit available; and
- special accommodations for fly-in, northern, and remote communities.

A841

Heegsma et al
Applicants

-and-

CITY of HAMILTON
Respondents

Court File No. CV-21-00077187-0000

Ontario
Superior Court of Justice

PROCEEDING COMMENCED AT HAMILTON

Affidavit of Benjamin Hognestad dated June 7, 2024

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Court File No. CV-21-00077187-0000

ONTARIO SUPERIOR COURT OF JUSTICE

B E T W E E N:

KRISTEN HEEGSMA, DARRIN MARCHAND, GORD SMYTH, MARIO MUSCATO, SHAWN ARNOLD, BRADLEY CALDWELL, CHRISTINE DELOREY, GLENN GNATUK, TAYLOR GOGO- HORNER, CASSANDRA JORDAN, JULIA LAUZON, AMMY LEWIS, ASHLEY MACDONALD, COREY MONAHAN, MISTY MARSHALL, SHERRI OGDEN, JAHMAL PIERRE, LINSLEY GREAVES and PATRICK WARD

Applicants

-and-

CITY OF HAMILTON

Respondent

AFFIDAVIT OF RACHEL LAMONT

SWORN JUNE 7, 2024

I, Doctor Rachel Lamont, of the City of Hamilton in the Province of Ontario, AFFIRM AND STATE:

1. I have personal knowledge with respect to the facts and reports set out below, except where stated otherwise. Where the information is not based on my personal knowledge, it is based upon information provided by others which I believe to be credible and true.

2. I am a physician with the Shelter Health Network (SHN) and the Hamilton Social Medicine Response Team (HAMSMaRT). These organizations provide medical care to individuals affected by homelessness or housing precarity. I have worked with SHN since May 2022. I also joined HAMSMaRT in September 2021.

3. I met with Kristen Heegsma prior to the time that the report was prepared, attached as Exhibit ‘A’ and I endorse the contents therein.
4. I met with Darrin Marchand prior to the time that the report was prepared, attached as Exhibit ‘B’ and I endorse the contents therein.
5. I met with Shawn Arnold prior to the time that the report was prepared, attached as Exhibit ‘C’ and I endorse the contents therein.
6. I met with Cory Monahan prior to the time that the report was prepared, attached as Exhibit ‘D’ and I endorse the contents therein.
7. I met with Ammy Lewis prior to the time that the report was prepared, attached as Exhibit ‘E’ and I endorse the contents therein.
8. I met with Sherri Ogden prior to the time that the report was prepared, attached as Exhibit ‘F’ and I endorse the contents therein.
9. I met with Jahmal (Jammy) Pierre prior to the time that the report was prepared, attached as Exhibit ‘G’ and I endorse the contents therein.
10. I met with Linsley Greaves prior to the time that the report was prepared, attached as Exhibit ‘H’ and I endorse the contents therein.

Affirmed remotely by Dr. Rachel Lamont stated as being located in the City of Hamilton in the Regional Municipality of Hamilton-Wentworth, before me at the Town of New Tecumseth in the Region of Simcoe on June 7, 2024, in accordance with O. Reg 431/20, Administering Oath or Declaration Remotely.

.

Commissioner for Taking Affidavits
Michelle Sutherland LSO#:70159T

……

Dr. Rachel Lamont

This is Exhibit ‘A’ referred to in the affidavit of Dr. Rachel Lamont affirmed before me this 7th day of June, 2024.

EXHIBIT ‘A’

McMaster University
DEPARTMENT OF PSYCHIATRY AND BEHAVIOURAL NEUROSCIENCES

June 20, 2023

ATTN: Sharon Crowe

RE: Heegsma, Kristen DOB: 1990-10-20

I am a psychiatrist with both the Hamilton Social Medicine Response Team and the Shelter Health Network in Hamilton, Ontario. Both services provide health care to people who are unhoused or precariously housed.

I have been Ms. Heegsma's treating psychiatrist since November 2021 and can confirm that she has diagnoses of Post-Traumatic Stress Disorder (PTSD), Borderline Personality Disorder, Generalized Anxiety Disorder, Depression, and Opioid and Stimulant use disorders (severe).

When I first met with Ms. Heegsma, another physician providing care to her had expressed significant concern for mental health and referred her to me. Ms. Heegsma had just been evicted from a tent in Corktown neighbourhood by the City of Hamilton. She had been repeatedly evicted from encampments previously. Following this particular eviction, she experienced an exacerbation of PTSD symptoms as well as severe suicidal ideation and described feeling the most desperate she had in her entire life. Additionally, because her tent had been destroyed, she was sleeping on a park bench in the days following the encampment eviction. Despite daily attempts to get into shelter, there were no spaces available. A few days after the eviction from her tent in Corktown neighbourhood and while she was sleeping on the park bench, she was the victim of a violent sexual assault. This caused additional severe worsening of her mental health conditions and substance use. She also had her belongings stolen repeatedly.

Ms. Heegsma has since spent brief amounts of time in shelter and in YWCA transitional housing, though has also been asked to leave those spaces due to her complex health needs and those services being unable to offer the required level of support. She has thus continued to spend most of her time living outside. When she is living in a tent and surrounded by community, there is notable improvement in her sense of personal safety, and we are able to initiate treatment for her conditions, and members of our team are able to reliably locate Ms. Heegsma for follow-up. Unfortunately, she is unable to remain in one place for very long due to ongoing pressure from By-Law officers and Police to move repeatedly. While Ms. Heegsma has identified goals of working toward stabilization of her mental health and substance use, her ongoing experiences of being unhoused and focus on day-to-day survival have made it very difficult for the focus of any appointments to move beyond trying to help her find ways to have her most basic survival needs met. As a result, her mental health conditions and substance use disorders have remained under-treated and continue to cause her immense suffering.

McMaster University
DEPARTMENT OF PSYCHIATRY AND BEHAVIOURAL NEUROSCIENCES

It is my opinion that repeated encampment evictions, and in particular the encampment eviction in November 2021 and subsequent sexual assault, have been a major contributor to the ongoing instability in Ms. Heegmsa's mental health and worsening of her substance use disorders over the past three years. This has been exacerbated by the ongoing lack of available, suitable shelter spaces or permanent housing options.

Please feel free to contact me should any further information be required.

Sincerely,

R. Lst

Dr. Rachel Lamont, MD, FRCPC
Psychiatrist, Hamilton Social Medicine Response Team and Shelter Health Network
Assistant Professor
Department of Psychiatry and Behavioural Neurosciences
McMaster University
Email: lamonr@mcmaster.ca
Phone: 1-833-426-7678
Fax: 1-833-563-2210

This is Exhibit ‘B’ referred to in the affidavit of Dr. Rachel Lamont affirmed before me this 7th day of June, 2024.

EXHIBIT ‘B’

McMaster University
DEPARTMENT OF PSYCHIATRY AND BEHAVIOURAL NEUROSCIENCES

Dec 14, 2023

ATTN: Sharon Crowe

RE: Darrin Marchand (DOB Oct 15 1966)

I am a psychiatrist with both the Hamilton Social Medicine Response Team and the Shelter Health Network in Hamilton, Ontario. Both services provide health care to people who are unhoused or precariously housed.

I have known Mr. Marchand since May 2023 and can confirm that he has diagnoses of Psychosis (substance-induced vs. schizophrenia), and opioid and stimulant use disorders (severe).

Mr. Marchand has shared his story with me, dating back prior to my involvement with him. He has endured numerous traumas in his life which impact the way he views himself, regulates his emotions, and relates to other people. In the summer of 2021, he was evicted from an encampment along Strachan St in Hamilton and again from an encampment on Rebecca St during that summer. Following this, he gave up on trying to stay in a tent and slept outside in the open. He describes feeling a sense of hopelessness and despair following these encampment evictions, and that his substance use escalated. For Mr. Marchand, there is a direct link between his substance use (particularly that of stimulants) and symptoms of psychosis. As his substance use escalated and mental health declined further, he continued on a downward trajectory in terms of his wellbeing. Additionally, while sleeping out in the open in Dec 2021, he was shot by a gun in the shoulder, which has contributed to additional ongoing trauma symptoms. Mr. Marchand said that he felt much more secure in a tent with community who looked out for each other, something that is not possible when sleeping alone outside, as he had resorted to doing because of repeated evictions.

RE: Darrin Marchand (DOB Oct 15 1966)

Mr. Marchand shared that he has avoided living in encampment because of the toll eviction has taken on his well being. He said he feels like he is losing his mind because he cannot function living outside; he has been repeatedly kicked out of and service-restricted from shelters in the city. At present, he contemplates suicide regularly because he cannot stay in shelter, he cannot stay in a tent, and staying outside is becoming unbearable. He cannot sleep for long for fear of being assaulted or having his possessions stolen, leading to profound sleep deprivation. This sleep deprivation has further destabilized his mental health condition as well as contributed to escalation in substance use. The last time Mr. Marchand was housed was in 2017.

~~It is my opinion that repeated encampment evictions have been a major contributor to the deterioration in Mr. Marchand's mental health and worsening of his substance use disorders over the past 3 years.~~

Please feel free to contact me should any further information be required.

Sincerely,

R. Lt

Dr. Rachel Lamont, MD, FRCPC
Psychiatrist, Hamilton Social Medicine Response Team and Shelter Health Network
Assistant Professor
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Fax: 1-833-563-2210

This is Exhibit ‘C’ referred to in the affidavit of Dr. Rachel Lamont affirmed before me this 7th day of June, 2024.

EXHIBIT ‘C’

INTENTIONALLY OMITTED PER JUSTICE RAMSAY NOVEMBER 12, 2024 ENDORSEMENT

INTENTIONALLY OMITTED PER JUSTICE RAMSAY NOVEMBER 12, 2024 ENDORSEMENT

This is Exhibit ‘D’ referred to in the affidavit of Dr. Rachel Lamont affirmed before me this 7th day of June, 2024.

EXHIBIT ‘D’

INTENTIONALLY OMITTED PER JUSTICE RAMSAY NOVEMBER 12, 2024 ENDORSEMENT

INTENTIONALLY OMITTED PER JUSTICE RAMSAY NOVEMBER 12, 2024 ENDORSEMENT

This is Exhibit ‘E’ referred to in the affidavit of Dr. Rachel Lamont affirmed before me this 7th day of June, 2024.

EXHIBIT ‘E’

McMaster University
DEPARTMENT OF PSYCHIATRY AND BEHAVIOURAL NEUROSCIENCES

October 5, 2023

ATTN: Sharon Crowe

RE: Lewis, Ammy (1978-07-04)

I am a psychiatrist with both the Hamilton Social Medicine Response Team and the Shelter Health Network in Hamilton, Ontario. Both services provide health care to people who are unhoused or precariously housed.

I have been Ms. Lewis' treating psychiatrist since October 2021 and can confirm that she has diagnoses of Post-Traumatic Stress Disorder (PTSD), Borderline Personality Disorder, Generalized Anxiety Disorder, Depression, and Opioid and Stimulant use disorders (severe).

Ms. Lewis was referred to me in October 2021 by another physician providing care to her, who noted significant concern for her mental health. Ms. Lewis had recently been released from a federal penitentiary and had returned to Hamilton in late 2020. She was briefly housed after her release, though reports having suffered sexual assault from her landlord and she left that residence. Ms. Lewis lived outside for the latter part of 2021 and most of 2022 in a tent with her dog. She was evicted by the city from a tent in November 2021 which led her to have to return to an abusive living situation, causing considerable decline in her mental health. She then returned to living outside because of the harm of that situation. Ms. Lewis suffered chronic severe suicidal ideation, an exacerbation of symptoms of Post-Traumatic Stress Disorder and Depression, and worsening of her substance use disorders while living outside. She would regularly report to me her intense fear of having her tent taken down and belongings stolen. She was unable to go to shelter because of her dog, as her dog was her main source of support and companionship.

~~It is my opinion that encampment evictions~~ and the threat thereof repeated threat have ~~been major contributors to the ongoing instability~~ in Ms. Lewis' mental health ~~and worsening of her substance use disorders from 2021-2022.~~ Due to considerable support from our team and outside agencies, Ms. Lewis was able to secure housing in 2023.

McMaster University
DEPARTMENT OF PSYCHIATRY AND BEHAVIOURAL NEUROSCIENCES

Please feel free to contact me should any further information be required.

Sincerely,

R. Lamont

Dr. Rachel Lamont, MD, FRCPC
Psychiatrist, Hamilton Social Medicine Response Team and Shelter Health Network
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EXHIBIT ‘F’

INTENTIONALLY OMITTED PER JUSTICE RAMSAY NOVEMBER 12, 2024 ENDORSEMENT

INTENTIONALLY OMITTED PER JUSTICE RAMSAY NOVEMBER 12, 2024 ENDORSEMENT

EXHIBIT ‘G’

McMaster University
DEPARTMENT OF PSYCHIATRY AND BEHAVIOURAL NEUROSCIENCES

May 11, 2023

ATTN: Sharon Crowe

RE: Jahmal (Jammy) Pierre, DOB Dec 20, 1989

I am a psychiatrist with both the Hamilton Social Medicine Response Team and the Shelter Health Network in Hamilton, Ontario. Both services provide health care to people who are unhoused or precariously housed.

I have known Ms. Pierre since fall 2021 and can confirm that she has diagnoses of PostTraumatic Stress Disorder (PTSD), generalized anxiety disorder, depression, and opioid and stimulant use disorders (severe).

Ms. Pierre has shared her story with me, prior to my involvement with her. In March 2019, she was evicted from her apartment at 881 King St and had nowhere to go, as she had a dog, and shelters do not accept pets. Her income is through OW and thus did not have enough to cover rent for a new apartment. Thus, she went and bought a tent for herself and her dog. Due to repeated evictions from the city over the course of several months in 2019, she had to move her tent once every few days. At one point, several months into living outside, her tent was taken down and thrown out as part of a city-led encampment eviction, while she was away at a store. She had left her dog in the tent and her dog was gone when she returned.

~~Individuals suffering from complex mental health conditions and substance use disorders, in particular individuals who have suffered repeated traumatic events, commonly experience a marked decline in their mental health and substance use following repeated traumatic events.~~ Ms. Pierre describes the repeated forced movement of her belongings and particularly the loss of her dog as highly traumatic. Following this, she suffered worsening PTSD symptoms, depressive symptoms, and anxiety disorder symptoms. As is common with individuals who have comorbid substance use disorders, the worsening of her mental health conditions drove increased substance use. She has subsequently suffered multiple overdoses from the toxic street drug supply, which include an ICU admission in August 2020 as well as ER visit in November 2020.

Given ongoing severe mental health symptoms, high levels of substance use, and lack of appropriate housing options for Ms. Pierre, ~~as well as the constant threat of being forced to move,~~ she continues to spend most of her time living outside, and has largely given up on trying to set up a tent because of the trauma that repeated evictions cause. She is thus living rough, and ~~forced to~~ stay awake for prolonged periods to protect her personal safety. This has led to

profound sleep deprivation, which further exacerbates her underlying mental health conditions and substance use. She has had brief times in shelter and in the YWCA but has also been asked to leave those spaces due to her complex health needs and those services being unable to offer the required level of support.

~~It is my opinion that repeated encampment evictions have been a major contributor to the profound deterioration in Ms. Pierre's mental health and worsening of her substance use disorders over the past four years. This is due to the profound stress caused by the constant threat of encampment eviction, the impact of eviction itself, encampment eviction causing the loss of a beloved pet, and the resultant need to live outside without the protection a tent can afford, causing extreme sleep deprivation, which further exacerbates symptoms of her mental health conditions.~~

Please feel free to contact me should any further information be required.

Sincerely,

R. Lt

Dr. Rachel Lamont, MD, FRCPC
Psychiatrist, Hamilton Social Medicine Response Team and Shelter Health Network
Assistant Professor
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This is Exhibit ‘H’ referred to in the affidavit of Dr. Rachel Lamont affirmed before me this 7th day of June, 2024.

EXHIBIT ‘H’

INTENTIONALLY OMITTED PER JUSTICE RAMSAY NOVEMBER 12, 2024 ENDORSEMENT

INTENTIONALLY OMITTED PER JUSTICE RAMSAY NOVEMBER 12, 2024 ENDORSEMENT

Heegsma et al
Applicants

-and-

CITY of HAMILTON
Respondents

Court File No. CV-21-00077187-0000

Ontario
Superior Court of Justice

PROCEEDING COMMENCED AT HAMILTON

Affidavit of Dr. Lamont dated June 7, 2024

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Ashley Wilson (LSO# 82988A)
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Counsel to the Applicants

Court File No. CV-21-77187

ONTARIO

SUPERIOR COURT OF JUSTICE

B E T W E E N:

KRISTEN HEEGSMA, DARRIN MARCHAND, GORD SMYTH, MARIO MUSCATO, SHAWN ARNOLD, BRADLEY CALDWELL, CHRISTINE DELOREY, GLEN GNATUK, TAYLOR GOGO-HORNER, CASSANDRA JORDAN, JULIA LAUZON, AMMY LEWIS, ASHLEY MACDONALD, COREY MONAHAN, MISTY MARSHALL, SHERRI OGDEN, JAHMAL PIERRE, LINSLEY GREAVES and PATRICK WARD

Applicants

- and -

CITY OF HAMILTON

Respondents

--- This is the Cross-Examination of DR. RACHEL LAMONT, upon her two affidavits sworn July 4, 2023 and her affidavit sworn June 7, 2024, taken via video conference hosted by the offices of Nimigan Mihailovich Reporting Inc., 1 James Street South, Suite 701, Hamilton, Ontario, L8P 4R5, on the 7th day of October 2024.

A P P E A R A N C E S :

Sharon Crowe, Esq., for the Applicants
& Michelle Sutherland, Esq.,
& Curtis Sell, Esq.

Bevin Shores, Esq., for the Respondents

REPORTED BY: Lorraine Fedosoff, (CSR) Ontario

A5155

I N D E X

WITNESS: DR. RACHEL LAMONT

PAGE

CROSS-EXAMINATION BY MS. SHORES..... 5
RE-EXAMINATION BY MS. CROWE..... 135

The following list of undertakings, advisements and refusals is meant as a guide only for the assistance of counsel and no other purpose

INDEX OF UNDERTAKINGS

The questions/requests undertaken are noted by U/T and appear on the following pages: None

INDEX OF ADVISEMENTS

The questions/requests taken under advisement are noted by U/A and appear on the following pages: None

INDEX OF REFUSALS

The questions/requests refused are noted by R/F and appear on the following pages: 26:21, 27:2, 27:7, 27:13, 27:19, 28:23

INDEX OF EXHIBITS

NUMBER/DESCRIPTION	PAGE NO.
1: Capture of September 2, 2021 Twitter comment of Dr. Rachel Lamont in response to a comment by Joey Coleman.	12
2: Thread of Twitter posts.	17

A871

--- upon commencing at 1:33 p.m.

DR. RACHEL LAMONT: Affirmed

CROSS-EXAMINATION BY MS. SHORES:

1. Q. Good afternoon, Dr. Lamont. As I indicated off record, my name is Bevin Shores. My pronouns are she and her. I'm one of the lawyers for the City of Hamilton in this matter.

Can we start by just having you please state for the record your full name, how you would like to be addressed and if you have any pronouns you wish to share?

A. Thank you. My full name is Rachel Lamont. I'm happy to be called Rachel or Dr. Lamont, whatever is more comfortable for you, counsel, and pronouns are she and her.

2. Q. And where are you participating in your examination from today?

A. I am in an apartment in Hamilton.

3. Q. And can you confirm that you're alone in the room?

A. I can confirm I'm completely alone, yes.

4. Q. And as we discussed off record, you're aware that you're to have no assistance in giving your answers today?

A. Yes.

5. Q. And if you're referring to any materials in giving your answers other than your affidavits and the exhibits to your affidavits, we need to state what you're referring to, make an exhibit and explain how it forms your evidence. Is that understood?

A. Yes, it is.

6. Q. You've been affirmed to tell the truth just now?

A. Yes.

MS. SHORES: I'd like to just state for the record before we get underway there is currently a dispute among counsel about whether Dr. Lamont's evidence is fact witness or expert witness evidence, and so this examination is being conducted without prejudice who are observing all positions regarding that dispute.

BY MS. SHORES:

7. Q. Dr. Lamont, what do you understand your role is in this litigation?

A. I understand my role was to provide my medical knowledge in relation to some of the individuals who are applicants in the matter and to state whether in my medical -- based on my

A5156

medical knowledge if I believe there to be any sort of impact on encampment evictions -- sorry, from encampment evictions on the health and well-being of the applicants.

8. Q. And I understand that you haven't previously been qualified to give evidence as an expert witness in a court in Ontario; correct?

A. That is correct.

9. Q. Okay. And perhaps stating the obvious, but there's no Rules of Civil Procedure Form 53 appended to your affidavits; correct?

A. That is correct.

10. Q. And no curriculum vitae appended to your affidavits; correct?

A. That is correct.

11. Q. You're a psychiatrist?

A. Yes, I am.

12. Q. And you're currently working with the Shelter Health Network in Hamilton?

A. Yes.

13. Q. And I believe if I understand on the CP -- or College of Physicians and Surgeons' website, that you gained your independent practice certificate in June 2019?

A. Yes, that is correct.

14. Q. Okay. And the independent practice certificate is what permits you to provide independent and unsupervised medical practice in Ontario; correct?

A. Yes, it is.

15. Q. So basically to put it in more lay terms, you've been practicing independently as a psychiatrist for about five years to the present day?

A. Yes, that is correct.

16. Q. Now, the College of Physicians and Surgeons has your main office located in Welland; is that accurate?

A. Yes, it is. I have a number of practice locations in addition to the Shelter Health Network and Hamilton's Social Medicine and Response Team.

17. Q. So you're still practicing in Hamilton, but also practicing in Welland and potentially other locations as well?

A. Yes, that is correct.

18. Q. Now, your affidavits append several letters collectively between them, the subject matter of which are eight of the applicants in this proceeding, one per letter. Were each of

A872

the letters written by you?

A. Yes, they were.

19. Q. All of the letters are addressed to Sharon Crowe who is here with us today, one of the lawyers for the applicants; is that correct?

A. Yes, they are.

20. Q. Were there instructions provided to you in writing those letters?

A. No, there were no instructions. There was a question asked of me, which was if I, in my knowledge -- or sorry, if I could complete assessments of individuals to see if -- based upon those assessments if I thought there were any impact of encampment evictions on the health and well-being of those individuals, but I was asked that as a question. I was not given instructions.

21. Q. And you haven't conducted any research independently in the preparation of the letters appended to your affidavits; correct?

A. I'm not sure what you mean by "research". Could you clarify?

22. Q. I've not been asked that question before. Research meaning did you conduct any experiments, do any reviews of literature, anything like that, research?

A. I see. I see what you're saying. No, I did not, not specifically related to this. I wonder if you meant research into the clinical records and that type of thing before --

23. Q. You perhaps anticipated my next question, which is that I noticed that there were no documents identified in your letters as points of reference. So can we take it that there were no documents reviewed in preparing your letters?

A. No, you cannot. I did review many clinical records for each applicant.

24. Q. Okay. So how do you know looking at your letters which records were reviewed?

A. I did not specify in the letters; however, before every assessment that I completed of those individuals, I can confirm that I did review Clinical Connect, which is a centralized repository of hospital records for Southwestern Ontario, and reviewed any and all records available for each applicant contained within Clinical Connect.

I also reviewed every applicant's Shelter Health Network electronic medical record and reviewed their Hamilton Social Medicine Response Team electronic medical record.

A5157

25. Q. And none of that is indicated in any of the letters?

A. It's not indicated in the letters, no.

26. Q. Have you ever used a social media platform known as X formally Twitter?

A. I used to have Twitter, yes.

27. Q. All right. Your handle was @lamontrachell1?

A. Yes, it was.

28. Q. I'm going to take you to a document which I'll place on the screen. Now, this is a capture, Dr. Lamont, and it is a capture of a tweet.

If you see at the bottom, it's dated 2 September 2021, and at the top it says Rachel Lamont, @lamontrachell1. Is that your Twitter handle?

A. Yes, it is.

29. Q. And it appears to be a tweet responding to a tweet by Joey Coleman, Twitter handle @joeycoleman stating:

"The @cityofhamilton encampment support team operates out of this building. The closure of public

washrooms to block their use by homeless individuals is one of the many reasons medical and social professionals who help homeless people say City Hall is making things worse."

He goes on with his hashtags, and then you respond stating:

"I used to feel proud to call Hamilton home. Actions by City officials, especially over the past year, make me ashamed. I cannot comprehend the complete lack of understanding, compassion or even common sense in these situations @cityofhamilton."

You made that tweet?

A. I did.

30. Q. And you agree with that statement?

A. I do.

31. Q. Now, I'll take you --

MS. SHORES: Let's, I'm sorry, mark this as Exhibit 1 to the examination of Dr. Lamont.

EXHIBIT NO. 1: Capture of September 2, 2021 Twitter comment of Dr. Rachel

A873

Lamont in response to a comment by Joey Coleman.

BY MS. SHORES:

32. Q. I'll take you to another printout, Dr. Lamont. This one is again a capture and it appears to be dated September 5, 2022, again, from the Twitter handle @lamontrachell1, and the first one says:

"A few days ago, my attention was drawn to a deeply disturbing sign posted at 124 Walnut Street South. I could not stop thinking about it. Thanks @marcie58632320 for writing this response poem with me."

Did you write that tweet?

A. Yes, I did.

33. Q. And @marcie58632320, that's Marcie McIlveen?

A. Yes, it is.

34. Q. She's a friend of yours?

A. She's a colleague of mine.

35. Q. And you are aware that she's also -- she was a witness in the injunction motion in this proceeding?

A. I was not aware of that, no.

36. Q. Okay. So let's scroll down in the capture of this tweet and I'll zoom in. So there appears to be a tweet by Marcie, @marcie58632320:

"What is this? Who put this up? Presently writing a response poem with a friend."

And then there's a photograph of a sign for 124 Walnut Street South and there's a poem in yellow type on a black background there. Do you see that?

A. Yes, I do.

37. Q. And you'd agree that that is the deeply disturbing sign posted at 124 Walnut Street South referenced in your tweet?

A. Yes, it is.

38. Q. Now, in terms of your response powem referenced in your tweet, Ms. McIlveen tweets in another tweet dated September 3 "Our response", and there appears to be a photograph of a word processor with a poem typed on it. Do you see that?

A. Yes, I do.

39. Q. Okay. And did you work with Ms. McIlveen in creating that poem?

A5158

A. Yes, I did.

40. Q. Now, if we scroll down, there's another tweet by Marcie, @marcie58632320:

"@lamontrachell1, we shall post it, right?"

And then beneath it, it says:

"Replying to @marcie58632320 and @jennbrasch [spelled J-E-N-N, B-R-A-S-C-H] I have the supplies."

And a smiley face emoji. You wrote that tweet?

A. Yes, I did.

41. Q. And then subsequently, there is a photograph showing the -- what appears to be the same sign at 124 Walnut Street South. You'd agree that was the same sign?

A. It appears to be, yes.

42. Q. Okay. And there's some black paint over the wording of the yellow type on the black background; correct?

A. There is, yes.

43. Q. And there is what appears to be a handwritten poem pasted -- or I'm sorry, taped beneath; correct?

A. Yes, there is.

44. Q. What appears to be white paper with some sort of black handwriting?

A. Yes.

45. Q. And you'd agree that's the poem that you and Ms. McIlveen wrote?

A. Yes, it is.

46. Q. The black paint over the yellow and -- the yellow type on the black background appears to be in the shape of an upside down "A" with a circle. Do you agree?

A. It's very hard to see, but I can appreciate what you're suggesting what the outline is.

47. Q. That's commonly known as a symbol for anarchy?

A. Yes.

48. Q. Did you have any involvement in the spray painting or the pasting of the poem on this board?

A. Absolutely not, and I've actually not seen a picture with -- I didn't see the sign after the -- I knew the sign was being put up, the poem sign. I did not see any sort of picture that showed that symbol above.

49. Q. So you have no knowledge of this?

A874

A. I have no knowledge of that.
50. Q. But you did partake in writing the poem?
A. Yes, I did.
51. Q. And you were aware that the poem was intended to be posted on that sign?
A. Yes, I was.
MS. SHORES: I'm going to mark this thread of Twitter posts as Exhibit 2 to Dr. Lamont's examination.
EXHIBIT NO. 2: Thread of Twitter posts.
BY MS. SHORES:
52. Q. You'll agree, Dr. Lamont, that you're an advocate for people experiencing homelessness?
A. I would agree that on many occasions, that in my professional role as a physician, it is my obligation to advocate for my patients, many of whom are unhoused.
53. Q. And your involvement in this case is part of that work, advocating for people who experience homelessness?
A. Yes, it is.
54. Q. You've attended at least one of

the meetings of Hamilton City Council; correct?
A. Yes, I have.
55. Q. And at least one of those meetings was in January 2023?
A. I can't remember the date. I know I did attend one. I don't recall the date it was specifically.
56. Q. And your attendance on that occasion was with the intention of urging the City Council to allow people to remain in encampments?
A. I don't know which meeting you're specifying. So I can't say with certainty what my role was there.
57. Q. Have you ever attended at Hamilton City Council for any other reason other than on the subject matter of encampments?
A. I have watched many council meetings.
58. Q. Okay. But specifically with respect to a delegation at the City of Hamilton City Council meeting, have you ever attended on any subject matter other than encampments?
A. No, I have not.
59. Q. I'm going to turn you to your affidavits now, and I'll start with your June 7,

A5159

2024 affidavit which will be the bulk of my examination today.
I'm going to ask you first about the first paragraph of this affidavit, which I'll put to you and you can take a minute to look at them, but it appears to be the same wording as in your July 4th affidavits. So I'll read for the record and then I'll let you read for yourself:
"I have personal knowledge with respect to the facts and reports set out below, except where stated otherwise. Where the information is not based on my personal knowledge, it is based upon information provided by others which I believe to be creditable and true."
So first question is just confirming that that's the same in each of your affidavits. So this is your July 4, 2023 affidavit appending the report of -- the report concerning Kristen Heegsma, your July 4, 2023 affidavit which appends the report of Dr. Pierre -- or I'm sorry, of Ms. Pierre, and then, again, the first paragraph of your June 7, 2024 affidavit. So we agree those are all the same text?

A. Yes, they are.
60. Q. Okay. And you'll agree that that paragraph is accurate?
A. Yes, it is.
61. Q. Now, just with respect to the two July 4 affidavits, those each append letters dated May 11, 2023. So I'll take you to Exhibit A to your first July 4, 2023 affidavit. This is the letter dated May 11, 2023 with respect to Ms. Pierre.
As best I can tell, Dr. Lamont, that seems to be the same letter that appears as Exhibit G to your July 7 -- I'm sorry, June 7, 2024 affidavit which I'll take you to now. Would I be correct in that understanding, it's the same letter?
A. Yes.
62. Q. Okay. And so I'll ask you the same question with respect to your letter concerning Kristen Heegsma.
So taking you first to your July 4, 2023 affidavit, Exhibit A to that affidavit is a June 20, 2023 letter regarding Kristen Heegsma, and then if we go to your June 7, 2024 affidavit, Exhibit A to that affidavit is also a June 20, 2023

A875

letter regarding Kristen Heegsma, which again, as far as I can tell, is the same letter. Is that also correct?

A. Yes, that's correct.

63. Q. Okay. All right. So then for purposes of this cross-examination, I'm going to focus on your June 7, 2024 affidavit.

So turning back to the body of your affidavit, you describe at paragraph 2 of your June 7, 2024 affidavit that you're a physician with Shelter Health Network and the Hamilton Social Medicine Response Team, which goes by HAMSMaRT, and then you go on to describe in the last sentence that you've worked with SHN, Shelter Health Network, since May of 2022 and that you joined HAMSMaRT in September 2021.

Can you just describe what your role is first with Shelter Health Network?

A. Yes, so my role with Shelter Health Network is primarily as a consulting psychiatrist, so providing comprehensive diagnostic assessments and treatment recommendations for individuals experiencing homelessness or who are precariously housed.

I often as well act as a point person

for some of the family doctors working for Shelter Health who may call me for advice about a specific patient in relation to mental health diagnosis or treatment.

64. Q. And around the time that you gave these affidavits, so 2023 and 2024, how frequently were you working at Shelter Health Network?

A. About once per week.

65. Q. Okay. And on those once per week occasions, would you be seeing patients the entire time?

A. It depended on the week and the number of people that would attend. But yes, most weeks I would be seeing patients for Shelter Health Network.

66. Q. And how long were the days that you worked at Shelter Health Network?

A. A half day, one-half day.

67. Q. Okay. And half days means different things in different professions. What would a half day be in term of hours, roughly?

A. Three to four hours.

68. Q. And is that still your -- an accurate description of your role at Shelter Health Network these days?

A5160

A. With Shelter Health Network these days, primarily I'm actually only with them about one half day per month.

69. Q. Okay. And when did that change?

A. It's about a year, in the last year, yeah.

70. Q. So we're in October of 2024. So about fall of 2023 you would have gone down to about once a month at Shelter Health Network?

A. Yes, that is correct.

71. Q. And with respect to HAMSMaRT, are you still working with HAMSMaRT?

A. Yes, I am.

72. Q. And so at the time that you gave these affidavits, so 2023 and the first half of 2024, what was your role at HAMSMaRT?

A. So my role at HAMSMaRT is also consulting psychiatrist, though at HAMSMaRT I do follow people longitudinally as well. So I work every Tuesday afternoon with HAMSMaRT every week, and I often work Tuesday mornings, perhaps one to two Tuesday mornings per month.

And again, I'm available for advice for my colleagues, internal medicine colleagues at HAMSMaRT if they have questions or require advice

about specific patients.

73. Q. And the afternoons that you're there, again, would that be about three to four hours?

A. Yes, it is.

74. Q. And the work that you do for HAMSMaRT is separate than the work that you do with Shelter Health Network? So in other words, you would have one day at Shelter Health Network and a separate day at HAMSMaRT seeing separate patients?

A. Yes, that is correct.

75. Q. Are you aware that HAMSMaRT previously sued the City of Hamilton regarding encampments in 2020?

A. I am aware, yes.

76. Q. And you'd agree with me that HAMSMaRT is, among other things, an advocacy organization?

A. Yes, it is.

77. Q. With respect to your -- sorry, you indicate at paragraph 2 of your affidavit that the Shelter Health Network and HAMSMaRT are organizations that provide medical care to individuals affected by homelessness or housing precarity.

A876

I want to ask you some questions about homelessness. You'd agree that people who become homeless often have physical and mental health problems which worsen over the period that they're homeless; correct?

MS. CROWE: Ms. Shores, I want to just interject for a moment because she's here to speak about the individual applicants that she saw and assessed.

MS. SHORES: Well, but her -- but Dr. Lamont's evidence is expressing among other places opinions, in our submission, on the effects of homelessness on individuals including the individuals that she speaks to, and it's perfectly in bounds to get a baseline of her understanding about what the causes -- or I'm sorry, about what the effects of homelessness cause of these individuals.

MS. CROWE: In these individuals. Yes, so -- okay. So if we're confining it to the -- her patients that she's seeing and assessing, then I take no issue with that.

MS. SHORES: Well, but I want to be absolutely clear. My question is just about homelessness in general.

MS. CROWE: So the difficulty that we have, Ms. Shores, is, as you know, we disagree on -- so our intention is very clear to have Dr. Lamont here and participate as a fact witness, and so to give her factual knowledge of the individuals that she assessed in completing her affidavits. So I think those are the proper boundaries of her examination.

MS. SHORES: Well, I maintain my position that this is a proper question. So I will ask my questions and you can provide your position. With respect to that one, is that a refusal, or will Dr. Lamont be answering the question?

MS. CROWE: Can you ask it again, please?

BY MS. SHORES:

78. Q. Would you agree, Dr. Lamont, that people who become homeless often have physical and mental health problems which worsen over the period that they're homeless?

R/F MS. CROWE: That's a refusal.

BY MS. SHORES:

79. Q. And Dr. Lamont, would you agree that deaths due to unintentional overdose of drugs or alcohol or both are also common in a population

A5161

of people who experience homelessness?

R/F MS. CROWE: That's a refusal as well.

BY MS. SHORES:

80. Q. Dr. Lamont, would you agree that the prevalence of serious mental illness is high among people who experience homelessness?

R/F MS. CROWE: It's a refusal.

BY MS. SHORES:

81. Q. And Dr. Lamont, would you agree that infectious diseases are a common cause of health problems in people who experience homelessness?

R/F MS. CROWE: It's a refusal on the same grounds.

BY MS. SHORES:

82. Q. Would you agree, Dr. Lamont, that homeless people with mental illnesses often receive inadequate care for their medical comorbidities?

R/F MS. CROWE: Ms. Shores, that's a refusal, and I think -- obviously you can continue to ask the questions, but I think you understand the nature of my objections.

MS. SHORES: And I am asking my questions, put them on the record, and you --

MS. CROWE: Okay.

MS. SHORES: -- your objection on the record.

BY MS. SHORES:

83. Q. Dr. Lamont, you'd agree that people can be assaulted in encampments; that's correct?

THE WITNESS: I'm okay to answer this one?

MS. CROWE: Yes.

THE WITNESS: Okay. It is possible for a person to be assaulted anywhere. So yes.

BY MS. SHORES:

84. Q. And similarly, you'd agree that people can have things stolen from them in encampments; correct?

A. Things can be stolen from someone anywhere. So yes.

85. Q. You'd agree that people can suffer hypothermia in encampments; correct?

A. It is theoretically possible, yes.

86. Q. You'd agree that people can suffer frostbite in encampments; correct?

R/F MS. CROWE: So I think I'm going to interject again because, again, we're just talking about generalized statements. We're really moving

A877

away from the individual applicants.

And the other point, the other basis for my refusal on that question is that, as you know, Dr. Lamont is here as a psychiatrist.

MS. SHORES: Well, we'll get to that.

BY MS. SHORES:

87. Q. Now, Dr. Lamont, you'd agree that in treating a patient it's important to obtain an understanding of their medical history?

A. Yes.

88. Q. And that it's important to obtain an accurate medical history to the extent you can?

A. Yes.

89. Q. And that to the extent you can, it's also important to obtain a comprehenstive medical history in the sense that it doesn't leave out anything significant?

A. Yes.

90. Q. And you'd agree that an accurate and comprehensive medical history is also important in giving a medical opinion about a patient?

A. Yes.

91. Q. You'd agree that an inaccurate or incomplete medical history would affect the reliability of a medical opinion that's based on

that history; correct?

A. It's possible that it could, yes.

92. Q. In a sense that it could be less reliable if the medical history is inaccurate or incomplete, yes?

A. It's possible, yes.

93. Q. And you'd agree that some patients may not be able to give you an accurate or comprehensive medical history; correct?

A. That is correct in all areas of medicine, yes.

94. Q. And that some patients may not be able to accurately or comprehensively report their experiences to you; correct?

A. That does happen, though I would say, for the most part, individuals are able to relay their own experiences quite well.

95. Q. If a patient is unable to accurately or comprehensively report their medical history or experiences to you, you'd agree that could compromise the reliability of a medical opinion based on that report; correct?

A. Well, I would place a caveat on that, that within psychiatry in particular, a special part of our training is ascertaining

A5162

whether the information an individual is providing is reliable or not based on internal consistencies within their report as well as consistencies in relation to collateral information, and a very important piece of any psychiatric and medical history is obtaining collateral information.

96. Q. And so did you obtain collateral information with respect to the patients that you're speaking to in your June 7, 2024 and July 4, 2023 affidavits?

A. Yes, I did wherever possible, and I can speak to each applicant as we raise their letters, if that's helpful.

97. Q. Okay. We will do that. You'd agree that opioid and stimulant use disorder are conditions that could affect a patient's ability to give you an accurate and complete history; correct?

A. Having the diagnosis itself doesn't necessarily make someone unable to provide accurate information. I think at times if someone is particularly intoxicated or if they've had long cycles of intoxication and withdrawal, it may give them some difficulty with memory and recall of information, yes.

98. Q. And a psychosis could be a

condition that would affect a patient's ability to give you an accurate and complete history; correct?

A. It can, although typically it only impacts a person's ability to provide information in relation to whatever the nature of their psychosis is.

For example, if they have delusions about a particular person, the information they provide about that particular person may not be reliable, but they might be quite reliable in providing information about other topics that are not central to their psychotic symptoms.

99. Q. Schizophrenia would be a condition that could affect a patient's ability to give you an accurate and complete history?

A. I don't -- I mean, certainly it's possible, especially if someone's very acutely unwell and thought disordered, but most people with schizophrenia would actually be able to provide a reliable history.

100. Q. And fetal alcohol syndrome, the symptoms of that condition, you'd agree, could affect a patient's ability to give you an accurate history?

A. Some of the symptoms, particularly

A878

the cognitive symptoms of that condition, could affect an individual's ability to provide information, yes.

101. Q. Turning to your letters that are appended to the affidavits as exhibits, just looking at the letterhead, there's two logos that appear at the top for each of these letters. One of them is the McMaster Department of Psychiatry and Behavioural Sciences and the other appears to be HAMSMaRT.

Are these letters provided under the auspices of the McMaster Department of Psychiatry and Behavioural Services?

A. Behavioural Neurosciences? No, they're not. That's simply one of my credentials as an assistant professor with the university, and so it's typically on the letterhead that I use.

102. Q. Are you still an assistant professor with McMaster University?

A. Yes, I am.

103. Q. And you were at the time that you wrote these letters?

A. Yes, I was.

104. Q. Is the McMaster Department of Psychiatry and Behavioural Neurosciences affiliated

with HAMSMaRT?

A. Not in any way, no.

105. Q. And were you providing these letters under the auspices of HAMSMaRT?

A. Not directly, no. It was my own -- I was seeing the patients through HAMSMaRT's electronic medical record, but there was no direction from the organization of HAMSMaRT for me to provide these letters.

106. Q. Referring first to Exhibit A to your June 7, 2024 affidavit, which again for the record also appears as Exhibit A to your July 4, 2023 affidavit regarding Kristen Heegsma, at paragraph 2 you state that you've been Ms. Heegsma's treating psychiatrist since November 2021. I take it, then, you saw her either through Shelter Health Network or HAMSMaRT?

A. Yes, she was my patient through HAMSMaRT since November 2021.

107. Q. Approximately how many times would you have seen her for treatment before writing this letter in June of 2023?

A. [Indiscernible] 15.

108. Q. You state at paragraph 2 that you can confirm that she has diagnoses of

A5163

post-traumatic stress disorder, borderline personality disorder, generalized anxiety disorder, depression and opioid and stimulant use disorders, but you don't say that you diagnosed her with these. Can I take it that someone else diagnosed these conditions previously?

A. Those diagnoses were all pre-existing prior to my involvement and already a part of her medical record; however, I did confirm those diagnoses while I treated her.

109. Q. And when you say "medical record", you're referring to that electronic medical record that you described previously?

A. Yes.

110. Q. And in the third paragraph of your letter, the third sentence you state with respect to Ms. Heegsma:

"She had been repeatedly evicted from encampments previously."

And in the sentence immediately preceding that, you say that:

"She had just been evicted from a tent in Corktown neighbourhood by the City of Hamilton."

I take it that's information that Ms. Heegsma reported to you?

A. Yes, it was.

111. Q. Okay. Was that information that she reported to you, or was that documented in a medical record? Do you know?

A. I believe it was both. I do distinctly remember the first time I met Ms. Heegsma because she was highly distressed, and Dr. O'Shea was her treating physician at that time. I believe he documented the eviction from Corktown and then she also reported it to me.

112. Q. And so Dr. O'Shea would have been recording in the records what Dr. -- or I'm sorry, what Ms. Heegsma reported to him?

A. That's correct.

113. Q. So you don't have any first knowledge of how these so-called evictions transpired? You didn't witness them?

A. I did not witness them, no.

114. Q. And so in terms of corroborating information that's relayed to you, that's not something that you took independent steps to verify?

A. No, I did not.

A879

115. Q. And similarly, if we go to the middle of the second paragraph, you state:

"Additionally, because her tent had been destroyed, she was sleeping on a park bench in the days following the encampment eviction."

Again, that was reported to you?

A. By Ms. Heegsma, yes.

116. Q. And again, was that reported to you, or written down in a medical record?

A. It was reported to me by Ms. Heegsma.

117. Q. And again, you weren't aware of -- firsthand of her tent having been destroyed; correct?

A. Not firsthand, but I did see her shortly after it did happen.

118. Q. And similarly, the sleeping on a park bench, that's not something that you independently viewed yourself? That's what she reported?

A. That is what she reported, yes.

119. Q. In the second -- or I'm sorry, third to last sentence of the second paragraph of this letter you state:

"A few days after the eviction from her tent in Corktown neighbourhood and while she was sleeping on a park bench, she was the victim of a violent sexual assault."

Did you treat her for that?

A. In terms of her mental health in the immediate aftermath, yes.

120. Q. And what is the source of your information that she was a victim of a violent sexual assault?

A. Ms. Heegsma.

121. Q. And in writing this report, the source of your information is those records that you have referred to previously?

A. In terms of other alternate sources of information? Is that what you are asking?

122. Q. Yes.

A. Yes. And I would also note that Ms. Heegsma regularly attended the Keeping Six Drop-In Centre, and other individuals that attend the drop-in expressed a lot of concern about her well-being at that time.

A5164

123. Q. When you say in the second to last sentence of the second paragraph "This caused additional, severe worsening of her mental health conditions and substance use", what's your source for that?

A. That was my direct observation of worsening in symptoms, both in frequency and severity of both her mental health conditions and escalations in her substance use.

124. Q. I have to put it to you, though, Dr. Lamont, you indicate that at that time, that was when you had just met her. So wouldn't you agree that you didn't have a baseline for her substance use prior to that incident?

A. I did have records from Dr. O'Shea, who is my colleague who works in the same clinic and who had been following her for a period of time before that, who was -- very clearly indicated a worsening in the substance use and a very clear deterioration in her mental health, which was also corroborated by other individuals using the space who knew Ms. Heegsma.

125. Q. The last sentence of the second paragraph you state:

"She also had her belongings

stolen repeatedly."

Again, what was the source of that information?

A. That was reported by Ms. Heegsma, and I would often see her coming into clinic asking for very basic necessities and refills of her prescriptions because everything had been stolen.

126. Q. So again, she indicated that things had been stolen and she was asking for refills of her prescriptions?

A. And other basic necessities like clothing and hygiene products.

127. Q. Now, with respect to prescriptions, in particular, Dr. Lamont, I have to ask you'd agree that that can sometimes be an indicia of drug seeking behaviour; correct?

A. Not typically, and especially not the medications I was prescribing Ms. Heegsma. I was prescribing her anti-depressant medications which have absolutely no street value and do not provide a high for anyone. So they're not -- asking for a refill of that medication is not a sign of drug seeking behaviour.

128. Q. In the fourth paragraph of the letter concerning Ms. Heegsma, you state in the

A880

first sentence that:

"Ms. Heegsma has since spent brief amounts of time in shelter and in YWCA transitional housing, though has also been asked to leave those spaces due to her complex health needs and those services being unable to offer the required level of support."

Speaking specifically to the reasons that she was reportedly asked to leave, what is the source for that information?

A. So I did not call the shelters specifically. I only know that she was asked to leave and service restricted and I was not given a reason from the shelters.

I did speak to the YWCA personally because I was trying to advocate for her to get a spot, and they said that her -- they simply said, "Her needs are higher than that which we can support." They have some sort of scoring system that they use and they felt that her needs were too high.

129. Q. When did that occur?

A. Oh, I don't have a specific

recollection of the date, I'm sorry.

130. Q. And with respect to incidents other than your consultation with the YWCA, do you have any knowledge speaking about your firsthand knowledge about whether she was, in fact, asked to leave those spaces or the reasons for that?

A. Just as they were reported to me by Ms. Heegsma.

131. Q. You say that Ms. Heegsma in the next sentence "Thus continued to spend most of her time living outside." Again, what is the source for that information?

A. It is both her report as well as when I reviewed her medical record because she saw Dr. O'Shea more frequently than myself, and he would take note during their visits of where she was staying and the vast majority of the time she was outside.

132. Q. When you say "living outside", in the next sentence you refer to living in a tent. And so are those synonymous, she's living outside in a tent?

A. There were times when she was in a tent and there were times when she's been unsheltered outside.

A5165

133. Q. And again, based on her report to you?

A. That's correct. I just would like to add, because it keeps coming up, that people don't generally lie about whether they're sleeping in a tent or sleeping rough. They have no reason to do so.

134. Q. And your source for this letter in here again would be your recollection of what Ms. Heegsma reported to you and those records that you consulted that -- aren't referenced in this letter; correct?

A. Yes, that's correct.

135. Q. The second to last paragraph of your letter, so the first paragraph on the second page, you state:

"It is my opinion that that repeated encampment evictions and, in particular, the encampment eviction in November 2021 and subsequent sexual assault, have been a major contributor to the ongoing instability in Ms. Heegsma's mental health and worsening of her substance use disorders over the

past three years."

I take it, Dr. Lamont, that you're giving that opinion based primarily on information that was relayed to you?

A. No, I would say I'm basing that largely on my clinical assessment of Ms. Heegsma in the time that I knew her and the deterioration I witnessed throughout that process and the impact that each encampment eviction, particularly the November 2021 eviction, had on her well-being.

136. Q. But again, those encampment evictions are what she has reported to you; correct?

A. Yes, she reported them to me, and would show up in absolute crisis after losing all of her belongings and having her tent torn down.

137. Q. And speaking of the corroboration that you described previously when I was asking you about patients reporting their histories and experience to you, you haven't done any sort of independent corroboration of those experiences; correct?

A. I would say that it would be uncommon in medicine to seek third party information for which something someone -- there's

A881

no reason that Ms. Heegsma would lie about having her tent torn down. The way that she was presenting was very much in keeping with someone who would have had that experience.

There was no need for me to independently verify that. Just as much as if someone came in with, you know, chest pain, I wouldn't call their family and verify that they, too, had been told this person had chest pain. It doesn't -- it's not necessary.

138. Q. With respect to your opinion about the ongoing instability in Ms. Heegsma's mental health and her substance use disorders, you don't indicate any other potential causes such as other sequela of homelessness or any other conditions or factors; correct?

A. I did not indicate in this particular letter, no.

139. Q. And you'd agree that if the information provided to you was incorrect, that may change your opinion?

A. It would depend on the information that was provided.

140. Q. So let's go to Exhibit B of your June 7, 2024 affidavit. This is a letter dated

December 14, 2023 concerning Darrin Marchand.

Now, at the second -- or I'm sorry, second paragraph of this letter, you state that you've known Mr. Marchand since May 2023. So first off, if I'm doing the math correctly, that would be about seven months before writing this letter?

A. Yes, that is correct.

141. Q. Okay. And you say you've known Mr. Marchand, but was that in a doctor-patient relationship, or were you acquainted with him some other way?

A. So he was in a doctor-patient relationship with me since May of 2023, though I had seen him around and knew that he was someone named Darrin. Before that, I had no personal knowledge of him until he became my patient.

142. Q. And in that second sentence you state that you confirm:

"He has diagnoses of psychosis (substance-induced versus schizophrenia), and opioid and stimulant use disorder (severe)."

Again, you don't say that you diagnosed him with these. So may I take it that these were previous diagnoses?

A5166

A. They were previous diagnoses that I then confirmed with my own assessment, yes.

143. Q. Do you know when he was diagnosed with these conditions?

A. So again, I don't have specific dates, but I know that he was on a long-acting injectable anti-psychotic medication for at least ten years which is used to treat psychosis. So he would have been diagnosed with that condition many, many years before my involvement with him.

And the opioid and stimulant use disorders were also longstanding diagnoses, but I cannot comment specifically on the number of years.

144. Q. In the third paragraph you start with the sentence:

"Mr. Marchand has shared his story with me dating back prior to my involvement with him."

And then in this third paragraph you go on to describe incidents that appear to have occurred in 2021. You're welcome to review that paragraph if you want. My question is that is everything in that paragraph based on what he reported to you?

A. It is based on what he reported to

me. However, when he was shot in the shoulder, that was then -- I independently verified that with his medical record, electronic medical record via the hospital system, as well as other peer workers at HAMSMaRT and Keeping Six who had known him during that time.

145. Q. When you say he was shot in the shoulder, you mean his treatment for the gunshot wound; correct?

A. Yes, that's correct.

146. Q. You didn't witness the gunshot?

A. No, I did not.

147. Q. And none of the other providers that you interacted with witnessed the gunshot?

A. No.

148. Q. Okay. And so just to put a finer point on it, you weren't his medical treatment provider at the time in 2021; correct?

A. That's correct.

149. Q. So you describe in the third sentence of the third paragraph:

"In the summer of 2021, he was evicted from an encampment along Strachan Street in Hamilton and again from an encampment on Rebecca

A882

Street during that summer."

Again, you weren't treating him at the time that that -- those alleged encampment evictions occurred, right?

A. That is correct.

150. Q. And so when you say two sentences ahead that "He describes feeling a sense of hopelessness and despair following these encampment evictions and that his substance use escalated again", that's based on his reporting?

A. It is based on his reporting. Mr. Marchand also has a number of outreach workers that work with him and, in particular, an outreach worker out of the AIDS Network named Tess, and she also had observed a significant change in his substance use, a worsening in his substance use since that time.

151. Q. And to put a finer point on it, an outreach worker is someone who's going out in the community and interacting with Mr. Marchand when she can find him?

A. That's correct, and when he comes to the drop-in space at the AIDS Network.

152. Q. Okay. So you'd agree with me, though, that that doesn't provide a very regular

set of interactions in order to gauge the extent of his substance use?

A. I actually don't agree with that. I think an outreach worker that knows an individual and sees them, you know, whether it be every week or every two weeks or even every three weeks, you can notice a pattern over time and an escalation in someone's substance use.

153. Q. But in any event, this outreach worker's observations are not appended to or even referred to in your letter; correct?

A. That's correct.

154. Q. Now, with respect to your comment again in the third paragraph of your letter concerning Mr. Marchand, the second last sentence referencing the gunshot in December of 2021, you state that it contributed to additional ongoing trauma symptoms.

Again, you weren't treating him at the time. So that's not your medical opinion; correct?

A. It is what he reported to me, and it's very much consistent with what I would expect in someone with his history of mental health conditions and repeated traumatic experiences.

155. Q. In the last sentence of

A5167

paragraph 3 you state that:

"Mr. Marchand said that he felt much more secure in a tent with community who looked out for each other, something that's not possible when sleeping outside alone as he has resorted to doing because of repeated evictions."

So again, just with respect to the first part of that sentence, Mr. Marchand's reported feeling for security in a tent, you'd agree that there still can be violence against people who are staying in encampments; correct?

A. You did mention that earlier and, as I said, there can be violence toward anyone in any place. So of course there could be violence toward people in encampments.

I would say that for individuals with substance use disorders, with histories of trauma, a feeling of safety is extremely important and foundational for someone to find any sort of stability and recovery. And so when people feel unsafe, it is nearly impossible to find recovery.

And so for Mr. Marchand, when he said he did not feel safe when alone outside, that to me

is kind of a -- it would be a very common time when someone's substance use would escalate because they're feeling unsafe, and that is a driver of the substance use.

156. Q. But wouldn't you also agree, Dr. Lamont, that if someone feels safe in a circumstance actually not very safe, that could also not be a good thing for them because they'll remain in that circumstance and, thus, exposed to risks for longer?

A. I think most individuals have common sense and will seek the safest -- like I don't want to speak too generally here, but in the individuals that I've worked with and what has been reported to me, people don't want to be outside period.

They want inside -- to be inside in dignified, adequate housing, but, in the absence of that, people want the next safest option, and for individuals like Mr. Marchand and what he described to me at that time, he felt safer in a tent than exposed to the elements and he did not feel there were other options available to him.

157. Q. And so when you say at the very end of the third paragraph that Mr. Marchand had

A883

resorted to sleeping alone outside because of repeated evictions, again, you don't have any firsthand knowledge of these so-called evictions; correct?

A. I don't have firsthand knowledge beyond which was reported to me by him and by -- and corroborated by the outreach worker.

158. Q. And so you don't know how long he would have been able to stay in a tent in between these so-called evictions; correct?

A. I don't know how long he was in between, that's correct.

159. Q. And you don't know whether he would have been offered shelter at any point in the process; correct?

A. I don't know.

160. Q. And whether he was offered help finding somewhere else to go; correct?

A. I'm assuming I know that Tess, the outreach worker, had often offered to try and find him help, but they were not able to secure him any anywhere.

161. Q. And at what point in time are you talking about? Is that on the one occasion where the -- I'm sorry, was that referring to the

evictions in 2021, or some other point in time?

A. I'm speaking when I knew Mr. Marchand. So beginning in the spring of 2023, I know that there were efforts and attempts to look for shelter and housing for him.

162. Q. And what is that knowledge based on?

A. Based on what Mr. Marchand and the outreach worker, Tess, reported to me.

163. Q. How frequently did the outreach worker, Tess, provide these reports to you?

A. There was no formal reporting. I don't know that I could offer you a specific timeline. I just know that when I worked with Mr. Marchand -- I have not seen him in sometime now, but, when I worked with Mr. Marchand, Tess would occasionally pop in and provide me with an update perhaps, you know, once every couple of weeks.

164. Q. Going to the top of the second page, in the third sentence you state:

"At present, he contemplates suicide regularly because he cannot stay in shelter, he cannot stay in a tent, and staying outside is

A5168

becoming unbearable."

I want to ask you a few questions about that sentence. The first one is with respect to the report that he contemplates suicide regularly, there's no indication here that he was referred to inpatient treatment.

So would you agree with me -- or I take it that he wasn't actually expressing suicidal ideation, but something different, being contemplation?

A. No, I would disagree with you very strongly, actually. He did have suicidal ideation. It's very common for individuals in the community to have suicidal ideation, sometimes even with a plan to harm themselves.

Part of my role as a psychiatrist -- as a physician in general, but, as a psychiatrist, is to have an ability to perform a risk assessment and determine whether or not someone requires hospitalization or involuntary admission.

And so if I'm able to speak with someone and come up with a plan, whereby even though they're having suicidal ideation with a plan to harm themselves, they also have other protective factors and they're willing to come up with a

safety plan, then I do not -- they do not require hospitalization or even an ER visit.

165. Q. So can we take it, then, in these circumstances with respect to Mr. Marchand, those mechanisms, the safety plan and other resources, were sufficient and he didn't require hospitalization?

A. That is true, though I don't want to minimize the degree of suffering to which someone is experiencing when they are having suicidal ideation. It is a very clear sign of deterioration in their health and a strong signal that meant suffering.

166. Q. In that same sentence where you say he cannot stay in shelters, is that again based on what Mr. Marchand is telling you?

A. Mr. Marchand and the outreach worker, Tess. Mr. Marchand was service restricted from a number of shelters.

167. Q. And at what point in time, to your knowledge, was he service restricted from a number of shelters?

A. Again, I would be guessing, so I don't want to provide a specific date and time. I just recall in my involvement with him the shelters

A884

were not an option because of service restrictions is what I was told.

168. Q. So to put a finer point on it, your understanding was that he was service restricted from every shelter and, therefore, could not stay in shelter?

A. That was my understanding, yes.

169. Q. For the entire time that you were treating him?

A. For those several months, yes.

170. Q. You say he cannot stay in a tent. Again, is this based on what he told you?

A. Yes.

171. Q. What was the reason for him not being able to stay in a tent?

A. He told me he was just too frustrated. It wasn't worth the effort to set up a tent just for it to be torn down again, and it was very upsetting to have that done repeatedly.

172. Q. So it would be more accurate to say, then, that he found it frustrating to stay in a tent, but not that he was unable to stay in a tent?

A. I think he felt unable to. Whether you want to say unable to because of the

intense frustration he felt, he just -- he felt it was not an option any more, not a viable option.

173. Q. And in the second to last sentences of the first paragraph on page 2, you describe sleep depravation and state that it further destabilized his mental health condition as well as contributed to an escalation in substance use. Again, this is based on Mr. Marchand's reports to you?

A. Yes.

174. Q. In the last -- or I'm sorry, second last paragraph of your letter, you state that it is your opinion that:

> "Repeated encampment evictions have been a major contributor to the deterioration of Mr. Marchand's mental health and worsening of his substance use disorders over the past three years."

So you're speaking about three years, but, again, I think we've just established that you had treated him for about seven months; correct?

A. That is correct, though I did receive information from an outreach worker that knew him well who also observed that decline.

A5169

175. Q. So your opinion, at least in part, is based on what Mr. Marchand told you and what this outreach worker told you?

A. Yes, that's correct.

176. Q. And so you can't say from your own personal assessment of Mr. Marchand whether, for example, substance use disorders have actually worsened over the previous three years to your letter?

A. I find that question particularly difficult to answer because, in general, in medicine we're not accompanying people through their entire life and observing every moment and everything that happens to them.

We take a history and we -- and when I take a history first of someone, I ask about their substance use and I ask specific questions about their use over time, and, from that, that is often how we can determine whether someone's substance use disorder has gotten worse or gotten better.

And so I do think that there is credibility to an assessment done at a point in time when a history is obtained from a patient and from other people that know the person.

177. Q. But in this context, in a legal

proceeding where you're speaking to your observations, I mean you could have just spoken to what you observed over the seven months that you treated him, right?

A. I could have -- that is not -- so the practice of psychiatry is not -- it's not only what I observe when I see a person. It's based on their entire life, really, but, in particular, around specific disorders and symptoms of those disorders, and we obtain a longitudinal history as part of our diagnostic process, and also in terms of our -- when we follow folks, we revisit those symptoms and their severity to evaluate whether things have gotten better or worse over time.

So I think it important to include the fullness of the history as it -- to obtain even in a legal proceeding because it does inform my opinion of a person at a point in time.

178. Q. But that history, the longitudinal history, to use your term, it's not included in this letter. You've provided your summary of it and your opinion that it deteriorated over three years, but we don't actually have that history that you base it on; correct?

A. Do you mean in terms of, like,

A885

detailing specific symptoms and the amount of substance use at one point versus another point versus another point? Is that what you mean?

179. Q. Well, I don't actually know what I'm referring to because I don't have it. You reference a longitudinal history --

A. Right.

180. Q. -- an explanation for why you felt confident to give your opinion with respect to three years when you've been treating this patient for seven months. So -- but we don't have it; correct?

A. You don't have a copy of his clinical records, no, you don't. But I did include information there that I obtained from Mr. Marchand and Tess, the outreach worker, in the years preceding my involvement with him, and that is detailed in the letter.

181. Q. With respect to your opinion about the causative effect of encampment evictions, again, you haven't mentioned any other potential causes, conditions or factors that may have contributed to Mr. Marchand's condition; correct?

A. I call it a major contributor. I didn't call it a cause. So I didn't feel a need to

A5170

I'm just going to leave it there. I'm just going to leave it there, yeah.

184. Q. So you haven't indicated in this letter whether you considered other potential major contributors; correct?

A. I did not include them in the letter, no.

185. Q. And again, here you'd agree that if the information that was relayed to you either by Mr. Marchand, the caseworker or other sources, if that information's correct [sic], that could change your opinion; correct?

A. It's possible, yes.

186. Q. So let's go to Exhibit C, which is a letter dated December 21, 2023 concerning Shawn Arnold. I note here in the second paragraph of this letter you just go right into describing Mr. Arnold's diagnosis and don't describe your history with him. Do I take it you haven't actually treated Mr. Arnold?

A. I met Mr. Arnold for a consultation on one occasion, and he did not follow up after that with me.

187. Q. And was the consultation for the purpose of generating this letter?

-- I didn't say the encampment evictions were the sole cause of his deterioration. I described them as a major contributor. So in that way, I wasn't identifying all major contributors. I was identifying a specific contributor for the purposes of the letter.

182. Q. So there could have been other major contributors, to use your terminology, to Mr. Marchand's condition?

A. There are always different elements contributing to someone's mental health and substance use disorder. They're never one sole contributor.

Part of my job is to ascertain what the predisposing, precipitating and perpetuating factors are to someone's mental health and substance use disorder and always there are several things happening, though I think that in this case, as I have mentioned, encampment evictions were a major component for Mr. Marchand.

183. Q. But with respect to Mr. Marchand in particular, were there other major contributors not identified in this report?

A. I mean, not that I have personal knowledge of. I would say in general -- actually,

A. No, it was actually because there was concern for Mr. Arnold's well-being from other outreach workers.

188. Q. And when was the consultation relative to your writing of this letter?

A. I don't -- when I did write the letter shortly after consultation and I was informed they were someone that was part of this application, then I generated a letter quite quickly.

So I don't have the date on the top of my head that I assessed him, but it would have been within a few weeks of providing the letter.

189. Q. Would it have been before, or after writing this letter?

A. Absolutely before. I didn't write a letter unless I assessed a patient.

190. Q. And in paragraph 2 where you describe Mr. Arnold has a diagnosis of opioid disorder severe, again, you don't say who diagnosed him. I take it someone else did?

A. I mean, that was very much noted throughout Mr. Arnold's medical record, and, again, in my assessment of him, his presentation was consistent with that of a severe opioid use

A886

disorder.

191. Q. So let me just back up. So when you saw Mr. Arnold, recognizing that you don't quite remember the date sometime before this letter was written, you saw him because someone had expressed a concern about his condition needing treatment --

A. Yes.

192. Q. And so you didn't see him again before writing this letter; correct?

A. That's correct.

193. Q. Okay. And your assessment of him, was that for -- to diagnose him of opioid use disorder or something related to his opioid use disorder?

A. I mean, with many people with substance use disorder, there's a question about whether or not there's a comorbid mental health condition in addition to the substance use disorder which was the purpose of my initial assessment.

194. Q. And what was the thing that was comorbid with his substance use disorder that you assessed him for?

A. Well, there was a question that there was something, and I was not able to

ascertain an additional disorder for Mr. Arnold. So I did not include an additional diagnosis.

195. Q. So when you say in the second sentence of the second paragraph that Mr. Arnold has been living outside since January 2023, what's your source for that information?

A. That is Mr. Arnold, as well as he sees the Shelter Health Network fairly frequently and their notes indicate where he is when they see him. So it was a combination of a report from Mr. Arnold and corroboration with his Shelter Health Network records.

196. Q. And you don't know if any of that time was in a tent; correct?

A. The timing since January 2023?

197. Q. Well, when you say Mr. Arnold has been living outside since January 2023, yeah, whether he had been in a tent for any of that time?

A. Well, he reported to me when I saw him that he was in a tent. I don't know how often that he was in and out of a tent, but he was in a tent when I saw him, I believe.

198. Q. And I take it, then, you also don't have any knowledge of whether he stayed in shelter for any periods of time, correct, indoor

A5171

shelter?

A. That's correct.

199. Q. In the third paragraph of your letter you state that Mr. Arnold shared with you that:

"He first achieved some stability while allowed to remain in an encampment at JC Beemer which allowed him to access nearby supports and, ultimately, find housing approximately two and a half years ago."

Again, this was reported to you -- sorry, was it reported directly by Mr. Arnold, or was this contained in the records?

A. It was reported to me by Mr. Arnold, and it was consistent with what was in his Shelter Health Network chart.

200. Q. And I take it you don't have firsthand knowledge of the circumstances of his obtaining housing; correct?

A. I don't, no.

201. Q. And to your knowledge, was he housed, or unhoused when he saw you?

A. He was unhoused when he saw me, to

my knowledge. He was in a tent.

202. Q. As is indicated in the following paragraph where you say he's staying outside in a tent now. So again, what was the source for that?

A. That was Mr. Arnold's report, and he also presented as someone who was staying in a tent, meaning that he appeared to have -- like to smell of campfire and to be a bit disheveled.

203. Q. And not to belabour the point too much, but in that sentence, you know, you're referring in the third person. This is what Mr. Arnold is either telling you or the people who are writing the records that you've reviewed?

A. Yes, that's correct.

204. Q. And just with respect to his connection to supports, in the second sentence you state that Mr. Arnold is connected with another person there who is also living outside, that he trusts to watch over his things from time to time. But then in the last sentence you state:

"He's concerned about eviction and about leaving his possessions to access services and, thus, misses many commitments and appointments which has been having a deleterious

A887

impact on his ability to stay connected with supports."

So like those two things seem not to line up. He has someone who watches his things, but he's nevertheless concerned about leaving his possessions to access services and thus doesn't.

Is it fair to say that you're not able to speak to what extent his concern about leaving his possessions affects his ability to stay connected with supports?

A. When I met with Mr. Arnold, he found it very difficult to leave and was quite anxious to get back even though this other person was looking after his possessions, and it -- I mean, I don't know that this person was always available whenever Mr. Arnold had a particular appointment to then watch over his things. I can't speak to that specifically, but I would be surprised if there were someone else available whenever he needed to watch his things.

205. Q. And if we go to the second last paragraph of your letter, again, you state it's your opinion that:

"The threat of encampment eviction at present is a major

contributor to Mr. Arnold's difficulty in connecting with needed supports, including a housing worker and medical substance use care, thereby increasing his risk of serious health harms including unintentional overdose."

So with respect to -- let's break that down because there's a few things in that sentence. So talking first about unintentional overdose, you know, in fairness to you, Dr. Lamont, you're not actually treating him. So you can't actually say that he's at risk of overdose; correct?

A. No, I did a comprehensive assessment of Mr. Arnold. In review of his records, he has a severe opioid use disorder. He had numerous overdoses. He had two that required paramedics and emergency department care. So -- and he has ongoing opioid use disorder. So he's very much at high risk of unintentional overdose.

206. Q. Are you aware that in Mr. Arnold's cross-examination, he gave evidence that he has not had escalating opioid use and that he disagreed that he had had numerous unintentional overdoses?

A. I mean, I can't speak to what

A5172

Mr. Arnold said during his cross-examination. I can only speak to what he reported to me and what I found in his medical record.

I found that he had, in fact, had unintentional overdoses and was brought to hospital for those.

207. Q. Again, the details of those are not reproduced anywhere in your letter; correct?

A. I summarized it by -- but I did not include the specific details of his overdoses, no.

208. Q. Well, when you say "summarize", I mean you say -- at the very bottom of the first page, you refer to numerous unintentional overdoses, but we don't have indication about when those happened, the circumstances of how they happened, what treatment he was provided, none of that; correct?

A. It's not in the letter, that's correct.

209. Q. And then when you say in the last sentence of that paragraph "Allowing him to remain in place was a major contributor to his finding in being housed two and a half years ago", that's not something that you can say from your firsthand

knowledge; correct?

A. It's not from my firsthand knowledge in terms of knowing him at the time, but it is what he reported and what I have observed to be a consistent pattern in my practice and which was outlined in his Shelter Health Network chart as well.

210. Q. In that chart that we don't have?

A. Correct.

211. Q. Now, with respect to, again, your comment about the threat of encampment eviction being a major contributor to Mr. Arnold's difficulty in connecting with needed supports thereby increasing his risk of serious self harms, just to put a finer point on it, you don't know if those actual harms have come to pass; correct?

A. I don't know if they've come to pass, but the increased risk was absolutely there.

212. Q. Now, you're talking about the threat of encampment eviction. This letter is dated December 21st, 2023. At the time you're writing this, the encampment protocol in the City of Hamilton had been in place for about four months, you'd agree?

A. I don't recall when the encampment

A888

protocol was put into place, but Mr. Arnold reported to me the day that I saw him that City workers had been repeatedly coming and telling him that he had to move. So he was quite afraid that his tent was going to be torn down.

213. Q. And did he say anything about any steps that he would have taken to prevent his tent being torn down such as packing it up and moving it and engaging with people on a more suitable place to place his tent?

A. He didn't speak to that, but he did have someone, a friend watching his things to protect them if someone did try and come and tear it down.

214. Q. But again, Dr. Lamont, because you're giving the opinion here that the threat of encampment eviction was a contributor to Mr. Arnold's difficulty and thus his risks, I want to narrow down this supposed threat of encampment evictions where there was a protocol that I put to you allowed encampments in parks in the City of Hamilton provided that they met the specified criteria; correct?

A. Again, I don't recall when the protocol was put in place. I'll have to trust that

you're offering the correct date and that that could have been in place, yes.

215. Q. So if that was the case, then, you know, that threat is something that could be mitigated, I'll put to you; correct?

A. Again, I don't know exactly where his tent was. I don't know what it was and wasn't in violation of. I don't feel comfortable or confident to comment on that.

216. Q. And again, with respect to your opinion about the major contributor that the threat of encampment evictions presented, again, you don't indicate any other causes that you would have considered as being a major contributor to Mr. Arnold's risks or conditions; correct?

A. Correct.

217. Q. And if the information that was relayed to you was incorrect or your understanding was incorrect, that could change your opinion; correct?

A. It's possible.

218. Q. So let's go to Exhibit D to your affidavit, which is a letter dated April 9, 2024 concerning Corey Monahan. And again in this letter, you don't describe your history with Mr.

A5173

Monahan. So may we conclude that you have not been in a treating relationship with Mr. Monahan prior to writing this letter?

A. I did meet Mr. Monahan on one occasion to conduct a diagnostic assessment.

219. Q. And when was that occasion that you conducted the diagnostic assessment?

A. Again, I don't have the date in front of me, but it would have been in close proximity to this letter and before this letter was provided.

220. Q. Was it for purposes of creating this letter?

A. The -- for Mr. Monahan, I was connected with him to provide an assessment and to see if I could ascertain whether there were any impact on encampment evictions on his health.

MS. SHORES: Off record.

-- OFF THE RECORD DISCUSSION --

BY MS. SHORES:

221. Q. So Dr. Lamont, at the second paragraph you describe again Mr. Monahan's diagnoses, and given what you've just told us about assessing him shortly before generating this letter, may I take it that these diagnoses were

made by someone else?

A. The majority of -- sorry, yes, the diagnoses already existed in his medical record. But in my assessment on Mr. Monahan, his presentation was consistent with those diagnoses.

222. Q. And those diagnoses would have been made sometime before you wrote your letter in April of 2024?

A. Yes.

223. Q. And you don't know when?

A. It would have been, again, within a short number of weeks prior to writing the letter, but I don't have a specific date off the top of my head, no.

224. Q. The third paragraph starts with:

"Mr. Monahan shared his story with me prior to my involvement in his care."

And then you go on to describe events taking place in 2020 going into 2021. I just want to put a finer point on it. Is this something that Mr. Monahan reported to you, or is this something that would have been based on the medical records?

A. The majority is that which was reported to me by Mr. Monahan, and then I went and

A889

cross-referenced any clinical records that could offer more specific dates or timelines if they were available.

225. Q. And so it's not indicated in that paragraph what is reported to you by Mr. Monahan versus what you were able to locate in the medical records; correct?

A. That's correct.

226. Q. And in any event, you were not treating him at the time, and so you would have not have any firsthand knowledge of the events that are described in that third paragraph; correct?

A. That's correct, yep.

227. Q. So in the fifth sentence of paragraph 3 you state that:

> "Mr. Monahan has since experienced numerous encampment evictions, firstly when his camp in Gage Park was 'bulldozed' as per his description in winter 2020."

And then you go on to describe other events. But again, you don't have firsthand knowledge of those encampment evictions; correct?

A. That's correct.

228. Q. And you don't have knowledge of

how those so-called evictions transpired; correct?

A. That's correct.

229. Q. And with respect to his camp in Gage Park being "bulldozed", as you've described, you don't know what was involved in that so-called bulldozing; correct?

A. That's correct.

230. Q. Are you aware Mr. Monahan gave evidence in his cross-examination that he wasn't even present for that so-called bulldozing?

A. I'm not aware of what he gave in his evidence. So no.

231. Q. So again, you don't know if the details that are reported in this third paragraph are accurate; correct?

A. I mean, I'm just re-reading that because I don't know that it even says that he suggested he was present when the camp was bulldozed. He doesn't suggest that he was present.

232. Q. But you do go on to state that he was traumatized by that experience because he lost all of his possessions and then felt extremely desperate because he had nowhere to go?

A. Right. So he might not have witnessed the bulldozing, but he might have gone

A5174

back to see that all of his stuff was gone, which is quite traumatic for many individuals.

233. Q. You said he might have. So again, you're engaging in conjecture based on what you were told; correct?

A. Well, he told me that he had lost all his stuff and had nowhere to go, and I don't have any reason to doubt that that is true.

234. Q. But bulldozed is used in quotes. So why is that in quotes?

A. Because those were his words and I -- as I indicated there by his description.

235. Q. So again, if we go back to what you told us earlier in your cross-examination about corroboration, those are not details that you had corroborated; correct?

A. No, but I'm quite clear there, I think, that the -- I put the word bulldozed in quotes and indicated that it was by his description. So I think it's clear there that that was my source of information.

236. Q. And in the last sentence -- or I'm sorry, the last paragraph of page 2 continuing on to -- I'm sorry, I misspoke. The last sentence of the last paragraph on page 1 continuing on to

page 2, you describe that:

> "Mr. Monahan has had at least four intentional -- unintentional overdoses since 2020 and reported to having none prior to this time, which coincides with an escalation in substance use following encampment evictions."

Again, if that's starting in 2020, you wouldn't have been treating him at the time of those overdoses; correct?

A. That's correct.

237. Q. What was the source for indicating that he had at least four unintentional overdoses since 2020?

A. That was contained in his medical record.

238. Q. And with respect to the escalation in substance use following encampment evictions, again, that's based on your understanding from his report of when and how those evictions -- so-called evictions happened; correct?

A. Yes, that's correct.

239. Q. And in terms of gauging his substance use, again, you weren't treating him at

A890

the time. So you can't say based on your assessment of Mr. Monahan that his substance use in fact escalated during that timeframe; correct?

A. It's simply based on the history provided by Mr. Monahan in terms of the worsening of substance use and -- which I mention coincided with an increase in unintentional overdoses which is consistent with worsening substance use.

240. Q. Are you aware that when Mr. Monahan was cross-examined he gave evidence that his most recent overdose was four years ago?

A. I'm not aware that he gave that evidence. When I reviewed his medical record, there were overdoses more recent than that.

241. Q. But I thought you said that this was based on what Mr. Monahan reported to you?

A. And his medical record.

242. Q. Which again we don't have?

A. You're right, you don't have his medical record, that's correct.

243. Q. Are you aware that Mr. Monahan also gave evidence on his cross-examination that his drug use has actually decreased?

A. I'm not aware of what evidence he gave in his cross-examination. So no, I was not

aware of that.

244. Q. If Mr. Monahan's report that his drug use has decreased is accurate, would that alter your opinion?

A. I would need to understand some of the contextual variables, and I would also want to have a conversation with Mr. Monahan that was not in front of legal counsel and other individuals where he felt more comfortable.

245. Q. Well, do you have any information that Mr. Monahan was unable to tell the truth when he gave his evidence on cross-examination?

A. No, I do not. Just in general, I know people can feel quite intimidated and ashamed about their substance use especially in formal settings.

246. Q. In the second to last paragraph of your letter, you state that it's your opinion that:

> "Repeated encampment evictions have been a major contributor to the profound deterioration in Mr. Monahan's mood, as well as worsening impulse control difficulties, substance use disorders, and resultant overdoses."

A5175

So again, these repeated encampment evictions, we're talking about a timeframe during which you haven't treated Mr. Monahan; correct?

A. That's correct, yep.

247. Q. And you don't say here that you considered any other causes for the deterioration in his mood, worsening impulse control, worsening substance use disorders or resultant overdoses; correct?

A. I don't include that there, that's correct.

248. Q. And you go on in the second sentence of this paragraph to state:

> "This is due to the profound stress caused by the constant threat of encampment eviction, the impact of eviction itself, including loss of beloved possessions, and the state of absolute desperation that encampment evictions have plummeted Mr. Monahan into."

Again, Dr. Lamont, what is that based on?

A. It's based on the information provided to me by Mr. Monahan and his clinical

records.

249. Q. And if the information that this is based on is incorrect, that would change your opinion; correct?

A. It's possible, yes.

250. Q. Now, again, just to orient us to a point in time, this letter is written April 9, 2024. You're referring to repeated encampment evictions and, again, I'll put it to you, Dr. Lamont, that at that point in time, the encampment protocol in the City of Hamilton had been in place since August of 2023. So for several months at that point in time; correct?

A. Again, trusting that those dates are accurate, yes.

251. Q. So you wouldn't be able to say the extent to which at this point in time, in April of 2024, he was facing a threat of encampment evictions; correct?

A. I cannot speak to that in that specific moment, though I would say most people remain afraid that their tents are going to be torn down even with the protocol in place because of what has happened over the years and the lack of trust in the City.

A891

252. Q. Do you have any knowledge that anyone's tent was actually torn down by the City of Hamilton, firsthand knowledge?

A. Like did I watch the tent be torn down, do you mean?

253. Q. Yes. Do you have firsthand knowledge of anyone's tent actually being torn down in the manner that you describe?

A. I have not witnessed that personally, no.

254. Q. We can go to Exhibit E of your June 7, 2024 affidavit. This is an October 5, 2023 letter regarding Ammy Lewis, and at paragraph 2 you describe that you've been Ms. Lewis' treating psychiatrist since October of 2021.

Would you have seen -- or I'm sorry. Did you see her through Shelter Health Network or HAMSMaRT, or some other form?

A. I saw her through HAMSMaRT.

255. Q. And approximately how many times would you have seen Ms. Lewis for treatment before writing this letter?

A. I saw Ms. Lewis very frequently. The letter is from 2023. I'd known her for almost two years. So I would say, like, more than 40

A5176

disorders to then ascertain a diagnosis.

So I completed a diagnostic assessment of Ms. Lewis and diagnosed her with those conditions, and that has remained consistent in terms of the way she continues to present as having those diagnoses.

259. Q. What were the factors that led you to give those diagnoses?

A. Review of her medical records, report by Ms. Lewis in terms of her symptoms over years. I also spoke to Ms. Lewis' mother for corroborating information, and Dr. O'Shea had been her treating physician as well who provided some corroborating information.

260. Q. And with respect to the post-traumatic stress disorder specifically, was that related to a singular event?

A. She has numerous traumatic events in her life which I don't think -- I think it's beyond the scope of this to disclose her personal trauma, but it predated -- much of it was in her childhood and adolescence, and she's had yeah, many unthinkable traumas in her life that have contributed to that diagnosis.

261. Q. Dr. Lamont, your hesitance to

times, at least.

256. Q. And when you say that you confirm that she has diagnoses of post-traumatic stress disorder, borderline personality disorder, generalized anxiety disorder, depression and opioid and stimulant use disorder severe, did you give those diagnoses, or were those previous diagnoses?

A. I did give her the diagnosis of post-traumatic stress disorder and generalized anxiety disorder. She has previously been diagnosed with the substance use disorder, as well as depression and borderline personality disorder.

257. Q. And when did you diagnose her with post-traumatic stress disorder and generalized anxiety disorder?

A. After my initial assessment of Ms. Lewis in October of 2021.

258. Q. And what was the basis for those diagnoses?

A. How I diagnose those in individuals? It's based on the history provided by the person. A psychiatric diagnostic assessment includes very specific screening questions related to specific disorders, and then very targeted questions about symptom clusters within those

disclose Ms. Lewis' trauma is perhaps understandable, but I do need to put it to you that she is seeking damages in this litigation and you're providing a medical report about her medical condition. So her pre-existing conditions, you would agree with me, would be informative to her present conditions; correct?

A. I don't disagree that her pre-existing conditions are informative, but I don't know that it's relevant to the case to know which specific traumas she endured in her childhood.

In fact, I think that's unnecessarily intrusive. Knowing the diagnosis and that she had predisposing trauma, I think, would be enough information.

262. Q. Well, Dr. Lamont, I put it to you that it's for the judge hearing this case to decide what is relevant. But in any event, we don't have the information here so we can only take your word for it.

You state in the third paragraph of your letter Ms. Lewis had been recently -- sorry, second sentence of the third paragraph that:

"Ms. Lewis had been recently

A892

released from a Federal penitentiary and had returned to Hamilton in late 2020."

So at that point in time, you hadn't treated her; correct?

A. That's correct. She had sought care from Dr. O'Shea.

263. Q. And you go on to describe that:

"She was briefly housed after her release, though reports having suffered sexual assault from her landlord and she left that residence."

You didn't treat her for that sexual assault; correct?

A. No, I don't provide -- I mean, I provide maybe some mental health support around sexual assaults, but I also don't treat people for sexual assault.

264. Q. So again, that is based on a secondhand report that you're describing her having sustained that sexual assault?

A. She reported it to me directly and had very much symptoms in keeping with someone who experienced a sexual assault.

265. Q. After it happened, right, because she wasn't a patient of yours at the time it happened?

A. She was a patient of mine very shortly afterward. Dr. O'Shea referred her to me very shortly after that.

266. Q. You go on to describe again in the third paragraph that Ms. Lewis was evicted by the City from a tent in November 2021. Just pausing there, again, you don't have any firsthand knowledge of that so-called eviction; correct?

A. I did not witness her being evicted from the tent, but I did see her very shortly thereafter in crisis because her tent had been torn down and her belongings thrown out.

267. Q. And again, she's telling you that her tent was torn down and her belongings were thrown out? That's what she reported to you?

A. Yes.

268. Q. You don't actually know if that's what happened or if something else occurred?

A. Again, I was not witness to it, but that was a very common experience for many people living in tents at that time. So I had no reason to and still have no reason to doubt that

A5177

that is what happened.

269. Q. Well, Dr. Lamont, you say it's a very common experience, but we've talked about several of your patients now, and to every single one you've indicated that you haven't actually witnessed any of these evictions or anyone's tents being torn down in the manner that you describe.

So I'll put it to you that it's actually a very common thing that's reported to you, but you don't know if that's a common experience?

A. It was a very common thing reported to me and I have no reason to doubt it. Just in the same way that I have no reason to doubt if a woman tells me she was sexually assaulted, I didn't have to witness the assault to be quite convinced that it happened as she described.

270. Q. Continuing on with that sentence, you state that the so-called eviction led Ms. Lewis to have to return to an abusive living situation. You don't say whether other options for living arrangements were discussed with her, do you?

A. So Ms. Lewis, as noted, she was with her dog, which significantly limited her option. We certainly explored other options with

her, and I have personally called shelters for Ms. Lewis on numerous occasions and other -- and explored other options and, at that time, there was no option.

There were no foster options for her dog. She was not willing to separate from her dog at that time. She wasn't able to because her dog was such an important part of her well-being.

And so in my working with her and I knew her at -- in that moment in time, she definitely felt her only option other than sleeping outside without a tent was to return to that situation.

271. Q. You also refer in this third paragraph about two thirds of the way down that Ms. Lewis suffered chronic, severe suicidal ideation and go on to describe other symptoms, but the suicidal ideation, again, is something I want to hone in on.

Again, you don't describe referring her to inpatient treatment. So again, we've asked a similar question with respect to one of your other patients. Can we conclude that there were other supports short of emergency inpatient treatment that you felt were sufficient to address the

A893

suicidal ideation?

A. Yes, that's correct.

272. Q. For someone who's experiencing homelessness, though, wouldn't inpatient treatment be helpful for them in terms of providing them, at least temporarily, with a roof over their heads and potentially connecting them to greater supports?

A. Having worked in the psychiatric emergency department at St. Joe's, if there's any whisper that this person is seeking respite from being unhoused for the purpose of admission, that person will not be admitted.

The hospital does not admit individuals primarily for the purposes of providing shelter. They will not admit people, and if I in the community conducted a risk assessment and did not feel she met criteria for hospitalization, I can guarantee you in the hospital they would not have.

273. Q. And so the criteria for hospitalization would be -- can we deduce that other supports are insufficient to address the suicidal ideation that's being presented?

A. That's correct.

274. Q. Similarly with Ms. Lewis to the other patients that you've written about, you state

A5178

277. Q. Are you aware that Ms. Lewis is currently housed or at least at the time of her cross-examination she reported being housed?

A. Yes, she is. She has been since February 2023.

278. Q. You'd agree that she's been doing better since she became housed?

A. Yes.

279. Q. Now, returning again to your opinion, you'd agree again that if the information relayed to you is incorrect, then that would change your opinion?

A. It would, but I know Ms. Lewis extremely well and have been following her very closely for a long time. So I'd be very surprised if there were other information.

280. Q. Just taking a look at the clock, Dr. Lamont, I've got three more letters to ask you questions about.

MS. SHORES: It's just after 3:00. Let's go off record for a moment.

--- Recess commenced at 3:11 p.m.

--- Upon resuming at 3:16 p.m.

BY MS. SHORES:

281. Q. Okay. So Dr. Lamont, I'll next

in the second last paragraph that it's your opinion that:

> "Encampment evictions and the threat thereof repeated threat have been major contributors to the ongoing instability in Ms. Lewis' mental health and worsening of her substance use disorders from 2021 to 2022." [As read]

Again, you don't mention any other possible major contributors to Ms. Lewis' mental health or her condition in 2021 and 2022; correct?

A. That's correct. I don't mention them.

275. Q. Are you aware that Ms. Lewis described being the subject of repeated assaults and threats by her associates of her former landlord when she was cross-examined in this proceeding?

A. I'm not aware of that, no.

276. Q. And so you don't mention that as a potential cause of her mental health challenges; correct?

A. I don't mention that as part of it, no.

ask you about Exhibit F to your June 7, 2024 affidavit, which is your February 22, 2024 letter regarding Sherri Ogden.

Again in this letter, you don't describe your treating history with Ms. Ogden. And so may I take it that you hadn't treated her prior in a treating relationship prior to generating this letter?

A. That is correct. I did do an assessment of Ms. Ogden prior to generating the letter, however.

282. Q. And in the second paragraph you state -- or sorry, third sentence you state that:

> "She has diagnoses of complex post-traumatic stress disorder, major depressive disorder, attention deficit hyperactivity disorder, opioid use disorder and stimulant use disorder."

And then you go on to describe that:

> "She's been on medication for depression for many years prescribed by her family physician."

So you don't indicate who diagnosed her with the conditions that you list. I take it was

A894

somebody other than yourself?

A. The diagnoses pre-dated my assessment, and my assessment was consistent with those diagnoses.

283. Q. And you don't say when she was diagnosed with any of these conditions. Do I take it you don't know?

A. I wouldn't be able to give a specific date, no. They are contained throughout her medical record, however.

284. Q. And when we talk about her medical record, you had described for us previously the -- in general the sort of medical records, but I think this is the first of your patients who you've described as also having a family physician. Were you provided with her family physician's records to review?

A. I unfortunately was not, but I did have her Shelter Health Network chart which was also quite fulsome.

285. Q. And do you know the timeframe that the Shelter Health Network chart spanned back to?

A. I can't give you a specific date, but I do recall it being over the course of years.

286. Q. And so just with respect to the

conditions listed in the second paragraph, given that you saw Ms. Ogden for an assessment, it's fair to say you weren't treating her for any of those disorders; correct?

A. That is correct. I certainly offered her follow-up to be treated for those conditions, but she did not follow up.

287. Q. In the third paragraph of your letter you state:

> "Ms. Ogden has been experiencing homelessness in the Hamilton area for over five years."

What is your source for that?

A. Ms. Ogden reported that to me. I also spoke with some Good Shepherd outreach workers, which were in the vicinity of where Ms. Ogden often stayed.

Not all of them had known her for that timeframe, but they did note that she had been chronically homeless, and there was -- again, it was like a community member that had taken compassion toward Ms. Ogden and had been working closely with her for at least a couple of years.

Her name was Anne, this woman, and she also indicated to me that Ms. Ogden had been

A5179

homeless for quite some time, and that was also consistent with the Shelter Health Network's charts.

288. Q. So with respect to this third paragraph here, would that have been based on what either Ms. Ogden told you, what the shelter worker told you or what was contained in those Shelter Health Network reports?

A. Yeah, just to be clear, it wasn't a shelter worker. It was an outreach worker for Good Shepherd, and then also just a community member named Anne. She wasn't affiliated with any particular organization, but was someone that had just taken an interest in helping Sherri.

289. Q. Now, you do indicate in this report -- again, we're in the third paragraph -- that:

> "Because of the chaotic nature of her daily life [referring again to Ms. Ogden], she has difficulty recalling specific dates and locations of where she has stayed outside."

So would it be correct to take from this that her difficulty with recall is greater

than what you would ordinarily see in patients?

A. It depends which type of patient you're referring to.

290. Q. Well, I guess I'll say the ordinary limits of human memory.

A. She certainly has more significant memory difficulties, yes.

291. Q. And so did that inform your history taking with Ms. Ogden?

A. It did. She had such difficulty, I did not include many of the specific details that she seemed much less sure of or that I could not corroborate.

292. Q. Okay. And so when you say you didn't include things that you couldn't corroborate, what, if anything, in paragraph 3 of your letter was corroborated?

A. The impact of the forced displacement in 2023, and then -- I'm just re-reading now. And then what was observed by this community member named Anne in terms of the worsening of Ms. Ogden's mood and trauma symptoms as well as substance use over time.

293. Q. So let's talk about the forced displacement. In the third paragraph, again you

A895

state:

"She has, however, repeatedly experienced forced displacement from encampment on numerous occasions including being forced to move from behind City Hall in 2023."

How did you corroborate that?

A. This woman named Anne knew Sherri at the time and saw her after that forced displacement. I know -- I do recall there being a significant displacement of individuals from behind City Hall. So that also corroborated my recall of events around that time.

294. Q. When you say "forced displacement", what do you mean?

A. People were forced to move from behind City Hall.

295. Q. But what do you mean by "forced"?

A. Well, again, I wasn't there, but from what I recall, notices were put on tents for a period of time, and then there was a level of enforcement by individuals who came and required people to move. I cannot recall if it was by-law officers or if there was police presence or both. I'm not sure.

296. Q. When you say "a level of enforcement", again, what are you describing?

A. Individuals with authority who are employed by the City. I don't know. Again, I wasn't there. So I can't be more specific than that, but I do know that people were told that they had to move, that they had no other option. If they didn't move by a certain point, their things would be thrown out.

297. Q. So that's what you're describing when you say "forced displacement"?

A. Yes.

298. Q. When you say "Most of her belongings were thrown out under the City's direction", again, that's not something that you have firsthand knowledge of; correct?

A. That's what she reported to me, and, again, it was consistent with what many other people had reported to me around that time that they had experienced.

299. Q. In the second to last sentence of that paragraph you state that:

"Ms. Ogden used to find safety and comfort living in a tent amongst others in the community."

A5180

Again, I take it this is based on what she reported to you?

A. It is, yes.

300. Q. But again, you'd agree that there are still risks to a person such as -- and particularly a woman such as Ms. Ogden -- staying outside in a tent; correct?

A. I would say that there are risks to any human being who is unhoused. However, I think that for Ms. Ogden, and for many individuals who are staying in a tent, there is at least protection from the elements and there can be other individuals they trust in the tent with them.

There's some barrier towards the outside world, and so people do feel a sense of safety in a tent that they don't feel otherwise.

301. Q. In the last sentence -- or the last part of the sentence of this paragraph you state:

"Each time she begins to build connections, she is forced to move and has difficulty re-engaging with supports because they have difficulty locating her."

Again, what is the source for that

statement?

A. That was, again, Ms. Ogden's report, as well as the community member named Anne supporting Ms. Ogden.

302. Q. But Ms. Ogden in particular, at least, seems to be able to engage with her family physician; correct?

A. It does not seem that that's reliable, a reliable connection. When I interviewed Ms. Ogden, I think that it's largely in the form or prescription renewals.

303. Q. But again, you haven't reviewed the family physician's records. So you can't say for certain?

A. I don't have their records, no.

304. Q. In the last paragraph on the first page of your letter about Ms. Ogden you state:

"Because she is forced to sleep outside, Ms. Ogden gets very little sleep and uses large amounts of stimulants to try to stay awake to protect both herself and her belongings."

Again, this is based on what she reported to you?

A896

A. It is based on what she reported to me, as well as the observations of the outreach workers from Good Shepherd and the community member named Anne who knows her.

305. Q. But with respect to her stimulant use in particular, you haven't assessed her for stimulant use when she's been outside versus not being outside; correct?

A. I have not observed her during those times, but I would say that it is extremely common for individuals living outside completely unsheltered to use stimulants to stay awake so that they don't lose their belongings.

It's not even necessarily -- even if they have a stimulant use disorder, their use tends to increase because they simply want to stay awake. So they have to use essentially continuously in order to do so; not even to get high, but simply to stay alert so they can protect themselves and their belongings.

306. Q. There's no indication here that you suggested or coordinated any treatment for the stimulant use?

A. I did certainly offer. And in fact when I was there, applications were being put

together for residential treatment for Ms. Ogden by this community member, but I don't -- when I did follow up shortly afterwards, it sounds like she unfortunately wasn't able to attend residential treatment, but there's been a lot of effort to try and offer Ms. Ogden support including from myself.

307. Q. In the second to last paragraph you state that it is your opinion that:

> "Encampment evictions and the repeated threat thereof have been major contributors to the ongoing instability in Ms. Ogden's mental health and worsening of her substance use disorders."

Again, this opinion is based on the information that was relayed to you; correct?

A. That is correct, information relayed to me and the review of her medical record.

308. Q. And again, you haven't identified any other potential major contributors to her condition; correct?

A. That's correct.

309. Q. And more particularly, you haven't indicated here whether any of those have been -- whether any possible other major contributors have

A5181

been considered as linked to her current condition?

A. They're not mentioned in the letter, that's correct.

310. Q. And you'd agree that if the information relayed to you is incorrect, that could change your opinion?

A. It's possible, yes.

311. Q. Again, just with respect to the threat of encampment evictions, this is a letter dated February 22, 2024. So you're not able to state to which -- you know, at this point in time the threat of encampment evictions was a feature for Ms. Ogden given the encampment protocol in August of 2023?

A. Right. I can't in relation to the protocol. Though again, as I said before, there's a general fear amongst individuals that has been shared with me that they don't necessarily trust that they will be able to stay where it says they're able to stay even if that's what the City said.

So there's still a feeling of threat. Like if someone is traumatized by something, there can be an ongoing feeling of threat. That's one of the core symptoms of PTSD, is an ongoing feeling of

threat even if the threat is no longer there.

312. Q. But you don't mention that as specifically being a contributing factor to Ms. Ogden's PTSD and, in fact, you were not the physician who diagnosed her with the PTSD; correct?

A. That was a pre-existing diagnosis. But again, when I assess individuals, I did a diagnostic assessment, and her assessment was consistent with that of PTSD.

313. Q. I'll take you next to Exhibit G to your June 7, 2024 affidavit. This is a letter dated May 11, 2023 with respect to Jammy Pierre.

You state at the second paragraph of this letter that you've known Ms. Pierre since fall of 2021. Just pausing there, did you know her in a doctor-patient setting, or some other way?

A. So my initial interactions with Ms. Pierre were actually as -- she was a peer worker with Keeping Six. And so I interacted with her in clinic in that way, though she also sought medical care from HAMSMaRT physicians, and both Ms. Pierre and other physicians suggested that she meet with me for mental health support. She had not done so until a month or two preceding my generation of this letter.

A897

314. Q. So to be clear, she would have seen in you in a doctor-patient setting approximately a month before this letter was written. So sometime around roughly April of 2023?
A. That is correct.
315. Q. Approximately how many times would you have seen her in a doctor-patient setting before writing this letter?
A. I only saw her one time in the doctor-patient setting before writing this letter.
316. Q. And was that for an assessment for purposes of generating this letter?
A. It was not. For Ms. Pierre, it was a diagnostic assessment for the purposes of any other diagnostic assessment for initiating treatment for Ms. Pierre.
317. Q. In the second sentence when you state "And can confirm that she has diagnoses of post-traumatic stress disorder, generalized anxiety disorder, depression and opioid and stimulant use disorders (severe)", those would have been diagnoses made by someone else?
A. She did have a number of pre-existing diagnoses, but, again, I did my own diagnostic assessment and confirmed those

diagnoses.
318. Q. And you can't say when she was first diagnosed with any of those conditions?
A. I cannot, no.
319. Q. In the third paragraph of your letter you state:
"Ms. Pierre has shared her story with me prior to my involvement with her."
So again, may I take it that everything in that third paragraph references her report to you of events that transpired before you started treating her?
A. That is correct.
320. Q. And so you don't have any firsthand knowledge of any of these events described in that paragraph; correct?
A. That is correct.
321. Q. In the second last sentence of the third paragraph you describe Ms. Pierre experiencing:
"...her tent being taken down and thrown out as part of a City-led encampment eviction while she was away at a store. She had left her

A5182

dog in the tent and her dog was gone when she returned."
Again, that event in particular you don't have firsthand knowledge of; correct?
A. No, I do not.
322. Q. Okay. Are you aware that Ms. Pierre when she was cross-examined confirmed that she was actually, in fact, out walking her dog at the time that her tent was taken down and that her dog had not been left in the tent?
A. Counsel did inform me that she had reported something that was not consistent with what she had reported to me when I generated this letter.
323. Q. Okay. And so is it possible that what has -- what's written in your letter is incorrect, or are you saying that Ms. Pierre told you something different?
A. She told me something different. I cannot verify which version -- in terms of what -- the location of the dog during the eviction, I cannot comment one way or the other because I don't know.
324. Q. You don't know what happened?
A. That's right.

325. Q. In the fourth paragraph of your letter concerning Ms. Pierre you describe that:
"Individuals suffering from complex mental health conditions and substance use disorders, in particular individuals who have suffered repeated traumatic events, commonly experience a marked decline in their mental health and substance use following repeated traumatic events."
So that sentence you're describing your medical opinion with respect to what happens generally in that population?
A. I would say I'm describing a pattern that I commonly observe.
326. Q. And you state that -- you go on to state in that fourth paragraph that:
"Ms. Pierre describes the repeated forced movement of her belongings, and particularly the loss of her dog, is highly traumatic. Following this, she suffered worsening PTSD symptoms, depressive symptoms and anxiety

A898

disorder symptoms."

Again, what is your source for your statement that she suffered these worsening symptoms?

A. Ms. Pierre's report of symptoms as well as corroborating information from other people working for HAMSMaRT and other physicians involved in her care.

327. Q. And again, with respect to this so-called repeated forced movement of her belongings, Ms. Pierre's belongings, you don't have any firsthand knowledge of what happened in those circumstances?

A. I was not present, no.

328. Q. Okay. And those aren't things that you've been able to corroborate?

A. No.

329. Q. In the last sentence of the fourth paragraph you describe that Ms. Pierre:

"...subsequently suffered multiple overdoses from the toxic street drug supply, which include an ICU admission in August 2020 as well as ER visit in November 2020."

Again, you wouldn't have treated her

for those; correct?

A. No, that's correct. That was based upon review of her medical record.

330. Q. And are you aware that Ms. Pierre when she was cross-examined gave evidence that those were unintentional overdoses?

A. I'm not aware, but that is -- that was my understanding, that they were unintentional.

331. Q. And specifically -- and again, this was Ms. Pierre's evidence -- that not only did she not intend to overdose, but she didn't intend to consume the substance that eventually caused her to overdose; is that correct?

A. Again, I wasn't there when she was cross-examined. So I don't know what information she provided to you, but I was able to ascertain from her medical record that she had had opioid overdoses on those dates as outlined in the letter.

332. Q. Okay. So you can't say based on your firsthand knowledge what the causes of those overdoses were?

A. Well, it was opioid toxicity. That was in the -- that was determined by the physicians that were treating her at the hospital, and that was the -- in her medical record from the

A5183

report.

333. Q. But with respect to what caused Ms. Pierre to overdose, you're not able to state to those causes?

A. Are you referring to intentionality of substance use or intent to harm herself? Is that what you're referring to?

334. Q. Well, you state here the worsening of her mental health conditions drove increased substance use, and then you state in the next sentence she subsequently suffered multiple overdoses.

So there's an implication here, although in fairness to you it's not explicitly stated in your letter, that she had a worsening mental health condition and that drove increased substance use and that's implied that it led to the overdoses, but you can't specifically say that; correct?

A. I can simply say what I said there, which is that there was an increase in substance use and, following that, there were a series of overdoses.

335. Q. In the last full sentence of the first page you describe that Ms. Pierre:

"...is thus living rough and forced to stay awake for prolonged periods to protect her personal safety."

Are you aware that Ms. Pierre is housed?

A. I am, yes. She's now in Dorothy Day.

336. Q. And according to Ms. Pierre, she became housed on June 1st, 2023?

A. That sounds accurate, yes.

337. Q. So that would have been within a few weeks after writing this letter which is dated May 11, 2023?

A. Yes.

338. Q. So you'd agree that as soon as a few weeks after you wrote this letter, it was no longer accurate to the extent that Ms. Pierre was reported to be living rough; correct?

A. That's correct.

339. Q. In the second to last paragraph of this letter you state that it's your opinion that:

"...repeated encampment evictions have been a major contributor to the profound

A899

deterioration in Ms. Pierre's mental health and worsening of her substance use disorders over the past four years."

But again, Dr. Lamont, you haven't actually treated Ms. Pierre over the past four years; correct?

A. I have not treated her, no, but other physicians had in the organizations that I worked for, and she also was present in the physical space that I worked in and I was able -- I witnessed as someone who worked in the same space that deterioration.

340. Q. And again, here you don't mention in giving your opinion any other potential contributors to her condition that may have been considered or may have been contributory, do you?

A. No, I do not.

341. Q. And in any event, your opinion is informed, at least in part, on the secondhand information relayed to you about Ms. Pierre's experiences and these so-called evictions; correct?

A. Yes, I mean in terms of psychiatric diagnoses and assessment, it is always based on the patient's report and any other

collateral sources of information. There is no blood test or other way of, you know, confirmatory testing that's done. So I wanted to highlight that, I guess.

342. Q. But even if we're talking about the evictions, again, you've described in your letter one eviction in 2019 where you were of the understanding that Ms. Pierre had left her dog in her tent and her dog was gone when she returned. Ms. Pierre's now told us that that's not actually what happened.

So you'd agree that if the evictions didn't transpire in the way that you understood, that may change your opinion; correct?

A. I think the piece about the dog, I think, is secondary to the eviction itself. We know that many people were evicted from encampments. This happened repeatedly.

I watched a very clear pattern emerge amongst individuals I was seeing that people experienced enormous distress and some crisis when their belongings were thrown out and their tents were thrown out.

So I don't have any reason to doubt. Just as anyone who's been through a trauma, I don't

A5184

have reason to doubt that the trauma occurred in the way that they described.

343. Q. Well, Dr. Lamont, you just said "we know" with respect to encampment evictions, but you told us earlier, I think quite clearly, that you haven't actually witnessed any of these encampment evictions, and so you can't say whether they've gone down in the way it was reported to you; correct?

A. I can't say with certainty, but I have no reason to doubt what people are describing to me.

344. Q. But again, that's different than knowing? That's being told; correct?

A. Well, I'm trying to recall what I had just said. I don't know that I said we know that encampment evictions occurred exactly in the way that people described. I didn't say that specifically. I said we know that people were evicted from encampments. We know that that happened.

345. Q. All right. Well, so what are you describing when you say evictions? You're talking about people's tents being torn down and their things being thrown out. Is it your evidence that

every time an eviction happens someone's tent is torn down and their things are thrown out?

A. Not every time because, again, I don't know. Like I'm not there to describe exactly what happens, but I know that that is -- that has been described repeatedly and I've -- I don't want to say anything that isn't -- I'm not confident of.

So I can't say I've -- I know I've seen videos of evictions happening, but I'm not confident that they were based out of Hamilton. So I can't say -- I can't speak to that specifically.

346. Q. I mean, is it possible that what is -- that an event that you would describe as an eviction is simply a by-law officer telling people that they're not allowed to be where they are and they have to move along?

A. It's possible. I think that happens sometimes, but I also -- anyway, I'll stop.

347. Q. And again, with respect to your opinion about Ms. Pierre, if the information that was relayed to you or the assumptions that your opinion is based on turned out to be incorrect, that would change your opinion, could it not?

A. It's possible that it could, yes.

348. Q. And Ms. Pierre in particular,

A900

would you agree that she has been doing better since she became housed?

A. Yes.

349. Q. I'll take you last to Exhibit H of your June 7, 2024 affidavit, which is a letter dated January 30, 2024 with respect to Linsley Greaves.

Again, in your letter about Mr. Greaves, you don't state your history with him. So can I take it that you haven't been in a treating doctor-patient relationship with him prior to writing this letter?

A. That's correct. I did complete an assessment of Mr. Greaves while he was hospitalized at the Hamilton General prior to generating this letter.

350. Q. In the second sentence of your -- sorry, second sentence of the second paragraph of your letter you state that:

"Mr. Greaves has diagnoses of stimulant use disorder as well as stimulant induced psychosis."

These are pre-existing diagnoses?

A. They are. And again, diagnoses that were confirmed during my assessment.

351. Q. And you don't know who diagnosed him with these -- who first diagnosed Mr. Greaves with these conditions?

A. I don't know who first made the diagnoses, no, but they were both longstanding.

352. Q. And so I take it from your previous answer that you don't know when those diagnoses were first made?

A. No.

353. Q. At the second paragraph, you go on to describe events in Mr. Greaves' life from 2021 to about 2022, and although you don't say how they were reported to you, I take it just given what you've told us about your assessment of Mr. Greaves and the timing thereof, that the third paragraph is all based on what was reported to you secondhand?

A. It was all based on what was reported to me by Mr. Greaves, yes.

354. Q. And with respect to Mr. Greaves' below-knee amputation, in the last sentence in the third paragraph you state -- well, actually, this won't make sense unless we read the sentence before that. So you state:

"Mr. Greaves was subsequently forced to sleep outside without any

A5185

protection from the elements in early 2022 and suffered frostbite of his lower limbs as a result. This went unattended for many months, and he ultimately became very ill and required a below-knee amputation of his left leg and amputation of several toes on his right foot in December of 2022."

So again, just with respect to the amputation, what is your source for that information?

A. That was upon review of his medical record and the information contained therein, both in HAMSMaRT medical record as well as his hospital records.

355. Q. And when you describe that Mr. Greaves was forced to sleep outside without any protection from the elements in early 2022, what was your source for that information?

A. Mr. Greaves mentioned that to me, and that was also consistent with what was in his medical record.

356. Q. And when you say that was consistent with what was in his medical record,

what do you specifically mean there?

A. I believe -- and again, I just reviewed a bunch of records in preparation for this, but I want to make sure that I'm providing you with accurate -- an accurate recall.

I know that in his HAMSMaRT record, certainly in the medical record there was indication that he had been outside, and that as a result of being exposed to the elements he suffered frostbite.

357. Q. All right. But specifically saying "forced to sleep outside", you don't have any indication of whether shelter was offered to or available to him? You just are aware that the records say he was outside; correct?

A. Sorry, I didn't realize what you were referring to there. In terms of the forced to sleep outside piece, that would have been based upon Mr. Greaves' report to me, that he felt that was his only option at the time.

358. Q. With respect to his frostbite going unattended for many months, are you aware that Mr. Greaves reports that he was seen by a Dr. Wiwcharuk -- for the record, W-I-W-C-H-A-R-U-K -- in June of 2022 for his frostbite?

A901

A. I don't recall that.
359. Q. Are you aware of any -- receiving any treatment at that point in time?
A. I'm not aware of that, no.
360. Q. You haven't examined him. So you can't say if his leg or toes could have been saved if he had prompt treatment; correct?
A. That would be far beyond the scope of my knowledge to even offer any sort of comment on.
361. Q. You're a psychiatrist. So you wouldn't be treating frostbite?
A. That's correct.
362. Q. In the fourth paragraph of your letter concerning Mr. Greaves you state that:

"Mr. Greaves identifies that his stimulant use also escalated after the encampment eviction at Woodlands in early 2022 because he needed to force himself to stay awake for prolonged periods while living outside unprotected from the elements and without the community that he had developed at Woodlands."

Again, this is based on what he

reported to you?
A. That's correct.
363. Q. And not to belabour the point, but just with respect to that specific encampment eviction at Woodlands in early 2022, you don't have any firsthand knowledge of what transpired with that so-called eviction; correct?
A. That's correct.
364. Q. And with respect to his reported stimulant use escalating, again, that's not something that you observed in a doctor-patient treating relationship because you hadn't been treating him at the time; correct?
A. Correct.
365. Q. In the third last paragraph of your letter you describe that:

"Mr. Greaves described a number of other encampment evictions he had faced both near Wesley Centre as well as on Ferguson Street near the train station, though he was less sure of the timelines of these evictions."

Again, this sentence would be based on Mr. Greaves reporting to you; correct?

A5186

A. That's correct.
366. Q. Okay. And so you don't have any knowledge of these so-called evictions or what would have happened when they took place; correct?
A. That's correct.
367. Q. Now, you describe in the second last sentence -- or I'm sorry, second last paragraph of your letter that it's your opinion that:

"...repeated encampment evictions and, in particular, the encampment eviction in early 2022 from Woodlands Park and subsequent experience of frostbite leading to tissue death and amputation have been a major contributor to the ongoing instability in Mr. Greaves' substance use disorder and symptoms of psychosis, as well as ongoing immense psychological and emotional suffering secondary to limb loss and resultant isolation from family."

There's a lot there so I just want to break that down a bit. So again, you're giving your opinion about the repeated -- so-called

repeated encampment evictions and the encampment eviction in 2022, but, again, you're not aware of the -- firsthand of the particular circumstances of those evictions; correct?
A. That's correct.
368. Q. And when we talk about the frostbite, as you had said previously, that's not something within your area of expertise because you're a psychiatrist and not a physician who would treat something like frostbite; correct?
A. That's correct, which is why I just included what was in his medical record and didn't offer my own opinion on the matter.
369. Q. Okay. So you're not speaking to the cause of the frostbite or the tissue death or amputation? That's not your diagnosis? That's just you repeating what was in the medical record that you consulted?
A. That is correct.
370. Q. Okay. And the medical record isn't appended to your report?
A. No.
371. Q. And when you describe the instability in Mr. Greaves' substance use disorder, symptoms of psychosis and his suffering -- although

A902

let me break that down a little bit because otherwise it will be a tricky question for you to answer. So strike that.

With respect to Mr. Greaves' instability with his substance use disorder and symptoms of psychosis, again, you're describing the encampment evictions being a major contributor to those. Again, you're not -- you haven't indicated in this letter here whether you've considered any other major contributors to those conditions; correct?

A. I haven't indicated that in the letter, no, you're correct.

372. Q. And with respect to the psychological and emotional suffering secondary to his limb loss and resultant isolation, again, are you saying that the limb loss is related to the encampment evictions?

A. Well, limb loss is related to frostbite from being exposed to the elements, which seemed to be proximally related to him being evicted from the encampments.

373. Q. Okay. But when I asked you at the beginning of this examination about whether people could get frostbite in encampments, you know, you

said -- and I'm paraphrasing here. This isn't verbatim, but that wasn't something that you were able to speak to. So is that something that you're now giving an opinion on?

A. Based upon I'm pulling together what was in his medical record and putting it in a timeline and that he is suffering immensely because of limb loss which happened when he was sleeping outside.

374. Q. But again, speaking to whether or not if he had been in a tent, you can't say whether or not he would have still suffered the frostbite if he had been in a tent?

A. I think -- yeah, I'm offering opinion here, and I don't know that that's what's being asked of me. So I don't know that I should answer.

375. Q. Well, I'm not asking for opinion. I'm just asking for the scope of what you're saying here. You can't say whether or not Mr. Greaves would have still suffered frostbite if he had been in a tent on that occasion; correct?

A. I think from my understanding of what happened from Mr. Greaves, he was outside completely exposed to the elements, and when he was

A5187

in a tent, he had the shelter of the tent as well as blankets and sleeping bags. So it will be much less likely to have suffered frostbite when he had some protection.

376. Q. And you also can't say whether or not -- or sorry, you can't speak to the circumstances that led Mr. Greaves to, as he reports, not being covered by blankets or other protections from the elements?

A. That's correct.

377. Q. When you say in the last sentence of the second last paragraph "This has been exacerbated by the ongoing lack of available, suitable shelter spaces or permanent housing options", again, you haven't yourself investigated shelter space availability for Mr. Greaves; correct?

A. I had not, but it was clear that others had, and, in fact, he was in hospital in part still because they hadn't been able to secure a shelter bed for him.

378. Q. Are you aware that Mr. Greaves has given evidence that he didn't even try to obtain shelter at certain points?

A. I'm not aware of evidence he

provided, no.

379. Q. And again, if the information that was relayed to you that forms the basis of your opinion turns out to be inaccurate, you'd agree that may alter your opinion; correct?

A. It's possible, yes.

380. Q. And with respect to this specific point, if there were shelter spaces available for Mr. Greaves, you'd agree that that would not be an exacerbating factor; correct?

A. Well, my answer to that would be it depends because there are some individuals who for very valid reasons are not comfortable staying in shelter either. So even if there's a shelter bed available, it does not mean that it's -- that that person will access it.

381. Q. But you'd agree, Dr. Lamont, if someone is facing a survival threat by being outside and they just might not feel comfortable in shelter, surely you'd agree that it's preferable for them to be inside in shelter in that circumstance, no?

A. I mean, on the outside looking at the situation, I would say that that seems the common sense approach. However, I would say there

A903

are individuals who have such complicated histories and such significant trauma, many people have experienced traumatic events in shelters, and a common response to a traumatic event is to avoid anything, a profound avoidance to avoid anything that could cause that trauma experience to be triggered.

So many people will avoid shelter for that reason, but I don't know if that's the case for Mr. Greaves. I didn't speak to that specifically with him, but I would say that is a common experience.

MS. SHORES: Just go off record for a brief moment.

-- OFF THE RECORD DISCUSSION --

BY MS. SHORES:

382. Q. So Dr. Lamont, you've with each of these patients given an opinion with respect to the contributory effective encampment evictions on their condition, and we've also discussed that you don't actually have firsthand knowledge of what happens with these so-called encampment evictions. So again, I'd like to put a finer point on that.

If these encampment evictions are not happening in the way that is reporting to you,

you'd agree that that may change your opinion with respect to these patients; correct?

A. Well, I guess my answer to that would be it depends. I liken it to if someone lives in an apartment and they receive an eviction notice, for some people they can deal with it. Other people find it extremely upsetting and traumatic likely related to predisposing conditions for them.

So regardless of how violent an eviction was from an encampment, whether or not it was simply a by-law officer saying you have to move or whether someone's items were throw out, I think in either case that experience can be quite traumatic for someone, and if someone's told to move by an official, that is experienced by many as an enforced eviction, the same as receiving an eviction notice in an apartment would.

383. Q. Dr. Lamont, you've understood my questions today?

A. Yes.

384. Q. Do you wish to change any of your answers?

A. No, I don't think so. Thank you.

385. Q. Okay. Those are my questions, and

A5188

thank you again for giving us your time today.

A. Thank you.

RE-EXAMINATION BY MS. CROWE:

386. Q. Thank you, Dr. Lamont. I only have a few questions. We're almost done.

So with respect to Ms. Heegsma, you indicated that you received some information about her accessing drop-in services through Keeping Six. What is Keeping Six?

A. Keeping Six is a harm reduction group based out of Hamilton made up of individuals with [indiscernible] living experience of substance use and people that care about them.

387. Q. And how did you have knowledge of her attendance at these drop-in spaces?

A. The drop-in spaces are co-located with the HAMSMaRT clinic.

388. Q. Okay. Thank you. With respect to Ms. Heegsma's report, so you mentioned that you had talked to -- so your report is based on Ms. Heegsma's report and some records, but then you also mention that you had spoken to Dr O'Shea and you mentioned a couple other sources.

So I just wanted to clarify. Do you remember exactly what information sources you

consulted in preparing your report for Ms. Heegsma?

A. I know that for Ms. Heegsma I consulted her medical record with Shelter Health Network, with HAMSMaRT, Dr. O'Shea spoke with me directly, and, again, I don't recall which peers at Keeping Six, but there were peers at Keeping Six as well.

389. Q. Thank you. And when you were talking about Mr. Marchand, you mentioned an outreach worker with the AIDS Network named Tess. What is the relationship between the AIDS Network and HAMSMaRT or the AIDS Network and the Shelter Health Network?

A. I'm not aware of any direct relationship, but, at the time, the AIDS Network lent space to HAMSMaRT to have their clinics. And so Tess, who was an outreach worker with the AIDS Network, had an office directly across the hall from the clinic room I was using.

390. Q. Okay. Thank you. With respect to Mr. Arnold, you indicated that his presentation was consistent with severe opioid use disorder. What did you mean?

A. His history of reported amounts of the use of opioids, the significant consequences he

A904

faced as a result of use of opioids, ongoing use despite cravings -- sorry, despite consequences, intense cravings, experiences of withdrawal when he doesn't use and escalating tolerance.

391. Q. Thank you. And then you said something similar with respect to Mr. Monahan. You said that his presentation was consistent with a diagnosis, and those diagnosis were ADHD, fetal alcohol syndrome, opioid and stimulant use disorders severe.

So what did you mean by his presentation being consistent with those diagnosis?

A. So in my assessment of Mr. Monahan, again, reviewed -- I reviewed both -- I reviewed those substances in detail with him and he met criteria for both of those disorders with severe severity because of the number of symptoms similar to what I just described in the previous individual.

So ongoing use despite many consequences, development of tolerance, experience of withdrawal, all of which come together to make the diagnosis of severe stimulant use disorders. Did you want me to go through as well his ADHD and fetal alcohol?

392. Q. Yes, please.

A. So Mr. Monahan actually was able to recall being diagnosed with both of those conditions in childhood. He reported being put on stimulant medications in childhood, what are consistent with the diagnosis of ADHD.

He continued to display significant symptoms of inattention, executive dysfunction, very poor impulse control and significant concentration and comprehension deficits.

A lot of those symptoms co-occur with the fetal alcohol syndrome diagnosis. So again, the high impulse control, learning deficits, cognitive deficits, which he displayed during the assessment, and provided the history -- developmental history that was consistent with those diagnoses.

393. Q. Thank you. And then I just want to bring your attention to a portion of your report for Mr. Monahan. So I'm going to screen share.

So this is the third last paragraph -- sorry, third paragraph down on the first page, and it is the third last sentence. So Mr. Shores had asked you about some evictions that you reference in 2020 and 2021, and then there's a sentence that

A5189

begins with:

"Most recently, he was moved by City workers from the opening of Cootes Paradise."

So first to clarify, is this after 2021?

A. Yes.

394. Q. Do you have any knowledge of the timeframe surrounding that more recent eviction you were referencing?

A. I don't, unfortunately, no.

395. Q. Okay. And then with respect to Ms. Lewis, you indicated that you had personally called shelters on her behalf. Why were you calling shelters?

A. Yes, to see if they had any suggestions, essentially, for anyone with a small dog, if there were ever any exceptions if it was an emotional support animal, and they said no.

396. Q. Do you remember the timeframe?

A. I mean, from the time -- most of the time that Ms. Lewis was outside, which I have to look at the affidavit because I'm not great with dates, but that was much of 2022 I was calling shelters.

She was -- I called the YWCA. They would not accept her because her needs were too high, and so I -- and Ms. Lewis was unwilling to separate from her dog even temporarily, though over time built enough trust with me to allow me to try and find a foster for the dog as long as I could promise her that she would get her dog back.

And then myself and Dr. O'Shea started looking for a foster for her in -- I think it was May of 2023. It took seven months to find a foster for her dog, and that was with significant advocacy on our part to find that -- the foster. There's so little available.

397. Q. Thank you. Do you remember approximately how many times you were calling shelters trying to access space?

A. I can't give a specific number, but dozens and dozens. Like it was, you know, very hard.

398. Q. So you mentioned that you called the YWCA on behalf of Ms. Lewis and were told that her needs were too high, and you use that same expression when you were describing Ms. Heegsma. What is your understanding of that response that her needs were too high?

A905

A. I believe it's based on -- there's an acronym that I always mess up that is VI-SPDAT or something like that. People are given a score basically about how homeless they are, essentially, is what the score is, and, the higher the score, the more difficult it is for someone to find housing and their scores were above whatever the threshold that the YWCA will accept.

399. Q. Thank you. With respect to Ms. Pierre, did you have any knowledge of her medical diagnosis being PTSD, generalized anxiety disorder, depression, opioid and stimulant use disorder severe prior to seeing her for a medical assessment?

A. Yes, I did.

400. Q. What was your knowledge?

A. I knew that she had severe opioid -- that she had some substance use disorders primarily. I don't believe, actually, though, I had verification of her mental health diagnoses, but, when I assessed her, she reported having been given those diagnoses in the past, and then I completed my own assessment.

401. Q. Thank you. Okay. And you mentioned that you knew that encampment evictions

were occurring and had a discussion with Ms. Shores where you mentioned in addition to patient reports that you may have seen a video.

Did you have any other sources of information with respect to encampment evictions in Hamilton?

A. I mean, there's lots of reporting in the news about encampment evictions. I know that there were often, like, advocacy efforts made, people standing in front of encampments asking that they not be torn down on behalf of those in the encampments and those encampments were torn down anyway, but those were all news stories that I either read or heard about.

402. Q. You mentioned that when you saw Mr. Greaves, that you understood that others had investigated shelter spaces for him. Do you know what those others were?

A. I know that when he was involved with Shelter Health -- there's mention of it in the chart, but I don't know who called or what the circumstances were.

403. Q. Okay. So Ms. Shores asked you repeatedly about the reliability of patient reports as the basis for an assessment and diagnosis. So I

A5190

want to ask you what is hopefully a simple question. How do you assess if a patient report is reliable?

A. Yeah, I mean there's multiple ways to think about that. To assess if a patient report is a reliable one, it is does the information hang together that they're describing in a way that is coherent and makes sense.

It also depends on whether that information is consistent with collateral or corroborating information, either from other individuals that know the person or their medical record, and, further, it is whether or not what the person is saying is in keeping with what I would expect to see based on my clinical experience in terms of similar presentation, similar patterns of symptoms or triggers for symptom exacerbation.

404. Q. Thank you, Dr. Lamont. Those are my questions.

-- Whereupon the proceedings adjourned at 4:12 p.m.

REPORTER'S CERTIFICATE

I, LORRAINE FEDOSOFF, Chartered Shorthand Court Reporter, certify;

That the foregoing proceedings were taken before me at the time and place therein set forth, at which time the witness was put under oath by me;

That the testimony of the witness and all objections made at the time of the examination were recorded stenographically by me and were thereafter transcribed;

That the foregoing is a true and correct transcript of my shorthand notes so taken. Commissioner of Oath effective to May 1, 2025.

Dated this 16th day of October 2024

Lorraine Fedosoff

_____

PER: LORRAINE FEDOSOFF, CSR (Ontario)

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A5191

Rachel Lamont
@lamontrachel11

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Ex # 1 m/d/y 10/7/2024 Pg 1 of 2

Exam of Dr. Rachel Lamont

Heegsma v City of Hamilton

A5192

Rachel Lamont
@lamontrachel11

I used to feel proud to call Hamilton home. Actions by city officials, especially over the past year, make me ashamed. I cannot comprehend the complete lack of understanding, compassion or even common sense in these situations. @cityofhamilton

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A few days ago, my attention was drawn to a deeply disturbing sign posted at 124 Walnut St S. I could not stop thinking about it. Thanks @Marcie58632320 for writing this response poem with me. 1/2

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Chris Andersen @Bodhidrop · 1h

WTF ???? This is what I was reading about last night? Sheeeesh! Could you put up the text of your 'response' sign?

1

Rachel Lamont
@lamontrachel11

Replying to @Bodhidrop and @Marcie58632320

Where greed and power have come to sow
Seeds of stigma and ignorance grow
A breeding ground, drawing lines in the sand
Let's not forget we stole this land
In our community, hate has no place
Let us come together and show some grace

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Ex # 2 m/d/y 10/7/2024 Pg 1 of 5
Exam of Dr. Rachel Lamont
Heegsma v City of Hamilton
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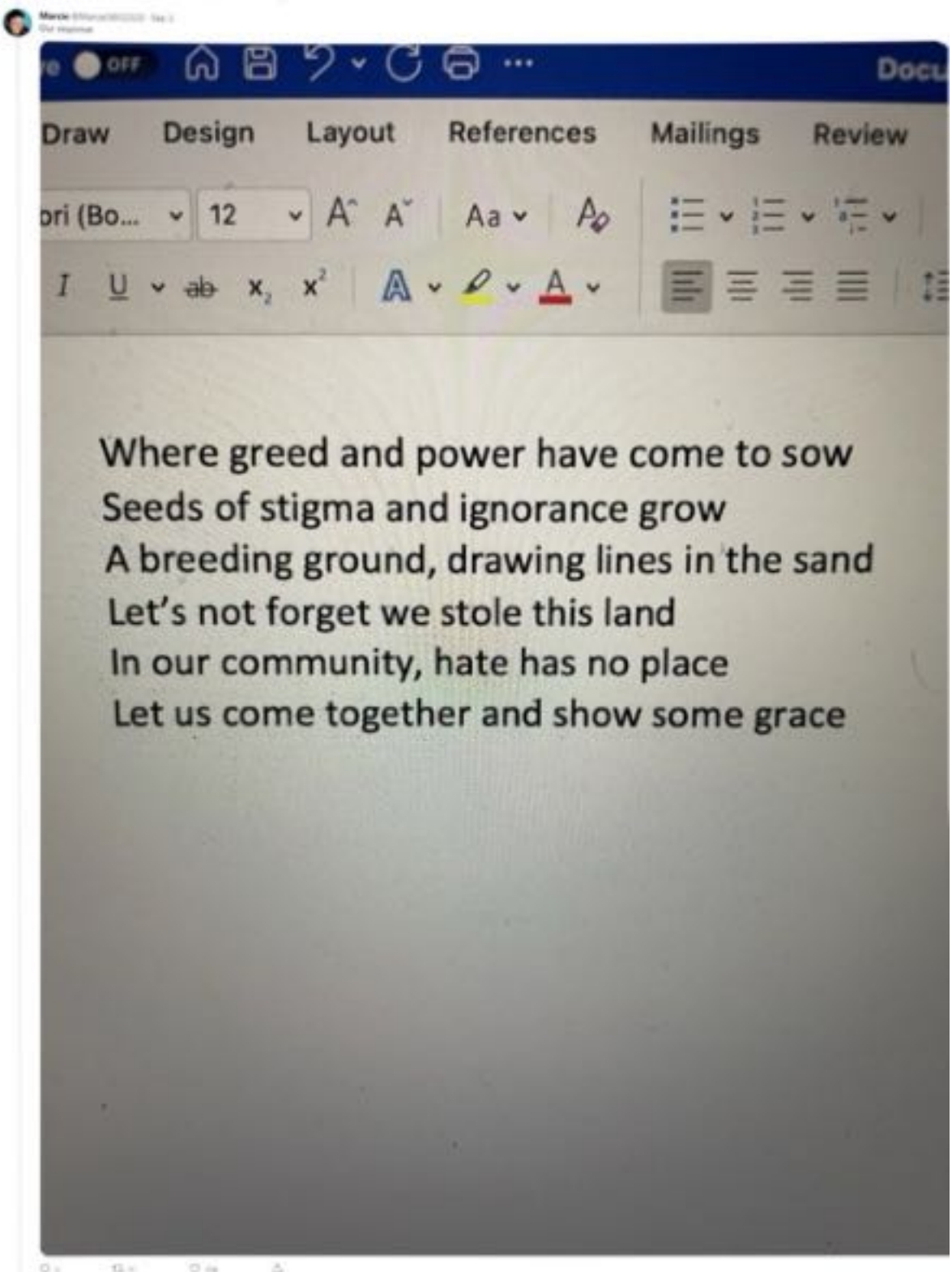
Where now pests roam
One day I shall again be someone's home.

A911


Draw
Design
Layout
References
Mailings
Review
Where greed and power have come to sow
Seeds of stigma and ignorance grow
A breeding ground, drawing lines in the sand
Let's not forget we stole this land
In our community, hate has no place
Let us come together and show some grace
I have the supplies

A5197

124 Walnut St. South
City of Hamilton
Application: ZAR-19-008
For information and updates visit
HomelessHome.ca
Report Trespassing or Disturbances
AJ Spider Security
905-526-0707

A913

Court File No.
CV-21-00077187-0000

ONTARIO
SUPERIOR COURT OF JUSTICE

BETWEEN

ASHLEY POFF, DARRIN MARCHAND, GORD SMYTH, MARIO MUSCATO & SHAWN ARNOLD

Applicants

-and-

CITY OF HAMILTON

Respondent

AFFIDAVIT OF OLIVIA MANCINI
(affirmed October 4, 2021)

I, Olivia Mancini of the City of Hamilton, in the Province of Ontario **AFFIRM AND SAY:**

1. I have personal knowledge with respect to the facts set out below about the emergency shelter system. Where information is not based on my personal knowledge, it is based upon information provided by other professionals, which I believe to be credible and true.

2. I worked at the Salvation Army Booth Centre (an emergency shelter for men) for six years as a case manager. In this role I supported men experiencing homelessness with reaching their housing goals, as well as other goals related, but not limited to substance use, mental health, financial assistance, legal concerns, etc.

3. I also worked at Carol Anne's Place (an overnight drop in space for women) as an Addiction Attendant. In this role I supported women experiencing homelessness with getting into detox or shelter (if that was their goal) and monitored women experiencing withdrawal symptoms.

4. I am a volunteer with Keeping Six – a community-based organization, founded in 2018 at the height of the opioid crisis to defend the rights, dignity and humanity of people who use drugs. I write this affidavit on behalf of Keeping Six.

5. I obtained a Bachelor of Arts in Psychology with a minor in Sociology in 2014 from Brock University, followed by a Concurrent Disorders Diploma from Mohawk College in 2015. I recently completed a Bachelor of Social Work in 2020 from McMaster University, and I am currently a Master of Social Work Critical Leadership Candidate at McMaster University.

Carol Anne's Place

6. Carol Anne's Place is not a shelter, it is an overflow drop in space, and has a capacity for 15 women, but typically see upwards of 25 women a night. During every shift we would call around to the women's shelters and they are always at capacity. It is more challenging to find shelter space for a single woman without children in her care as most shelters are for women with children fleeing domestic violence. Most women accessing Carol Anne's place are service restricted from the women's shelters due to complex mental health and substance use.

7. The women's shelters have a "do not admit list." For example, one woman has not been allowed to access shelter since 2018 for being removed by police once. There are significantly less shelter beds for women in the city compared to men's shelter. Women's clothing, cellphone, and other belongings were often stolen during the night. Carol's Anne's place is considered the "last stop" for women in the city as there is nowhere else to go if they cannot access Carol Anne's place. Benefits of Carol Anne's place is that it is low barrier and will only service restrict women for 24-48 hours maximum. They also provide harm reduction supplies, but they encourage women to not use on the property.

Salvation Army Booth Centre Bed Capacity

8. This has a capacity for 82 men, and 10 emergency overflow spaces. When the first lockdown took place, capacity went down to approximately 50 beds. There are dorm style beds that accommodates 11-3 men per dorm with a half wall built between them. There are two double rooms split by a divider and approximately 40 single rooms. The dorm beds are for everyone, and single rooms are reserved for clients who pose the least amount of risk first. If there are concerns with substance use

and possible overdose, clients will be placed into a dorm room. If none are available, client will be booked into ideally a double room, if not then a single room with the understanding that they will eb moved to a dorm bed when available.

9. When the pandemic hit, all the shelters reduced their bed capacity, and a temporary ad-hoc shelter was opened at First Ontario Centre. This did not increase bed capacity, it made up for the decrease in beds at the other shelters. Clients were being service restricted for two days for missing curfew at First Ontario in the middle of a pandemic. The expectation to return for 10pm curfew is difficult for people living on the streets that may not have concept of time, persistent mental health concerns, and substance use. During the pandemic Salvation Army had two common rooms available for clients to spend time in during the daytime as other essential services that clients would typically use were closed (shopping malls, coffee shops). Two common rooms were not enough for 82 people to maintain social distancing, so many people were still left outside during the daytime with nowhere to go.

Salvation Army Booth Centre Book in times/curfew

10. Shelter staff are available to clients 24/7. Clients can book in between the hours of 9am to 4pm daily. Curfew is at 10pm and if you are not in your bed then you are discharged, and your bed is given to someone else. If clients miss the 10pm curfew, they can return to book in after midnight if a space is available and they can return for their belongings the following day between 6pm-10pm. There are three additional bed checks between the hours of 11pm-4am. You can miss 1/3 of these bed checks and are welcomed back into your bed. If you miss 2/3 or 3/3 you are welcomed back into your bed until 8am, but you are not allowed to have breakfast. You must take your belongings and go, and if you need a bed for the following night, you must wait until 6pm. The logic is based on a standpoint of "if you want a bed, you will be in your bed all night." It does not take into consideration substance use and mental health.

11. The dorms are closed every day from 8am-6pm, so there is nowhere to sleep during the daytime. This can be particularly challenging for clients who work night shift as they will not be accommodated. Also, as an unhoused person you are in crisis and focused on surviving, so it can be quite difficult to remember all of the different rules and times. If the shelter is full, you are not allowed to wait for a bed to become available, staff will call the other shelters in the city, and then inform client of what is available. If all shelters are full then you are turned away to the street and

provided information on potential places to find food as meals are only for shelter residents. If you are service restricted (not allowed to access shelter due to behaviours, such as mental health, substance use) from all three men's shelters, you are turned away to the street, this is a very common practice.

12. The city's narrative that there are shelter beds available for everyone is false. Shelter beds are consistently at capacity nightly, and this will continue into the cold winter months. The city's narrative that there are no clients who are service restricted shelter wide is also false. I can think of several clients who are currently service restricted from all three men's shelters.

Salvation Army Booth Centre Atmosphere

13. The atmosphere is generally chaotic. The afternoon case managers are required to do many tasks outside of the role of case manager. The case managers must cover three breaks for front desk, attend one hour dinner to help kitchen staff feel safe with clients, unlock all the dorms (as they are locked during the daytime), obtain client belongings from storage after 6pm as requested by clients, locking the TV room and laundry room, doing hourly rounds throughout the building to ensure clients are alive and safe. On top of that there is an expectation to house 20 clients per month with an expectation of over 10 meaningful engagements with clients, such as helping a client secure income, search for housing, call landlords, set up housing views, secure payments for rent, and complete housing applications. It is easy to exceed over 10 meaningful engagements a day, but on average only 25% of these engagements are about housing and the remainder is crisis management. Often clients return to the shelter under the influence of an unknown substance and require supervision, clients will engage in altercations, females will present on site and refuse to leave, service restricted clients who are not allowed to be in the building will present and refuse to leave, clients have medical emergencies (mostly overdoses), and mental health crisis (i.e., psychosis – hearing or seeing things that are not there).

14. The City of Hamilton still currently pays shelters the same amount per year to run a shelter, but since the opioid epidemic began, the demands on staff are far greater and staff are pulled away from routine duties regularly. The response from the City is threatening removal of funding if housing stats aren't at expectation.

Salvation Army Booth Centre Theft

15. When new clients present staff make sure they understand that under no circumstance do you leave belongings unattended, or they will be stolen. Clients are informed to lock up their belongings in the locker provided. Many clients do not have a lock or money to purchase a lock, in this case we encourage clients to keep any valuables in their pockets. Clients fall asleep regularly with their phone on their pillow thinking it will be safe, and it will be stolen by morning. This proves difficult for those who understand limited English, or seniors, as they tend to fall victim to theft at a higher rate. Staff on site cannot review cameras in the moment and by the time management reviews the cameras, the belongings are long gone. If the client who stole the belongings can be identified on camera, they will be service restricted for a period of time. It is not uncommon for previous clients to sneak into building and search through the dorms and steal items. For example, a client who had been no trespassed for a year walked into the building and stole a client's laptop out of his single room while he was in the washroom. Also, clients are not allowed to bring their bikes into the building, but if they lock their bike up outside it will get stolen. Bikes are stolen on a regular basis out front of the Salvation Army. Client's belongings are often the only possessions they have, and for their belongings to get stolen it can be very upsetting and be a barrier to accessing shelter in the future due to fear of theft. For clients who do not return to their shelter bed for the night, their belongings are packed and labelled and put into storage. When the client returns for their belongings, more often than not clients become upset and state that some of their belongings are missing. I have often found clients missing items because their belongings were not labeled properly by housekeeping staff. This was an ongoing issue of mislabelling belongings. Staff's response is "we are not responsible for lost or stolen belongings" and there is nothing staff can do about the missing items. The shelter also only stores belongings for 48 hours and then the belongings are disposed of. Client's medications are also disposed of after 72 hours. This can cause a lot of unnecessary issues for clients as they are often unable to get a refill of their medications until the next refill date. Some clients will opt to keep their medications on them to avoid this issue, but then if they are caught with their medications in the shelter, they will be service restricted for a period of time.

Salvation Army Booth Centre Safety Concerns

16. Clients experience safety concerns, verbal threats, and physical violence on a regular basis in the shelter. I have personally witnessed a physical altercation where a client's leg was broken. Another client was brutally assaulted in the washroom, and as a result I had to attend court with my

colleague. There was a 12-person altercation in the parking lot where a belt was used as a weapon. One client chased another client with a hammer. One client brutally assaulted someone, to the point that he was in a coma and was charged with attempted murder. Staff are also susceptible to safety concerns, verbal threats, and physical violence. A client punched the side mirror off my car. Another client attempted to get into my vehicle after work and I later found out he was planning to murder me by strangulation. A handful of security guards have been physically assaulted by clients. A client attempted to punch me in the face, but security was able to intervene. Since the pandemic, there has been an increase in violence. For example, a client's face was macheted numerous times at Salvation Army and a client was murdered outside of Mission Services. These are just a few examples of the violence within the shelter system.

Salvation Army Booth Centre Service Restrictions

17. Service restriction is the practice of limiting or denying access to emergency shelter for a set period of time. Shelter staff may impose service restrictions for using substances, possession of illicit drugs or harm reduction supplies, mental health, or violating shelter policies. Service restrictions vary in length. A staff member can only service restrict for 24 to 48 hours pending management review. Management will then review the service restriction and implement an extension. Service restrictions can be from 24 hours to sometimes months and years. Typically, service restrictions are extended if it is a repeat behaviour. At times this is inappropriate as clients continue to be punished for incidences that may have happened a few years ago that they were already punished for, but because it is a repeat behaviour the service restriction gets extended for a longer period of time. Service restrictions also depend on the staff's personal values and beliefs, particularly around engaging in substance use. For example, a client overdosed in the washroom and was service restricted for 6 months. This sends the client a message that they will be punished for using substances in the shelter and encourages using substances alone or hiding their substance use due to fear of criminalization. Personally, I would rather clients use inside the shelter where there is staff to save them than to use in a back alleyway because they were service restricted for overdosing in the shelter. Another client attempted suicide by hanging, and he was service restricted for one year. The reasoning behind this was he "traumatized" staff. I do not agree with service restrictions involving substance use or mental health as people are being punished for having an illness. The length of service restrictions is also inconsistent. For example, to demonstrate the inconsistency, three clients were service restricted for smoking in the building – one was for 24 hours, one was for 14 days, and one was for 3 months.

18. There are no clearly documented policies or procedures for service restrictions in the shelter system in Hamilton for a practice that ultimately causes harm and trauma to service users. Many clients will end up being service restricted from all three men's shelters for similar behaviours or issues. The service restrictions will not be lifted in these situations unless it is a cold alert (-16 degrees), the shelter with the least severe service restriction would have to take the client, however, there have been times where this was not the case. Sometimes when clients are service restricted shelter wide, we will refer them to another city, but during the pandemic shelters were not accepting clients from other cities, so an additional barrier to accessing shelter was put in place for those who have nowhere else to go.

COVID-19 outbreaks in shelter

19. When all three men's shelters were in outbreaks at the same time, there were zero indoor options for unhoused men. Numerous people were turned away to the streets. Many clients asked where they are supposed to go when all the shelters are in outbreaks, and we had no answer for them. It was absolutely gut-wrenching to turn people away to the street with no other options. The city did not provide alternative indoor options, despite having a year to prepare for outbreaks within the shelter system. Unhoused people were essentially left behind and not included in pandemic response plans. I found myself reaching out to medical professionals in the field to have them advocate for clients who had nowhere else to go. Some days we were able to find an indoor option, but most day's people were left to sleep on the streets. The hotel programs that were opened were only for women and couples. Single men were not allowed to go to the hotel as they were deemed "high risk." A few men were able to get into hotels during the outbreaks in all the men's shelters, but as soon as a shelter was out of outbreak all the men were discharged from hotel to the street. Staff did not even secure them beds at the shelters, so when these men attempted to find space, the shelter was already at capacity.

Salvation Army Booth Centre – Substance abuse and the changing landscape with Covid -19

20. Overdoses within the shelter have rapidly increased. Throughout the pandemic, overdoses have been occurring on almost a daily basis. At one point, there was seven overdoses in one day. During the outbreak, a temporary safe injection site was implemented at the Salvation Army to encourage people to stay indoors and stop the spread of the virus. The safe injection site quickly closed before

the outbreak was declared over, and a client who was accessing the space ended up dying of an overdose in his dorm bed. Many clients were overdosing off property across the street when First Ontario was open and around the corner on the stairs at the Philpot church. Clients would come into the shelter and ask staff for naloxone (opioid reversal drug) due to an overdose. Staff would respond in these situations. Staff were then directed by management to not respond to overdoses off property because if they are injured off the property, the shelter would not be liable. Staff were even threatened to be fired for leaving property while on shift. The way we responded to overdoses also changed during the pandemic. It was recommended to not do CPR because of the risk of transmission and staff would need to receive verbal confirmation that other staff were comfortable with the staff person doing CPR.

21. The pandemic has made the opioid epidemic worse due to closure of harm reduction services/reduction in hours/online services, social distancing and stay at home guidelines has increased the likelihood of people using alone, closure of borders has increased toxic drug supply, and the city's drug strategy was put on hold to respond to the pandemic, despite the opioid epidemic also being a public health emergency.

22. The staff to client ratio is not appropriate. Staff are not appropriately trained or equipped to respond to complex mental health issues (including violence and crisis) and responding to an insanely high number of overdoses. Responding to overdoses on a daily basis should not be normalized in shelters, it is traumatic. Safe spaces to use drugs inside the shelter would ultimately save lives, improve health and safety, reduce staff burnout, and allow case managers to do the job they were hired to do. Staff in shelters are underfunded and under resourced, we are doing the best we can with very limited resources. We help clients navigate complex systems and try to remove barriers, but we are often unable to meet the complex needs of clients.

23. Case management has been proven difficult to do amidst a pandemic. There has been an increase in violence, we have been managing an increase in overdoses, and increase in crisis intervention. Shelter staff have been more focused on keeping people alive and safe, and providing basic necessities such as food, hygiene, and a place to sleep. Closure of services, reduced hours, or programs moving online due to COVID-19 has left very limited indoor options for unhoused people.

24. Barriers that unhoused people are facing are long waitlists for addiction and mental health supports – they need access to immediate interventions. There is also a lack of affordable and supportive housing. This is a major gap as people with higher needs, need supports in place in order to successfully maintain housing. The vaccine passport is also a challenge for unhoused people as many do not have proof of vaccination and do not have photo ID. ID is often lost or stolen. Again, there is very limited indoor options for unhoused people to go to the bathroom or practice public health guidelines such as washing their hands. In general, shelters are understaffed, the staff are understrained and underpaid, which leads to a high turnover rate, which leads to an even less stable environment for people in shelter.

AFFIRMED BEFOR ME at the City of Hamilton, this 4th day of October, 2021

A Commissioner etc.

AFIRMED at the City of Hamilton, in the Province of Ontario, this 4th day of October, 2021.

ASHLEY POFF *et al*
Applicants

-and-

CITY of HAMILTON
Respondents

A5207

Court File No.
CV-21-00077187-0000

Ontario
Superior Court of Justice

PROCEEDING COMMENCED AT HAMILTON

AFFIDAVIT OF OLIVIA MANCINI

HAMILTON COMMUNITY LEGAL CLINIC
100 Main Street East
Suite 203
Hamilton, ON L8N 3W4
SHARON CROWE (LSO #47108R
STEPHANIE COX (LSO #65464F)

Telephone: **905-527-4572**
Fax: **905-523-7282**
Lawyers for the Moving Parties

Court File No. CV-21-00077817-0000

ONTARIO

SUPERIOR COURT OF JUSTICE

BETWEEN:

KRISTEN HEEGSMA, DARRIN MARCHAND, GORD SMYTH, MARIO MUSCATO, AND SHAWN ARNOLD, ET AL.

Applicants

-and-

CITY OF HAMILTON

Respondent

AFFIDAVIT OF Olivia Mancini

(Sworn July 18, 2023)

I, Olivia Mancini, of the City of Hamilton in the Province of Ontario, AFFIRM AND STATE:

1. I have personal knowledge with respect to the facts set out below about the emergency shelter system. Where information is not based on my personal knowledge, it is based upon information provided by other professionals, which I believe to be credible and true.
2. I worked at the Salvation Army Booth Centre (an emergency shelter for men) for six years as a case manager from 2015 to 2021. In this role I supported men experiencing homelessness with reaching their housing goals, as well as other goals related, but not limited to substance use, mental health, financial assistance, legal concerns, etc. I also worked at Carol Anne's Place (an overnight drop in space for women) in a contract position as an Addiction Attendant from June 2021 to September 2021. In this role I

supported women experiencing homelessness with getting into detox or shelter (if that was their goal) and monitored women experiencing withdrawal symptoms.

3. I was an outreach volunteer with Keeping Six from April 2020 to November 2021- a community-based organization, founded in 2018 at the height of the opioid crisis to defend the rights, dignity and humanity of people who use drugs. I completed qualitative interviews with encampment residents about their experiences in encampments and developed a report outlining the study, setting and design, participants, research team, interview guide, procedure, data analysis, results, discussion and recommendations.
4. I obtained a Bachelor of Arts in Psychology with a minor in Sociology in 2014 from Brock University, followed by a Concurrent Disorders Diploma from Mohawk College in 2015. I recently completed a Bachelor of Social Work in 2020 from McMaster University, and I completed Master of Social Work (MSW) Critical Leadership program from McMaster University in August 2022.
5. I completed my MSW field practicum with the Canadian Drug Policy Coalition (CDPC). During field practicum, I completed a project where I planned and organized a public health drug dialogue with community partners. I facilitated the public health drug dialogue "Integrating bet practices of harm reduction into the shelter system" with 100 key stakeholders in Hamilton followed by developing a report with recommendations.
6. I am employed as a Registered Social Worker in an emergency department from January 2022 to present where I work with various community partners, including shelter providers and drop-in spaces for unhoused folks.
7. I was a Research Assistant with the Community University Policy Alliance (CUPA) at McMaster University from September 2020 to January 2022 where I developed policy recommendations for permanent low-barrier spaces for women and gender-diverse individuals who experience complex homelessness.
8. I am a co-investigator with the Hamilton Social Medicine Response Team (HAMSMaRT)

from September 2020 to present where I completed qualitative semi-structured interviews with unhoused participants who have accessed homeless shelters and experienced service restrictions at shelters in Hamilton.

9. I volunteered for the Hamilton Point in Time Count where I counted and surveyed unhoused people in Hamilton in 2016 and 2018.

Carol Anne's Place

10. Carol Anne's Place is not a shelter, it is an overflow drop in space, and has a capacity for 15 women, but typically see upwards of 25 women a night. During every shift we would call around to the women's shelters and they are always at capacity. It is more challenging to find shelter space for a single woman without children in her care as most shelters are for women with children fleeing domestic violence. Most women accessing Carol Anne's Place are service restricted from the women's shelters due to complex mental health and substance use.
11. The women's shelters have a "do not admit list." For example, one woman has not been allowed to access shelter since 2018 for being removed by police once. There are significantly less shelter beds for women in the city compared to men's shelter. Women's clothing, cellphones, and other belongings were often stolen during the night. Carol's Anne's place is considered the "last stop" for women in the city as there is nowhere else to go if they cannot access Carol Anne's place. The benefits of Carol Anne's place is that it is low barrier and will typically service restrict women for 24 to 48 hours maximum, unless it is an extreme incident, such as sexual or physical assault of staff or service users. Carol Anne's place provides harm reduction supplies, and in April 2022, the YWCA Hamilton opened a safer drug use space within Carol Anne’s Place

Salvation Army Booth Centre Bed Capacity

12. This shelter has a capacity for 82 men, and 10 emergency overflow spaces. When the first

lockdown took place, capacity went down to approximately 50 beds. There are dorm style beds that accommodates 11-13 men per dorm with a half wall built between them. There are two double rooms split by a divider and approximately 40 single rooms. The dorm beds are for everyone, and single rooms are reserved for clients who pose the least amount of risk first. If there are concerns with substance use and possible overdose, clients will be placed into a dorm room. If none are available, client will be booked into ideally a double room, if not then a single room with the understanding that they will be moved to a dorm bed when available.

13. When the pandemic hit, all the shelters reduced their bed capacity, and a temporary ad-hoc shelter was opened at First Ontario Centre. This did not increase bed capacity, it made up for the decrease in beds at the other shelters. Clients were being service restricted for two days for missing curfew at First Ontario in the middle of a pandemic.
14. The expectation to return for 10pm curfew is difficult and unrealistic for people living on the streets that may not have concept of time, persistent mental health concerns, and for those who use substances, and for those working evening or night shift. During the pandemic Salvation Army had two common rooms available for clients to spend time in during the daytime as other essential services that clients would typically use were closed (shopping malls, coffee shops). Two common rooms were not enough for 82 people to maintain social distancing, so many people were still left outside to face the elements during the daytime with nowhere to go.

Salvation Army Booth Centre Book in times/curfew

15. Shelter staff are available to clients 24/7. Clients can book in between the hours of 9am to 4pm daily. Curfew is at 10pm and if you are not in your bed then you are discharged, and your bed is given to someone else. If clients miss the 10pm curfew, they can return to book in after midnight if a space is available and they can return for their belongings the following day between 6pm- 10pm. There are three additional bed checks between the hours of 1lpm-

4am. You can miss 1/3 of these bed checks and are welcomed back into your bed. If you miss 2/3 or 3/3 you are welcomed back into your bed until 8am, but you are not allowed to have breakfast. You must take your belongings and go, and if you need a bed for the following night, you must wait until 6pm. The logic is based on a standpoint of "if you want a bed, you will be in your bed all night." It does not take into consideration substance use, mental health, trauma, employment or other related factors.

16. The dorms are closed every day from 8am-6pm, so there is nowhere to sleep during the daytime. This can be particularly challenging for clients who work night shift as they will not be accommodated. Also, people deprived of housing tend to be in acute crisis and focused on surviving, so it can be quite difficult to remember all the different rules and times. If the shelter is full, you are not allowed to wait for a bed to become available, staff will call the other shelters in the city, and then inform the client of what is available. If all shelters are full, you are turned away to the street and provided information on potential places to find food as meals are only for shelter residents. If you are service restricted for a period of time that can range anywhere from 24 hours to indefinitely due to “non-compliance” or behaviours related to mental health and substance use from all three men's shelters, you are turned away to the street with nowhere to go, and this is a very common practice.
17. The city's narrative that there are shelter beds available for everyone is false. Shelter beds are consistently at capacity nightly. Shelter staff are required to input data into the HIFIS database, such as recording when they “turn away” people from shelter whether that be due to capacity, service restriction, or other reason. However, shelter staff often do not have the time to document how many people they turn away in HIFIS due to a highly chaotic work environment. When I was working in the shelter during the pandemic, I can confirm I was not recording how many people I turned away in HIFIS for the reasons above.

18. In addition, there are no accountability measures in place to ensure they are recording

each incident where someone is turned way into HIFIS. This skews the data that the City of Hamilton receives.

19. For example, a shelter worker recently turned away 35 people in an eight hour shift and consistently has anywhere from 10 to 30 people on the “overflow” waitlist nightly, when there are only 10 overflow beds available.

20. The city's narrative that there are no clients who are service restricted shelter wide is also false. I can think of several clients who are currently service restricted from all three men's shelters. These clients who are service restricted from all of the shelters often present to the emergency department for support with housing, however, are almost always discharged to the local drop-in centres (if not also service restricted from there, which they often are) as their situation is considered a "social problem", not a medical or psychiatric emergency. It is outside of staff's scope of practice in the emergency department to support unhoused folks with securing housing and this role is meant for case managers and outreach workers in the shelters and drop-in spaces.

Salvation Army Booth Centre Atmosphere

21. The atmosphere is generally chaotic. The afternoon case managers are required to do many tasks outside of the role of a case manager. The case managers must cover two 15 minute breaks and 30 minute lunch for front desk, attend one hour dinner to help kitchen staff feel safe with clients, unlock all the dorms (as they are locked during the daytime), obtain client belongings from storage after 6pm as requested by clients, locking the TV room and laundry room, and doing hourly rounds throughout the building to ensure clients are alive and safe. On top of that there is an expectation to house 20 clients per month with an expectation of over 10 meaningful engagements with clients, such as helping a client secure income, search for housing, call landlords, set up housing views, secure payments for rent, and complete housing applications. It is easy to exceed over 10 meaningful engagements a day, but on average only 25%

of these engagements are about housing and the remainder is risk assessments, crisis management, and overdose response. Often clients return to the shelter under the influence of an unknown substance and require supervision, clients will engage in altercations, females will present on site and refuse to leave, service restricted clients who are not allowed to be in the building will present and refuse to leave, clients experience medical emergencies (mostly overdoses), and mental health crises (i.e., psychosis – experiencing visual, auditory, or tactile hallucinations), which frontline staff are not adequately trained in overdose prevention and response or risk assessments for clients in mental distress.

22. The City of Hamilton still currently pays shelters the same amount per year to run a shelter, but since the drug poisoning crisis escalated in 2015, the demands on staff are far greater and staff are pulled away from routine duties regularly. The response from the City is threatening removal of funding if housing statistics are not meeting their expectations.

Salvation Army Booth Centre Theft

23. When new clients present staff make sure they understand that under no circumstance do you leave belongings unattended, or they will be stolen. Clients are advised to lock up their belongings in the locker provided. Many clients do not have a lock or money to purchase a lock, so in this case we encourage clients to keep any valuables in their pockets. Clients fall asleep regularly with their phone on their pillow thinking it will be safe, and it will be stolen by morning. This proves difficult for those who understand limited English, vulnerable seniors, and people with developmental/cognitive disabilities as they tend to fall victim to theft at a higher rate. Staff on site cannot review cameras in the moment and by the time management reviews the cameras, the belongings are long gone. If the client who stole the belongings can be identified on camera, they will be service restricted for a

period of time.

24. It is not uncommon for previous clients to sneak into building and search through the dorms and steal items. For example, a client who had been no trespassed for a year walked into the building and stole a client's laptop out of his single room while he was in the washroom. Also, clients are not allowed to bring their bikes into the building, but if they lock their bike up outside it will get stolen. Bikes are stolen on a regular basis out front of the Salvation Army.

25. For clients who do not return to their shelter bed for the night, their belongings are packed, labelled and put into storage. When the client returns for their belongings, more often than not clients become upset and state that some of their belongings are missing. I have often found clients missing items because their belongings were not labeled properly by housekeeping staff. This is an ongoing issue of mislabeling belongings. Staff's response is "we are not responsible for lost or stolen belongings" and there is nothing staff can do about the missing items. The shelter only stores belongings for 48 hours and then the belongings are disposed of in the dumpster of the parking lot. Client's medications are also disposed of after 72 hours. This can cause a lot of unnecessary issues for clients as they are often unable to get a refill of their medications until the next refill date.

Salvation Army Booth Centre Safety Concerns

26. Clients experience safety concerns, verbal threats, and physical violence on a regular basis in the shelter. There was a 12-person altercation in the parking lot where a belt was used as a weapon. One client chased another client with a hammer. One client brutally assaulted someone, to the point that he was in a coma and was charged with attempted murder.

27. Staff are also susceptible to safety concerns, verbal threats, and physical violence. A client punched the side mirror off my car. Another client attempted to get into my vehicle after work and I later found out he was planning to murder me by strangulation. A handful of

security guards have been physically assaulted by clients. A client attempted to punch me in the face, but security was able to intervene. Since the pandemic, there has been an increase in violence. For example, a client's face was macheted numerous times at Salvation Army and a client was murdered outside of Mission Services. These are just a few examples of the violence within the shelter system.

Salvation Army Booth Centre Service Restrictions

28. Service restriction is the practice of limiting or denying access to emergency shelter for a set period of time. Shelter staff may impose service restrictions for using substances, possession of illicit drugs or harm reduction supplies, mental health crisis or psychosis, or violating shelter policies. Service restrictions vary in length. A staff member can only service restrict for 24 to 48 hours pending management review. Management will then review the service restriction and implement an extension if deemed necessary. Service restrictions vary from 24 hours in length to indefinitely.

29. This means that an individual can continue to be banned for shelter based on an incident that happened years earlier that they were already punished for, but because their behaviour is repetitive, the service restriction is extended for a longer period of time.

COVID-19 outbreaks in shelter

30. When all three men's shelters were in outbreaks at the same time, there were zero indoor options for unhoused men. Numerous people were turned away to the streets. Many clients asked where they are supposed to go when all the shelters are in outbreaks, and we had no answer for them. It was absolutely gut-wrenching to tum people away to the street with no other options. The city did not provide alternative indoor options, despite having a year to prepare for outbreaks within the shelter system. Unhoused people were essentially left behind and not included in pandemic response plans. I found myself reaching out to medical professionals in the field to have them advocate for clients who had nowhere else to go. Some days we were able to find an indoor option, but most day's

people were left to sleep on the streets.

31. The hotel programs that were opened were only for women and couples. Single men were not allowed to go to the hotel as they were deemed "high risk." A few men were able to access hotels during the outbreaks in all the men's shelters, but as soon as a shelter was cleared from an outbreak all the men were discharged from hotel to the street. Staff did not secure them beds at the shelters upon discharge from the hotel, so when these men attempted to find space, the shelters were all at capacity.

Salvation Army Booth Centre - Substance use and the changing landscape with Covid -19

32. Overdoses within the shelter have rapidly increased. Throughout the pandemic, overdoses have been occurring on almost a daily basis. At one point, there was seven overdoses in one day. During the outbreak, a temporary safe injection site was implemented at the Salvation Army to encourage people to stay indoors and stop the spread of the virus. The safe injection site quickly closed before the outbreak was declared over, and a client who was accessing the space ended up dying of an overdose in his dorm bed. Many clients were overdosing off property across the street when First Ontario was open and around the corner on the stairs at the Philpot church. Clients would come into the shelter and ask staff for naloxone (opioid reversal drug) due to an overdose. Staff would respond in these situations. Staff were then directed by management to not respond to overdoses off property because if they are injured off the property, the shelter would not be liable. Staff were even threatened to be fired for leaving property while on shift. The way we responded to overdoses also changed during the pandemic. It was recommended to not do CPR because of the risk of transmission and staff would need to receive verbal confirmation that other staff were comfortable with the staff person doing CPR.

Inadequate Support in Shelters

33. Case management has been proven difficult to do amidst a pandemic. Case managers have not been able to fully support clients with housing for a number of reasons. There has been an

increase in violence, we have been managing an increase in overdoses, and increase in crisis intervention. Shelter staff have been more focused on keeping people alive and safe, and providing basic necessities such as food, hygiene, and a place to sleep. Closure of services, reduced hours, or programs moving online due to COVID-19 has left very limited indoor options for unhoused people.

34. Barriers that unhoused people are facing include long waitlists for addiction and mental health supports - they need access to immediate interventions. There is also a lack of affordable and supportive housing. This is a major gap in services for people with higher needs who require wrap around supports in place to successfully maintain housing. The vaccine passport was also a challenge for unhoused people as many do not have proof of vaccination and do not have photo ID. ID is often lost or stolen. Again, there is very limited indoor options for unhoused people to go to the bathroom or practice public health guidelines such as washing their hands. In general, shelters are understaffed and under resourced, the staff are undertrained and underpaid, which leads to a high turnover rate, and less stable environment for people in shelter.

Emergency Department & Shelter

35. As a social worker in the emergency department, part of my role is to find patient's shelter space if needed. I will highlight three examples to demonstrate shelter being over capacity, the criminalization of unhoused folks, and the extremely inhumane treatment of unhoused folks.

36. Example 1: I called the Four Points hotel to refer a client. The client was service restricted from all shelters except for Four Points. In addition, there were less shelter beds available in the city due to Mission Services being closed for a structural fire. Four Points had a bed available, however they would not take my patient based on

past behaviors at other shelters, stating they did not think he would be an "appropriate" fit. I made staff aware my patient is service restricted from all shelters except for Four Points and that my patient would be sleeping on the street.. Staff still refused to accept him, so I asked for on-call management's phone number to advocate for my patient and they refused to share their information with me. In the end my patient was discharged to the streets.

37. Example 2: A patient presented at the hospital for injuries related to domestic violence and was seeking shelter. I called all of the women's shelters, and they were all full. I called back the first shelter I was in contact with, and staff are supposed to complete a referral to the hotel program as per shelter protocol. However, staff stated the hotels for people experiencing domestic violence were also full. I stated that my understanding of the shelter's protocol is for them to secure the individual fleeing domestic violence a space in a hotel for their safety. Staff stated they would not be able to accommodate my patient, despite being at high risk for further violence and abuse. I made them aware that my patient would be sleeping on the street or returning to their abusive partner, and they still declined to help my patient, despite shelter protocols in place to ensure this does not happen to people fleeing domestic violence.

38. Example 3: An unhoused patient tested positive for COVID-19. The patient was asymptomatic, therefore unable to access hospital beds as they are utilized for those who are extremely ill from COIVD-19. The patient had no present psychiatric concerns and was stable, therefore unable to access psychiatric services. The patient was referred to the Wesley Isolation Centre to isolate as he is unhoused and positive for COVID-19. The Wesley Isolation Centre declined to support patient as he was currently no trespassed from the Wesley Day Centre, which is in the same building as the Wesley Isolation Centre. We inquired where to send this patient as he is not eligible to stay in the hospital and highlighted that the Wesley Day Centre is a different program and service vs. the Wesley

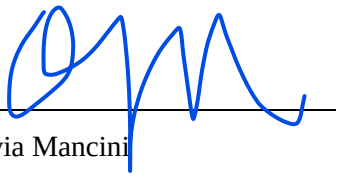
Isolation Centre. Wesley was unable to accommodate the individual.

39. I make this Affidavit in support of the Application, and for no improper purpose.

Sworn remotely by Olivia Mancini at the City of Hamilton, in the Province of Ontario, before me on July 18, 2023 by "zoom" videoconference, in accordance with O. Reg. 431/20, Administering Oath or Declaration Remotely.

Mohamad Bsat

Commissioner for Taking Affidavits
Mohamad Bsat 75897L, LSO



Olivia Mancini

ONTARIO
SUPERIOR COURT OF JUSTICE

B E T W E E N:

KRISTEN HEEGSMA, DARRIN MARCHAND, GORD SMYTH, MARIO MUSCATO, SHAWN ARNOLD, BRADLEY CALDWELL, CHRISTINE DELOREY, GLEN GNATUK, TAYLOR GOGO-HORNER, CASSANDRA JORDAN, JULIA LAUZON, AMMY LEWIS, ASHLEY MACDONALD, COREY MONAHAN, MISTY MARSHALL, SHERRI OGDEN, JAHMAL PIERRE, LINSLEY GREAVES and PATRICK WARD,

Applicants,

- and -

CITY OF HAMILTON,

Respondent,

This is the Cross-examination of OLIVIA MANCINI on her affidavit sworn July 18, 2023, conducted via Zoom videoconference hosted by the offices of Nimigan Mihailovich Reporting, One James Street South, 7th Floor, Hamilton, Ontario, on August 20, 2024 at 1:00 p.m., with all participants attending remotely.

APPEARANCES:

MS. SHARON CROWE — For the Applicants
CURTIS SELL, ESQ.
HCLC

MS. BEVIN SHORES — For the Respondent
MS. VIVIAN CALDAS
Gowling

A5221

TABLE OF CONTENTS

	Page No.
MANCINI, OLIVIA: Affirmed	
CROSS EXAMINATION BY MS. SHORES	1
RE-EXAMINATION BY MS. CROWE	49

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INDEX OF EXHIBITS

Exhibit No.	Description	Page No.
A	Integrating Best Practices of Harm Reduction	3

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---Upon commencing at 1:00 p.m.

OLIVIA MANCINI: AFFIRMED

CROSS EXAMINATION BY MS. SHORES:

1. Q. Good afternoon, Ms. Mancini. As I introduced off the record, my name is Bevin Shores. I am one of the lawyers for the Respondent, The City of Hamilton. We are here this afternoon to conduct a cross-examination of an affidavit that you've given in this proceeding dated July 18, 2023. So before we get started, can you just confirm your full name for the record.

A. Yes, my name is Olivia Mancini.

2. Q. Where are you participating in this examination from today?

A. I'm just at work right now, so at St. Joseph's Healthcare. Just in my office.

3. Q. Okay. And you are alone in the room?

A. Yes.

4. Q. And you're aware that you're to have no assistance in giving your answers?

A. Yes.

5. Q. And that you're not to refer to any materials other than your affidavit or any materials that are presented to you in the course

of this cross-examination?

A. Yes.

6. Q. If you don't understand a question that I'm asking, please let me know and I can repeat or rephrase it to you. Is that understood?

A. Okay, yes.

7. Q. You've just been affirmed to tell the truth today?

A. Yes.

8. Q. I'm going to start -- are you familiar with the website gettingtotomorrow.ca?

A. Yes.

9. Q. And that's a website of the regulation project by the Canadian Drug Policy Coalition?

A. Yes, that's correct.

10. Q. I'm going to put something on the screen here. I understand, based on that website, that on or about August 2, 2022 you posted or a presentation was posted prepared by you on Integrating Best Practices of Harm Reduction. Is that correct?

A. Yes, that's correct.

11. MS. SHORES: The document that I've placed on the screen is a capture of that

A937

website or of the regulation project and we'll mark this for identification as Exhibit A to Ms. Mancini's examination.

EXHIBIT NO. A: Integrating Best Practices of Harm Reduction

BY MS. SHORES:

12. Q. The thing I'd like to ask you about is there is a biography or a little biographical paragraph at the bottom of this website capture and it states, I'll read for the record, "Olivia Mancini brings her passion, dedication and expertise across various organizations in Hamilton, providing mental health and harm reduction support to folks as a registered social worker and harm reduction worker. When she is not on the frontline, Olivia works in drug policy and advocates for the decriminalization of drugs, safe supply, legal regulation and the right to housing. Olivia also recently completed her Master of Social Work at McMaster University."

The sentence here I'd like to focus on is, "Olivia works in drug policy and advocates for the decriminalization of drugs, safe supply, legal regulation and right to housing." You agree with that statement about you?

A5222

A. I no longer work in that role, but at the time that that was published, I was working in drug policy as a community engagement coordinator.

13. Q. And you still advocate for the decriminalization of drugs?

A. I'm not actively advocating for that in this exact moment, but I would advocate for that if I needed to, yes.

14. Q. Do you still advocate for safe supply?

A. Yes.

15. Q. Do you still advocate for legal regulation?

A. Yes.

16. Q. And you still advocate for the right to housing?

A. Yes.

17. Q. You'd agree that your involvement in this case is part of your advocacy work?

A. Yes, I would say so.

18. Q. Okay. I want to turn next to your affidavit and, again, for the record, it's an affidavit affirmed July 18, 2023. In paragraph 2 of your affidavit you describe your work at the Salvation Army Booth Centre and indicate that you

worked there for six years as a case manager from 2015 to 2021, so you haven't worked at the Booth Centre since 2021, correct?

A. That's correct.

19. Q. Which month in 2021 did you leave the Booth Centre?

A. I can't recall the exact month.

20. Q. In your role as a case manager at the Booth Centre, that would have primarily involved helping people who were staying at the shelter connect with supports?

A. Yes. So I was a case manager, so I would help with them securing housing and any other case management goals that they might've had. So like it says in my affidavit, it could be related to substance abuse or mental health, financial assistance or legal concerns.

21. Q. You weren't the person who was admitting people to the shelter?

A. The residential worker would do the admission, but at times, case management would cover the front desk where the residential worker does their role. So I would, at times, be doing admissions to the shelter, yes.

22. Q. Okay. In the course of doing

admissions to the shelter, was your role involving communicating shelter policies to residents at the shelter?

A. Yes.

23. Q. Would your role as a case manager have involved dealing with discharging people from the shelter?

A. Yes.

24. Q. What portion or proportion or percentage, however you're comfortable saying, of your work would involve admitting or discharging people from shelter at the Booth Centre?

A. I would say maybe 80 percent.

25. Q. So that would only be about 20 percent of your time spent as a case manager doing your case manager duties?

A. No, maybe I would say that it's more 20 percent of the role -- sorry, I think I misunderstood the question.

26. Q. So let's rephrase that so you understand. So you indicated that you would sometimes help out with admitting people to shelter or discharging people from shelter. What proportion of your time at the Booth Centre was spent admitting or discharging people from shelter

A938

as opposed to your work as a case manager?

A. In a shift I would say potentially 20 percent, but it definitely varies depending on what time of the day it is. If I was working at afternoon shift, curfew is at 10 p.m. so we would be discharging folks at that time, so it could take up more time in the evening. If I was working a dayshift, I might be doing more admission, so it's hard to give an exact percentage. But I would say it takes up a fair amount of time to admit and discharge folks.

27. Q. And when you were at the Booth Centre, were you full time or part time?

A. I was full time, but when I started in 2015, I had started in a casual role. But the last three years was full time.

28. Q. So would that be 35 or 40 hours a week, something like that?

A. Yes.

29. Q. At paragraph 2 of your affidavit you also describe working at Carol Anne's Place in a contract position as an addiction attendant from June 2021 to September 2021. Do you remember whether it was those four months or how -- I'm trying to ascertain whether you were there for

A5223

three months? Four months?

A. Four months.

30. Q. Were you there full time or part time during those four months?

A. I was there full time.

31. Q. So, again, 30 to 40 hours per week?

A. Yes.

32. Q. And so you haven't worked at or volunteered with Carol Anne's Place since 2021?

A. Correct.

33. Q. I'm going to take you to paragraph 5 of your affidavit -- I'm sorry, paragraph 10 of your affidavit under the heading, "Carol Anne's Place." In the second sentence of this paragraph you state, "During every shift we would call around to the women's shelters and they are always at capacity." So, gain, the time frame that you're speaking of here is the four months from June 2021 to September 2021, correct?

A. Yes.

34. Q. Okay. And I want to be clear about your evidence. Is your evidence that there was not a single time between June 2021 and September 2021 when you were working that you ever once found shelter in the women's system that had capacity?

A. No, I would say we were sometimes able to secure shelter space.

35. Q. And at that point, were you calling around to the hotels or the overflow spaces?

A. So we would just call the emergency shelters, so it depends on what their needs were. If it was a single woman, there's the three emergency shelters that you can contact, and then if it was a woman fleeing domestic violence, then there's four Violence Against Women shelters that we can contact. If there was no space at any of the shelters, you're supposed to call the first shelter back for support with potentially arranging like hotel or overflow access.

36. Q. Okay. And on the topic of those Violence Against Women shelters, the second last sentence of paragraph 10 it states here, "It is more challenging to find shelter space for a single woman without children in her care as most shelters are for women with children fleeing domestic violence." You're referring to the Violence Against Women shelters, those four shelters?

A. Yes.

37. Q. And those would be the shelters funded through the Ministry of Community and Social

Services?

A. I'm not sure what the funding source is.

38. Q. Okay. Those Violence Against Women shelters, do you have any knowledge of whether they are in the City of Hamilton shelter system?

A. Yes, they are.

39. Q. Your belief is that they are?

A. Yes.

40. Q. The City of Hamilton -- sorry, I'm going to put to you that there are shelters within the City of Hamilton that are not limited to women with children fleeing domestic violence. Do you agree with that?

A. Yes, there are three shelters.

41. Q. There is Mary's Place, correct?

A. Yes.

42. Q. There is Emma's Place, correct?

A. Yes.

43. Q. There's St. Joseph's Womankind, correct?

A. Correct.

44. Q. And also at 2021, when you were at Carol Anne's Place, there would have been hotels operated by Good Shepherd admission services?

A939

A. I believe there was overflow space at the hotels if the shelters were full, yes.

45. Q. Okay. And none of those shelters would have been restricted to women with children fleeing domestic violence, correct?

A. Sorry, can you say that one more time.

46. Q. Mary's Place, Emma's Place, St. Joseph's Womankind and the hotels, none of those shelters are limited just to women with children fleeing domestic violence, correct?

A. That's correct.

47. Q. Okay. And the four Violence Against Women shelters, those are also not restricted to women with children, correct?

A. It would be women with children or women fleeing domestic violence.

48. Q. Right. A woman does not have to have children with her in order to access those Violence Against Women shelters, correct?

A. Correct.

49. Q. Also at paragraph 10, in the last sentence of that paragraph you stated, "Most women accessing Carol Anne's Place are service restricted from the women shelters due to complex mental

A5224

health and substance use." Again, the time frame here that you're speaking to is your experience from the four months from June 2021 to September 2021?

A. Yes.

50. Q. And you don't cite any data here, so can we assume that this is just your recollection?

A. Yes, so I'd say my knowledge is based on my direct experience working with that population at Carol Anne's Place. So just observing the patterns and reasons why women were denied access to shelter from the women themselves or from the service providers. So those insights are kind of informed by my professional role there at the time and those specific interactions with the women.

51. Q. You don't actually know how many women were service restricted from all women's shelters between June 2021 and September 2021?

A. I wouldn't know that offhand, no, but the service restriction data is collected in HIFIS, the homeless serving database.

52. Q. Okay. And you wouldn't actually know if between June 2021 and September 2021 there were any women who were service restricted from all

shelters in the women's system, correct?

A. No, I can't confirm that.

53. Q. Also in this last paragraph -- sorry, last sentence of paragraph 10, you state, "The women are service restricted from the shelters due to complex mental health and substance use." Can we take it what you're saying is that women who have mental health -- complex mental health concerns or who use substances, exhibit behaviours that may get them service restricted?

A. Yes.

54. Q. And I want to just be clear about what your evidence is, you're not saying that the women shelters service restrict people merely for the status of having a mental health condition, correct?

A. No. However, for the substance use piece, though, they do simply restrict people for using drugs, so I would say that they tend to criminalize people that are using drugs in the shelter system because they're not restricting them for behaviour attached to that, it's simply for being caught using substances within the shelter.

55. Q. I want to unpack a little bit of what you said. So, first of all, you said criminalize,

the shelters are not actually causing criminal charges to be levied against people, correct?

A. No.

56. Q. They are not incarcerating people?

A. No.

57. Q. When you say substances, it is the use of substances that may result in a service restriction, not the status of being a substance user, correct?

A. Correct.

58. Q. And women can hypothetically -- well, I won't say hypothetically. Women are permitted in the women shelter system to exit the shelter, use substances outside of the shelter, either at a safe use site or elsewhere, and then return to the shelter, correct?

A. Yes.

59. Q. At paragraph 11 of your affidavit you state, in the first sentence, "The women shelters have a 'Do not admit list'." Are you referring there to a list of women who have service restrictions?

A. It would be -- I guess it's not an official list. It's basically kind of a common and observed practice among shelter staff where they

A940

are denying individuals access that might have a history of problematic behaviour based on personal discretion rather than a formal policy. Even if there were beds available I was witnessing this happen in the shelter system at the time.

60. Q. So you're saying that you witnessed, outside of any formal policy, a list that was kept by people at Carol Anne's Place of women that would not be admitted, notwithstanding that this was separate from a service restriction?

A. I did not witness a specific list. It was a list within the shelter system, not at Carol Anne's Place. So when calling around to the other shelters, like Mary's Place, for example, they sometimes would not take people despite having beds based on past behaviours.

61. Q. What you're describing is a service restriction, is it not?

A. No. So sometimes people aren't service restricted and they're still declined a bed despite having one based on staff's personal discretion. There's no formal policy. This is just kind of common practice and knowledge that happened when I was working in the system.

62. Q. I want to be clear because it sounds

A5225

like what you're saying is that outside of the policies of the shelters within the system, that staff are exercising discretion not to admit women despite them having spaces and despite those women not having service restrictions for that shelter, that's what you're saying?

A. Yes.

63. Q. When did that happen?

A. When I worked at Carol Anne's Place, I have called shelters and they advised me they've had a bed available and then once speaking to the women or hearing the person's name, they would state that they're ineligible for service, that they're not appropriate for the shelter bed.

64. Q. I put it to you, Ms. Mancini, that what you're describing is someone who had a service restriction at that particular shelter. Do you know any different?

A. I would say that that -- in that specific situation that I'm citing, it was not a service restriction.

65. Q. What is your source for that?

A. The staff in the shelter advising the individual is not service restricted but not appropriate for service.

66. Q. What was the name of the staff member who informed you that?

A. I'm not sure.

67. Q. Which shelter was it?

A. Mary's Place.

68. Q. When did that occur?

A. I don't know the exact date. So it would have been sometime when I was working there. I'm just looking at the date. From June to September 2021.

69. Q. You turned your face away from the camera and I think it resulted in the microphone not picking up your answer. Can you repeat that?

A. When I was working at Carol Anne's Place between June and September of 2021.

70. Q. So the person that you spoke to said, "This person is not eligible for service here."?

A. Yes.

71. Q. Were there any other occasion on which this happened?

A. I can't think of the specific occasion, no.

72. Q. At paragraph 11 you also state, "For example, one woman has not been allowed to access shelter since 2018 for being removed by police

once." What is your source for that information?

A. It was another worker at Carol Anne's Place.

73. Q. Again, is what you're describing a service restriction?

A. I'm not sure in that situation.

74. Q. Do you know of the circumstances of the woman not having been allowed to access shelters since 2018 as you allege?

A. No.

75. Q. Is it possible that there were other factors at play in the women allegedly not being allowed to access shelter---

MS. CROWE: I'm going to object cause you're asking her to speculate. She doesn't have the knowledge.

76. MS. SHORES: I'm allowed to test the scope of her knowledge and what she is relying on in making this allegation that a woman has not been allowed to access shelter since 2018.

MS. CROWE: Right, but I think it's been asked and answered because she doesn't know any other information other than what's in her affidavit and what she's

A941

responded to today.

BY MS. SHORES:

77. Q. Do you adopt your counsel's answer, Ms. Mancini?

A. Yes.

78. Q. You don't have any more information about this?

A. No.

79. Q. At paragraph 11 you also state in the third sentence of that paragraph, "Carol Anne's Place is considered the 'last stop' for women in the City as there's nowhere else to go if they cannot access Carol Anne's Place." There's no requirement to exhaust all other shelter options before going to Carol Anne's Place, correct?

A. Correct.

80. Q. At paragraph 12 of your affidavit under the heading, "Salvation Army Booth Centre Bed Capacity" you state, "The shelter has capacity for 82 men and ten emergency overflow spaces." Again, you would be speaking to your knowledge as of 2021 when you last worked at the Booth Centre?

A. Correct.

81. Q. Okay. So if the capacity has changed since then, you wouldn't have any knowledge

A5226

of that?

A. My understanding is they still have the same capacity of 82 beds.

82. Q. Okay. Is that your knowledge or is that your understanding?

A. That's my understanding.

83. Q. Based on what?

A. I still have relationships with community partners that I liaise within the housing and homeless serving sector, so as far as I know, the capacity hasn't changed.

84. Q. I'm going to put to you an affidavit from James Moulton, just bear with me as I pull it up. So once this document loads, what will be on the screen is the affidavit of James Moulton affirmed July 31, 2024. Mr. Moulton identifies himself as the Executive Director of Housing and Support Services at the Salvation Army Hamilton. Have you ever encountered Mr. Moulton?

A. Yes.

85. Q. At the Booth Centre?

A. Yes.

86. Q. At paragraph 13 of Mr. Moulton's affidavit he states that, "The Booth Centre offers 86 beds," and at the end of paragraph 13 he adds,

"An additional 13 sleeping areas are also available as emergency overflow is needed." You don't have any information to suggest that Mr. Moulton is incorrect in giving this evidence, correct?

A. Correct.

87. Q. Returning to your July 18, 2023 affidavit, at paragraph 13 you state, "When the pandemic hit, all the shelters reduced their bed capacity and a temporary ad hoc shelter was opened at First Ontario Centre. This did not increase bed capacity, it made up for the decrease in beds at the other shelters." What's your source for that information?

A. When I was working at Salvation Army, at the time they reduced their bed capacity from 82 to 50. I can't comment on the other shelters. So then the temporary ad hoc shelter was open to make up for the decrease in the beds at the other shelters.

88. Q. I want to be clear. What you're not saying is that the shelter system in the City of Hamilton had no net increase in bed capacity during the COVID-19 pandemic, correct?

A. Sorry, can you say that one more time.

89. Q. You're only speaking about the reduction in bed capacity and corresponding increase in capacity through the First Ontario Centre shelter, correct, you're not speaking to the City of Hamilton shelter capacity in total?

A. Correct.

90. Q. And just to put a finer point on it, Rob Mastrioni has given an affidavit -- so Rob Mastrioni is the Manager of the Residential Care Facility Subsidy Program and Emergency Shelter Services within the Health and Safe Community Department of the City of Hamilton's Housing Services Division. Mr. Mastrioni gave an affidavit, October 6, 2021, so this could potentially have overlapped with the time you were at the Booth Centre or not, depending on when it was that you left, and at paragraph 57 of his affidavit, Mr. Mastrioni gives a chart summarizing the change in shelter bed capacity of the City of Hamilton both before and after COVID, and at the very bottom, he summarizes a change with a net increase of 289 beds as of the time of giving this affidavit. You wouldn't have any information to suggest that Mr. Mastrioni is incorrect, would you?

A. No.

A942

91. Q. Returning to your July 18, 2023 affidavit, again, at paragraph 13 in the last sentence you state, "Clients are being service restricted for two days for missing curfew at First Ontario in the middle of a pandemic." Your evidence is that a client misses curfew once, and then for no other reason is service restricted for two days?

A. Yes.

92. Q. How many times do you believe that this has happened?

A. I don't know an exact number.

93. Q. What is the source for that information?

A. It was documented in HIFIS and through direct contact with staff at First Ontario shelter when trying to secure shelter beds.

94. Q. Did you refer to those HIFIS affidavits in giving your -- I'm sorry. Did you refer to those HIFIS records in giving your affidavit of July 18, 2023?

A. No.

95. Q. So then how do you have any certainty that your information is accurate?

A. Because the staff member documented

A5227

that the individual was service restricted for two days for missing curfew.

96. Q. So you're referring to one incident when you believe an individual was service restricted for two days for missing curfew?

A. It had happened to more than one person.

97. Q. And, again, how did you determine that that was the case?

A. Just from documentation on HIFIS.

98. Q. Which you observed while you were at the Booth Centre?

A. Yes.

99. Q. I'm going to again put James Moulton's evidence to you. This is an affidavit given by James Moulton, again, Executive Director of the Salvation Army Hamilton, this affidavit is sworn October 6, 2021. At paragraph 28 of his affidavit, Mr. Moulton states, "Bed checks are conducted during the night to ensure our beds are being used. First bed check occurs at 10 p.m.. This is standard across all men's shelters in Hamilton. It is sometimes called a curfew. However, unlike a formal curfew, clients are not prohibited from leaving the Booth Centre after 10

p.m.. Often clients will leave during the night for a variety of reasons. We ask they advise whether they will be returning. If they do, their bed may be held for them. If, however, a client has left without advising that they will return, it is possible that the bed will not be held and will be reallocated to another client who needs it. A client would have to miss two bed checks at a minimum before the bed could be reassigned."

Ms. Mancini, I put it to you that there's no policy at the Booth Centre of service restricting individuals for missing curfew once or at all?

A. That is correct, but this happened at the First Ontario Centre, so it wasn't the Salvation Army specific. Any shelter has varying policies and practices. They're all different.

100. Q. Your evidence is that the First Ontario Centre had a policy of service restricting people for two days for missing curfew?

A. I don't know if they had a policy. It was just what I saw in the documentation on HIFIS.

101. Q. Which you were speaking to your recollection of anywhere two years prior to giving

your affidavit in 2023?

A. Yes.

102. Q. Returning to your 2023 affidavit. Bear with me one moment. I'm going to return actually to Mr. Moulton's affidavit. So, again, this is Mr. Moulton's affidavit of October 6, 2021. At paragraph 19, Mr. Moulton attests that, "Breaches of expectations are dealt with by a progressive engagement strategy, caseworkers and other staff always seem to work out an issue before any warnings are given or sanctions are imposed. There are typically many conversations before sanctions are imposed. We take into account the work done with the client in the past, the seriousness of the incident and how to best address the behaviour in question." You'll agree that that was the policy at the Booth Centre in 2021?

A. Is this about service restrictions?

103. Q. This is what Mr. Moulton is saying the policies were for breaches of expectations. You worked at the Booth Centre, would you not have been aware of this policy?

A. I wasn't sure if it was related to service restrictions, but I see now it's breaches of expectations. Yes, I would say that that's

A943

correct.

104. Q. At paragraph 20, Mr. Moulton states, "When breaches of expectations result in service restrictions for clients, the service restrictions are not intended to be punitive and they are tailored to be as minimal as possible. For example, if a client is found to have shouted threats at staff or another client, that client may be asked to take a walk to calm down. If repeated, they may be restricted from accessing services for a specified period of time or they may be transferred to another shelter." Do you agree with that?

A. No, because I think policy and what's actually happening on the ground is very different and it's often based on the personal discretion of staff. I would say lots of staff do not ask clients to take a walk first and they immediately go to a service restriction. I think it's very subjective based on the staff's experience with clients. If the quite has a history of problematic behaviour, they often do not give the warnings or time to take a walk or calm down. I think it's very dependent on the individual staff working and on the client.

A5228

105. Q. You say that you've observed staff not following the policy for service restrictions, have you ever complained about or escalated that?

A. No.

106. Q. At paragraph 21 of Mr. Moulton's affidavit, he -- and, again, this is the October 6, 2021 affidavit. He states, "The imposition of a full or permanent 'ban' from our services would only occur in exceptional circumstances. There is an internal appeal process as well which clients can access." Do you agree with that?

A. Yes, to the first sentence. The second sentence about internal appeal process, that is not provided to clients upon book in and they're often not made aware of that. They're made aware they can appeal it to management, but there's not an actual process in place from the time when I was working there.

107. Q. You're saying, at the time that you worked at the Booth Centre, there was no appeal process in place?

A. Not an official process, no.

108. Q. So Mr. Moulton, who gave this affidavit in October 6 of 2021, was incorrect in saying that there's an internal appeal process

which clients can access, that's your evidence?

A. I wouldn't say he's incorrect, but clients are not being made aware of a specific appeal process.

MS. CROWE: Let's be careful here because I think the record is going to show that her response is actually -- she's restated the response that she just gave in response to the question in the first instance, was that the clients can access it but they're not provided with it and often not aware, and she's just repeated that response. I don't want that misconstrued as saying that there's no policy.

109. MS. SHORES: I don't think that's what the evidence was.

BY MS. SHORES:

110. Q. Ms. Mancini, if you adopt the answer that's given by your counsel, then---

A. I do, yes.

111. Q. Paragraph 15 of your July 13 -- or July 18, 2023 affidavit, the second sentence under the heading, "Salvation Army Booth Centre Book In Time/Curfew," you state, "Clients can book in

between the hours of 9 a.m. and 4 p.m. daily," but I put it to you, Ms. Mancini, that at the Booth Centre beds are actually available 24/7, not just the shelter staff, isn't that correct?

A. You can't book in 24/7, no.

112. Q. Again, I'll refer you to the affidavit of James Moulton. This is the July 31, 2024 affidavit of James Moulton. At paragraph 13, Mr. Moulton states in the second sentence, "These beds are available 24 hours a day, 365 days per year." So your evidence is that Mr. Moulton is incorrect?

A. We don't book in during mealtimes. We also don't book in overnight if -- if say the shelter was full and then one person booked out in the middle of the night, we would not book a new person into that bed because they don't take that person off the list until the morning shift. So I would say that we are not booking in 24/7, no.

113. Q. So, again, your evidence is that Mr. Moulton is incorrect when he says that the beds are available 24/7?

A. Yes.

114. Q. And your evidence is that of somebody who worked at the Booth Centre up until 2021 as a

A944

case manager, you have greater knowledge and familiarity than Mr. Moulton, who is the Executive Director---

MS. CROWE: Asked and answered.

115. MS. SHORES: No, that's not asked and answered.

MS. CROWE: First of all, it's opinion evidence. She doesn't have to speculate on whether she's in a better position or has greater knowledge, that's opinion. She's indicated where she thinks the discrepancy lies.

116. MS. SHORES: It's not an opinion. I'm entitled to test the scope of her knowledge, which is what Ms. Mancini is here to give answers about. If Ms. Mancini is claiming that she knows more than Mr. Moulton, that is relevant and informs her evidence and how it will be received in court.

MS. CROWE: I'm going to object because I think we are wading to an opinion and I don't -- I don't see it's relevance either.

117. MS. SHORES: It is both relevance and not

A5229

opinion, but I'll move on.

BY MS. SHORES:

118. Q. Paragraph 16 of your July 18, 2023 affidavit, again, you state, "The dorms are closed every day from 8 a.m. to 6 p.m.." So, again, Mr. Moulton says that the beds are available 24/7, he's incorrect, is that your evidence?

A. That is correct, you cannot sleep in the shelter during the daytime from 8 a.m. to 6 p.m.. You can only sleep after 6 p.m.

119. Q. At paragraph 16, in the last sentence of that paragraph you state, "If you are service restricted for a period of time, that can range anywhere from 24 hours to indefinitely due to 'noncompliance or behaviours related to mental health and substance use' from all three men's shelters, you are turned away to the street with nowhere to go and this is a very common practice." So there's quite a few things in that sentence and I want to break them down.

First of all, with respect to behaviours related to mental health and substance use, we've addressed a similar concept when you were speaking of Carol Anne's Place, so again I want to put it to you that it's not having mental health conditions

or the status of being a substance user that results in someone being service restricted, it is the behaviours that people like that exhibit that may get them service restricted, correct?

A. Correct, aside from the piece about using substances. People do get service restricted for simply using their substances.

120. Q. In the Booth Centre?

A. Yes.

121. Q. They don't get service restricted for having used substances outside of the Booth Centre?

A. No.

122. Q. You also state in this sentence -- you refer to service restrictions from all three men's shelters, but I'll put it to you that a service restriction at the Booth Centre doesn't automatically apply to the other men's shelters, correct?

A. Correct.

123. Q. Okay. So if I understand what you're describing in this sentence, if someone is service restricted from all three shelters, they would not have anywhere else to go, is that what you're describing?

A. Yes, that's what I was trying to say.

124. Q. And are you saying that it is a "very common practice that men are restricted from all shelters."?

A. I think that was referring to common practice in the sense that folks are often turned away to the street with nowhere else to go.

125. Q. I don't think I understand your answer. Is it your evidence or is it not that it is very common practice for men to be service restricted from all three shelters at the same time?

A. Yes.

126. Q. What is your source for that?

A. Just direct contact with clients that are service restricted from all shelters and then trying to secure them shelter space, not being able to.

127. Q. When was this direct experience, when you were working at the Booth Centre?

A. Yes.

128. Q. So you're relying on this experience at the Booth Centre gained up to 2021 and recalling it when you're giving your affidavit in 2023?

A. Yes.

129. Q. You weren't referring to any sort of

A945

HIFIS records when you were giving your affidavit in 2023?

A. No, I no longer have access to HIFIS.

130. Q. And so you're not able to say how many men were restricted from three shelters at the same time?

A. Correct.

131. Q. And you're not able to say how long those service restrictions would have been in place?

A. No.

132. Q. At paragraph 17 of your affidavit you state, "The City's narrative that there are shelter beds available for everyone is false." What are you referring to when you say, "The City's narrative that there are shelter beds available for everyone."?

A. I believe during the pandemic there was the assumption that there was bed spaces available, but the shelters were consistently at capacity nightly.

133. Q. Tell me where the City has said that there are shelter beds available for everyone.

A. I can't recall.

134. Q. But you're alleging in sworn

A5230

affidavit evidence that's going to be given in court and on the public record that the City of Hamilton has given a false narrative. You can't even point to what you're saying the City is being false about, is that correct?

A. I can't recall where they stated there were shelter beds available.

135. Q. At paragraph 19 of your affidavit you state, "For example, a shelter worker recently turned away 35 people in an eight hour shift and consistently has anywhere from 10 to 30 people on the overflow waitlist nightly when there are only 10 overflow beds available." When did that happen?

A. It would have happened when I was working at the Salvation Army during the pandemic.

136. Q. So that would have been sometime in 2021 or earlier?

A. Yes.

137. Q. So that's not really recently when we talk about your affidavit in 2023, is it?

A. Correct.

138. Q. Which shelter?

A. The Salvation Army.

139. Q. How did you gain that knowledge?

A. From a coworker that was working that

had advised they had turned away 35 people in an eight hour shift.

140. Q. You didn't take any steps to independently verify what they said?

A. No.

141. Q. At paragraph 20 of your affidavit you state, "The City's narrative that there are no clients who are service restricted shelter wide is also false." What is your source for your claim that the City has given a narrative that there are no clients who are service restricted shelter wide?

A. I can't remember where they had stated that.

142. Q. Again, you're alleging now for the second time in sworn evidence that's going to be used in court and put on the public record that the City of Hamilton is giving a false narrative, and you're saying you can't even remember where it is that the City is alleged to have made that statement.

A. I can't recall, no.

143. Q. Do you recant that statement, that the City is giving a false narrative?

A. Sure.

144. Q. Also at paragraph 20 you state, "I

can think of several clients who are currently service restricted from all three men's shelters." Again, are you speaking about 2023 at the time you gave your affidavit or back in 2021?

A. In 2021.

145. Q. You, again, don't say how long these men were service restricted for, correct?

A. Correct.

146. Q. And I take it you don't know?

A. No.

147. Q. At paragraph 21 of your affidavit at the last sentence of that paragraph you state, "Frontline staff are not adequately trained in overdose prevention and response or risk assessments for clients in mental distress." Ms. Mancini, I put it to you that staff members are trained in, among other things, mental health first-aid and administration of Naloxone for opiate overdoses. Do you agree with that?

A. I was trained in Naloxone but not -- I was not given training for mental health first-aid when I worked in the shelter system, no.

148. Q. I'm going to put it to you, Mr. Moulton in his October 6, 2021 affidavit at paragraph 7, which I'll take you to, states, "All

A946

of our staff members have various levels of additional training as well, which includes, at a minimum, nonviolent crises intervention training, de-escalation training and first-aid training, including mental health first-aid and administration of Naloxone for opiate overdoses," and then he goes so far as to attach a copy of a then recent job opportunity posting at Booth Centre listing the experience and education required for their staff. Are you saying that Mr. Moulton is incorrect in stating that staff at the Booth Centre receive, among other things, mental health first-aid training?

A. No, I just did not receive mental health first-aid training when I worked there.

149. Q. Did you already have mental health first-aid training when you worked there?

A. I can't recall.

150. Q. Returning to your affidavit at paragraph 22, you state in the last sentence of that paragraph, "The response from the City is threatening removal of funding if housing statistics are not meeting their expectations." What is your source for that?

A. Management advising if we don't meet

A5231

our targets, we could lose our funding from the City.

151. Q. Do you know first-hand that the City has ever threatened to remove funding for shelters if they do not meet housing statistics?

A. Not from the City directly, but this is what management had communicated at the time.

152. Q. So, again, the question is, do you know first-hand, and let's be clear, your affidavit states at the very beginning, "I have personal knowledge with respect to the facts set out about the emergency shelter system," so do you have personal knowledge that the City has threatened---

MS. CROWE: Hold on. Before you put that to her, let's read out the second part of that sentence.

BY MS. SHORES:

153. Q. "Where information is not based on my personal knowledge, it is based upon information provided by other professionals, which I believe to be credible and true." And I want to know, where is that information coming from?

A. So it came from---

154. Q. Most of the information isn't stated, which is, I'll state for the record, not compliant

with the Rules, but let's test that out. So, again, do you have personal knowledge that the City of Hamilton has ever threatened to remove funding if housing statistics are not met?

A. No.

155. Q. At paragraph 30 of your affidavit, under the heading "COVID Outbreaks In Shelter," you refer to a circumstance when all three men's shelters were in outbreak at the same time. You state, "There were zero indoor options for unhoused men." I put it to you, Ms. Mancini, that shelter admissions were paused; however, people who were already in shelter were permitted to remain, isn't that correct?

A. Correct.

156. Q. So it's not entirely accurate that there were zero indoor options for unhoused me, the unhoused men who were already in shelter were permitted to stay, correct?

A. Correct.

157. Q. At paragraph 31 of your affidavit, referring to hotel programs, the last sentence of this paragraph you state, "Staff did not secure them (referring to people who were formerly staying in shelters) beds at shelters upon discharge from

the hotel, so when these men attempted to find space, the shelters were all at capacity." What is your source for this?

A. At that time, the hotel program discharged all men that were in the hotel and they weren't able to get shelter anywhere because they didn't attempt to get them shelter upon discharge, so they ended up coming to -- try to get shelter space and they were -- and told us they were discharged from the hotel and we weren't provided any transfer to another shelter space. So it was direct knowledge from the clients themselves.

158. Q. You said direct knowledge from the clients themselves, but the clients themselves are telling you that, so that's not direct knowledge, is it?

A. It's the knowledge from the client.

159. Q. We might have a misunderstanding about what knowledge is. If a client is telling you something, you don't have first knowledge of the thing that they're telling you about, correct?

A. Correct.

160. Q. So if clients are telling you that someone failed to secure a bed for them, as you allege in this paragraph, that knowledge is

A947

secondhand, correct?

A. Yes, it's the experience of the client.

161. Q. That's being reported to you?

A. Yes.

162. Q. Secondhand?

A. Yes.

163. Q. At paragraph 32 of your affidavit you say, "Overdoses within the shelter have rapidly increased." You don't set any source for that, that's just your impression?

A. From my first-hand experience working in the shelter system and seeing an increase in overdoses and---

164. Q. Sorry, I didn't mean to interrupt you. What did you say at the end of your answer.

A. And being the frontline worker responding to the overdoses that are occurring.

165. Q. So that would be at the Booth Centre?

A. Yes.

166. Q. And so you're speaking about the timeframe up to 2021 when you were there?

A. Yes.

167. Q. I take it you didn't take any -- record any data or measure the frequency of

A5232

overdoses within the shelter?

A. No, but the City of Hamilton demonstrates that overdoses have increased year after year since data started being collected in 2015.

168. Q. What data are you referring to?

A. On the City of Hamilton opioid recording system.

169. Q. I'm not familiar with that. What is the opioid recording system that you're referring to?

A. They record the number of overdoses that occur and overdose deaths in the City of Hamilton.

170. Q. Are you referring to publicly available information or something that's kept within the shelter system such as HIFIS?

A. Publicly available.

171. Q. In making this statement, despite not saying so in your affidavit, you're referring to a publicly available overdose information that is available on the City of Hamilton's website?

A. Yes, and my own personal experience in responding to an increase in overdoses while working in the shelter system.

172. Q. At paragraph 36 of your affidavit you give an example saying that you called the Four Points Hotel to refer a client, the client was service restricted from all shelters except for Four Points, and in addition, there were less shelter beds available in the City due to mission services being closed for a fire. You state that, "The Four Points had a bed available, however, they would not take your patient based on past behaviours at other shelters, stating that they did not think it would be an appropriate fit." I'm going to pause there. Your interpretation of that response is that the patient had been service restricted from shelters?

A. They were restricted from all the shelters except for the Four Points Hotel. That's what staff communicated.

173. Q. They said that this individual was service restricted from all shelters?

A. Yes.

174. Q. And, again, you don't say for how long this patient would have been service restricted from all shelters.

A. No.

175. Q. When did this happen?

A. That was in my role in the emergency department as a social worker, so it could have been anywhere from January 2022 to April 2023.

176. Q. You don't say what the past behaviours were, did they say what past behaviours they were referred to?

A. No, I don't recall.

177. Q. Was it communicated to you at all whether those behaviours were such that it posed a safety concern for others in the hotel?

A. Sorry, can you say that one more time.

178. Q. Did you inquire or did they inform you whether any of those past behaviours were behaviours that would pose a safety concern for others in the hotel?

A. No, they did not.

179. Q. At paragraph 37, again, you give an example of a patient presenting at hospital for injuries related to domestic violence who was seeking shelter. You state you called all of the women's shelters and they were all full. You don't indicate which shelters you called. Do you remember?

A. For domestic violence I would have

A948

called Martha House, Interval House, Inasmuch House and Native Women's Centre.

180. Q. Those are the shelters that were all full to your recollection?

A. Yes.

181. Q. So you didn't call the other shelters?

A. I did also call the single women's shelter. I don't think Emma's Place was open at the time, so it would have been Womankind and Mary's Place as well.

182. Q. But that's not what you said just now. When I asked you what shelters you called, you said the Violence Against Women shelter and now you're changing your answer and saying you also called the other shelters.

A. I called the Violence Against Women shelters first because she was pleading domestic violence but then I also attempted to secure a space in the single women's shelter as well.

183. Q. Again, you don't say when this happened. When did this occur?

A. That also would've been in my role in the emergency department, so it could've been January 2022 to April 2023.

A5233

184. Q. But you're not certain?

A. No.

185. Q. In paragraph 38 of your affidavit you give the example of an unhoused patient who tested positive for COVID-19 and that they were unable to access hospital beds, I'm paraphrasing here at the interest of time, but the patient, you state, was referred to the Wesley Isolation Centre but was declined to be supported by the Wesley Isolation Centre as he was currently "No trespass from the Wesley Day Centre, which is in the same building as the Wesley Isolation Centre." When did this incident occur?

A. Again, it could have been anywhere from January 2022 to April 2023. During the pandemic.

186. Q. And so you don't know with more precision than that?

A. No.

187. Q. You don't say where this patient ended up, you simply state that Wesley was unable to accommodate the individual.

A. From my recollection, I believe he was discharged to the street?

188. Q. And you don't know where they end up,

if this individual was able to find shelter elsewhere?

A. No, I don't know.

189. Q. You've understood all my questions today, Ms. Mancini?

A. Yes, I did. Thank you.

190. Q. You don't wish to change -- or do you wish to change any of your evidence?

A. No, I don't think so.

191. Q. Those are my questions. Thank you.

MS. CROWE: Thank you, Ms. Mancini. I just have a few re-direct questions for you, okay?

THE DEPONENT: Okay.

RE-EXAMINATION BY MS. CROWE:

192. Q. You refer in your affidavit to Carol Anne's Place as an overflow drop-in space, what does that mean?

A. It's not an official shelter, it's just an overnight drop-in, meaning every night they have to go to try to secure a drop-in space at 10 p.m.

193. Q. What do you mean when you say it's not an official shelter?

A. You don't get an assigned bed that

would be yours day in and day out.

194. Q. Okay. In your experience, who goes to Carol Anne's Place or when do women decide to access Carol Anne's Place?

MS. SHORES: Counsel, hang on. I'm objecting to this question. This is clearly an attempt to expand the evidence. This isn't anything that was elicited on cross-examination and it's not information that's in the original affidavit, so this is improper.

195. MS. CROWE: You did ask her about whether -- whether you have to -- sorry, there's just a siren outside my window. You asked her about whether women have to call around and confirm other shelters are full before going to Carol Anne's Place. I'm just trying to ascertain, you know, the circumstances under which women go to Carol Anne's Place.

MS. SHORES: Counsel, she gave a very clear answer in response to that question and that question was itself premised on a sentence that she says in that very paragraph. Expanding on the evidence is

A949

not permissible on re-examination.

196. MS. CROWE: That's fine. We'll move on.

BY MS. CROWE:

197. Q. So you mentioned when you were talking about services for substance use that the act of using substances inside shelters can trigger a service restriction, are there any other behaviours or circumstances where a substance use could trigger a service restriction in your experience?

A. Additionally if an individual has harm reduction supplies, like pipes or needles to use those substances, if they are caught with those supplies, they can also be service restricted in that instance.

198. Q. Thank you. There was some discussion about when people can access the Salvation Army Booth Centre and the language that was used was booked-in, what does that mean?

A. So booking into the shelter bed, so I guess, kind of, like an admission into the shelter.

199. Q. Can you reserve it ahead of time or is it -- help us understand what that means.

A. It would be on a first come, first serve basis. You can't reserve the bed ahead of

A5234

time, no.

200. Q. Okay. When we were talking about training for shelter staff in mental health and overdose response, the language that you had used was that staff are not given adequate training, what did you mean by that?

MS. SHORES: Again, Counsel, this is expanding on the evidence. Ms. Mancini gave a clear response. Re-examination is not an opportunity to expand on the evidence in the affidavit.

BY MS. CROWE:

201. Q. Is there a difference between a service restriction and just being denied access to a shelter or being asked to leave a shelter?

A. Yes, so a service restriction is formally documented in HIFIS for a specific length of time, whereas denying people access to shelter doesn't necessarily mean you are service restricted, it could be based on staff's like personal belief or discretion. There's been times where there's beds available, the person is not service restricted and they are still not given access to that bed.

202. Q. Thank you. Those are my questions.

---Whereupon the cross-examination was concluded at 2:00 p.m.

I hereby certify the foregoing to be the evidence of **OLIVIA MANCINI**, given under oath before me on the **20TH** day of **August**, 2024, recorded verbatim and later transcribed by me.

CERTIFIED CORRECT:

Helen Matsos

Helen Matsos, CVR

Certified Verbatim Reporter

Commissioner of Oaths (Expires July 18, 2025)

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A950

A5235

Ex # A mrdy 8/20/2024 Pg 1 of 2
Exam of Olivia Mancini
Heegsma v. City of Hamilton
Nirmigan Mihailovich Reporting Inc.

Integrating Best Practices of Harm Reduction

A presentation by Olivia Mancini on Integrating Best Practices of Harm Reduction to maximize the health and safety of People Who Use Drugs and frontline workers.

Olivia Mancini brings her passion, dedication, and expertise across various organizations in Hamilton, providing mental health and harm reduction support to folks as a Registered Social Worker and Harm Reduction Worker. When she is not on

A951

the frontline, Olivia works in drug policy and advocates for the decriminalization of drugs, safe supply, legal regulation, and the right to housing. Olivia also recently completed her Master of Social Work at McMaster University.

‹ Previous Post
Report from public health dialogue in Ottawa reveals decriminalization and government leadership are key in addressing drug toxicity crisis

Next Post ›
A letter to Nanaime

About Regulation Project

The Regulation Project is an international collaboration to advocate and educate for the legal regulation of drugs.

SFU SIMON FRASER UNIVERSITY

The Canadian Drug Policy Coalition is based out of Simon Fraser University's Faculty of Health Sciences.

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Getting to Tomorrow © 2021

Court File No. CV-21-00077187-0000

ONTARIO SUPERIOR COURT OF JUSTICE

BETWEEN:

KRISTEN HEEGSMA, DARRIN MARCHAND, GORD SMYTH, MARIO MUSCATO, SHAWN ARNOLD, BRADLEY CALDWELL, CHRISTINE DELOREY, GLENN GNATUK, TAYLOR GOGO-HORNER, CASSANDRA JORDAN, JULIA LAUZON, AMMY LEWIS, ASHLEY MACDONALD, COREY MONAHAN, MISTY MARSHALL, SHERRI OGDEN, JAHMAL PIERRE, LINSLEY GREAVES and PATRICK WARD

Applicants

-and-

CITY OF HAMILTON

Respondent

AFFIDAVIT OF TIMOTHY O'SHEA

Sworn June 7, 2024

I, Doctor Timothy O'Shea, of the City of Hamilton in the Province of Ontario, AFFIRM AND STATE:

1. I have personal knowledge with respect to the facts and reports set out below, except where stated otherwise. Where the information is not based on my personal knowledge, it is based upon information provided by others which I believe to be credible and true.

2. I am a physician with the Shelter Health Network (SHN) and the Hamilton Social Medicine Response Team (HAMSMaRT). These organizations provide medical care to individuals affected by homelessness or housing precarity. I have worked with SHN since its inception in 2007. I also joined HAMSMaRT at its formation in 2016.

3. I provided a report to the Hamilton Community Legal Clinic dated June 13, 2022 with respect to Kristen Heegsma. Attached hereto and marked as Exhibit "A" is a copy of this medical letter and I endorse the contents therein.

4. I provided a report to the Hamilton Community Legal Clinic (undated) with respect to Ammy Lewis. Attached hereto and marked as Exhibit "B" is a copy of this medical letter and I endorse the contents therein.

5. I make this Affidavit for no improper purpose.

Sworn remotely by Timothy O'Shea in the Province of Ontario, before me on June 7, 2024 in accordance with O. Reg. 431/20, Administering Oath or Declaration Remotely.

Commissioner for Taking Affidavits
Sharon Crowe LSO 47108R

Timothy O'Shea

This is Exhibit 'A' referred to in the affidavit of Dr. Timothy O'Shea affirmed before me this 7th day of June, 2024.

EXHIBIT 'A'

McMaster University

TIMOTHY O'SHEA, BSc, MD, MPH, FRCPC
Internal Medicine, Infectious Diseases, Medical Microbiology
Associate Professor, Department of Medicine
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Hamilton Health Sciences

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June 13, 2022

To Whom It May Concern:

Hamilton Community Legal Clinic
100 Main St. E. Suite 203
Hamilton ON L8N 3W4

Attention: Sharon Crowe and Stephanie Cox

Re: (Kristen Heegsma, DOB 1990/10/20)

I am a physician with the Shelter Health Network (SHN) and the Hamilton Social Medicine Response Team (HAMSMaRT), two organizations that provide medical care to individuals affected by homelessness or housing precarity. I have worked with the SHN since its inception in 2007, and similarly joined HAMSMaRT at its formation in 2016. I first met Ms. Heegsma in July of 2021 and have been seeing her on average once every two weeks since then. To the best of my knowledge, Kristen has been homeless for at least the past 4 years.

Kristen has the following medical conditions:

1) Crohn's disease
2) Opioid Use Disorder
3) Stimulant Use Disorder
4) Attention Deficit Hyperactivity Disorder
5) Post-traumatic stress disorder

~~It is my opinion that each of Ms. Heegsma's medical conditions have been negatively impacted by her lack of access to stable housing.~~ ~~Due to her lack of housing~~ Kristen has enormous barriers to accessing consistent medical care, leading to a pattern of starting and stopping treatments which has been in some cases counterproductive to her goal of improving her overall wellbeing. ~~Furthermore~~ the trauma that she ~~has experienced (outlined below) as a direct result of~~ her lack of ~~housing has further exacerbated her underlying mental health conditions to a severe extent~~. Despite her being able to see me on a fairly regular basis over the past six months Kristen's overall condition continues to fluctuate, ~~and our progress has been far below what I would expect if she were stably housed.~~

It is important to note that Ms. Heegsma's health status has fluctuated in concert with the degree to which her shelter status has been stabilized or destabilized. There have, for example, been short periods of time when Ms. Heegsma has been able to access shelter within the city's hotel shelter program, and briefly through a transitional housing program run by the YWCA. ~~Although in no way ideal,~~ These brief sojourns allowed Kristen some space to focus more on her health needs, and allowed,

for instance, time to more effectively titrate medications for the treatment of opioid use disorder and for some of her mental health concerns. However, for the majority of the last year Kristen has lived outside. She has stayed both within small formal encampments and when forced to has sought shelter elsewhere, including sleeping in stairwells and seeking shelter ~~in situations which put her physical safety in jeopardy. Again, although it is clear that sleeping in a tent in a park is not a desired outcome, Kristen's health was dramatically better in this situation than when she was in less safe, less stable, settings.~~ Kristen described feeling safe in the most recent park where she sought shelter due to the presence of others that looked out for her, and as well secondary to the fact that those involved in caring for her, including my clinic, knew where to find her if we needed to. Shortly after this small encampment was cleared Kristen began alternating her time sleeping outside on park benches, stairwells and abandoned buildings with staying inside with a male acquaintance who assaulted her multiple times physically and emotionally. As a result her mental health has significantly deteriorated, and her stability with respect to her opioid use disorder has dramatically worsened.

~~Due to the profound impact of Kristen's housing status on her physical and mental health~~ much of our appointments end up focusing on securing a more stable housing arrangement. Kristen is often reluctant to access shelter beds, with the primary reason being that she is fearful of her physical safety in a congregate shelter setting, after suffering physical assaults within shelter previously. Kristen has also previously been restricted from accessing shelter space due to behaviours related to her underlying mental health and substance use disorders, leading to a lack of trust with the shelter system. Nevertheless we have attempted on multiple occasions to secure shelter space for Kristen particularly through the cold winter months between December 2021 and March 2022. On at least three occasions we called multiple shelters for women from my clinic office and on each occasion were told that there was no shelter space available for Kristen; on each occasion we were asked to check back the following day.

Kristen's health has clearly suffered to a significant extent due to her homelessness and housing precarity. She has several medical conditions which in ideal circumstances could be managed effectively, however given her circumstances we have struggled to make consistent progress in terms of improving her health. ~~Furthermore her health status has been negatively impacted by policies which have led to her displacement from settings in which she has managed to achieve some degree of stability~~.

I would be happy to answer further questions as required.

Sincerely

Timothy O'Shea, BSc, MD, MPH, FRCPC
Internal Medicine, Infectious Diseases, Medical Microbiology
Associate Professor, Department of Medicine
Consultant Physician – Inpatient Addiction Service
Faculty of Health Sciences
McMaster University

This is Exhibit 'B' referred to in the affidavit of Dr. Timothy O'Shea affirmed before me this 7th day of June, 2024.

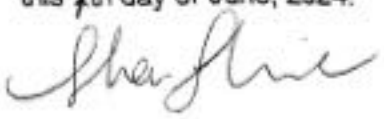

EXHIBIT 'B'

McMaster University

TIMOTHY O'SHEA, BSc, MD, MPH, FRCPC
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Hamilton Community Legal Clinic
100 Main St. E. Suite 203
Hamilton ON L8N 3W4

Attention: Sharon Crowe and Stephanie Cox

Re: (Ammy Lewis, DOB 1978/07/04)

I am a physician with the Shelter Health Network (SHN) and the Hamilton Social Medicine Response Team (HAMSMaRT), two organizations that provide medical care to individuals affected by homelessness or housing precarity. I have worked with the SHN since its inception in 2007, and similarly joined HAMSMaRT at its formation in 2016. I first met Ms. Lewis in March of 2021 and have been seeing her on average once every two weeks since then. To the best of my knowledge, Kristen has been homeless for at least the past 3 years.

Kristen has the following medical conditions:

- HIV infection
- Opioid Use Disorder
- Stimulant Use Disorder
- Post-traumatic stress disorder

~~It is my opinion that each of Ms Lewis' medical conditions have been negatively impacted by her lack of access to stable housing~~. Due to her lack of housing Ammy has ~~faced enormous barriers to~~ accessing consistent medical care. ~~As well~~ Ammy's search for housing has been all consuming for her, ~~making it very difficult to act upon recommendaitons from her healht care team with respect to her chronic medical conditions. Furthermore the trauma that she has experienced (outlined below) as a direct result of her lack of housing has further exacerbated her underlying mental health conditions to a severe extent~~. Despite her being able to see me on a fairly regular basis over the past six months Ammy's overall condition has overall deteriorated, and our progress has been far below what I would expect ~~if she were stably housed~~.

I first met Ammy when she was briefly housed in a rooming house in Hamilton. Ammy had been released from detention centre and was initially homeless, seeking shelter in a local park with her dog in the spring of 2020. She was able to access housing from this location, however she was unfortunately assaulted by the landlord at that location and evicted shortly thereafter. Since that time Ammy has been homeless and sleeping rough. Ammy was able to find some relateive stability while staying at a park which she choose due to its proximity to her pharmacy. Overall she stayed in this location for about two months, during which time she was able to get her medications daily and attend clinic visits with me. Furthermore she was able to engage with city housing workers during this time, in large part thanks to her being in a reliable place where she could be tracked down. Ammy was evicted from this park in late summer of 2021, and has been moving from place to place since. This most recent period of Ammy's life has been characterized by extreme instability. She has lost all of her belongings on multiple occasions, been subjected to verbal harrassment and has on at least two occasions been physically assaulted at her camping site. Ammy has become increasingly desperate to find shelter due to the trauma that she is suffering on a day to day basis. Unfortunately, despite engagement with my clinic and city housing workers, suitable inside accomodation has not been found. Barriers to this include shelters being full when we have attempted to call, and Ammy's devotion to her dog, who she does not want to leave despite the fact that shelters have refused to admit her with her dog. ~~With all of the above contributing, Ammy's mental and physical health have suffered severely.~~

~~Ammy's health has clearly suffered to a significant extent due to her homelessness and housing precarity.~~ She has several medical conditions which in ideal circumstances could be managed effectively, however given her circumstances we have struggled to ~~make consistent progress~~ in terms of improving her health. ~~Furthermore her health status has been negatively impacted by policies which have led to her displacement from settings in which she has managed to achieve some degree of stability.~~

I would be happy to answer further questions as required.

Sincerely,

Timothy O'Shea, BSc, MD, MPH, FRCPC
Internal Medicine, Infectious Diseases, Medical Microbiology
Associate Professor, Department of Medicine
Faculty of Health Sciences
McMaster University

TO/lb

Heegsma et al
Applicants

-and-

CITY of HAMILTON
Respondents

Court File No. CV-21-00077187-0000

Ontario
Superior Court of Justice

PROCEEDING COMMENCED AT HAMILTON

Affidavit of Dr. O'Shea dated June 7, 2024

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21 Dunlop Street, Richmond Hill, ON L4C 2M6
Sharon Crowe (LSO# 47108R)
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Counsel to the Applicants

Court File No. CV-21-00077187-0000

ONTARIO SUPERIOR COURT OF JUSTICE

B E T W E E N:

KRISTEN HEEGSMA, DARRIN MARCHAND, GORD SMYTH, MARIO MUSCATO, SHAWN ARNOLD, BRADLEY CALDWELL, CHRISTINE DELOREY, GLENN GNATUK, TAYLOR GOGO- HORNER, CASSANDRA JORDAN, JULIA LAUZON, AMMY LEWIS, ASHLEY MACDONALD, COREY MONAHAN, MISTY MARSHALL, SHERRI OGDEN, JAHMAL PIERRE, LINSLEY GREAVES and PATRICK WARD

Applicants

-and-

CITY OF HAMILTON

Respondent

AFFIDAVIT OF TIMOTHY O'SHEA

Sworn August 12, 2024

I, Doctor Timothy O'Shea, of the City of Hamilton in the Province of Ontario, AFFIRM AND STATE:

1. I have personal knowledge with respect to the facts and reports set out below, except where stated otherwise. Where the information is not based on my personal knowledge, it is based upon information provided by others which I believe to be credible and true.

2. I am a physician with the Shelter Health Network (SHN) and the Hamilton Social Medicine Response Team (HAMSMaRT). These organizations provide medical care to individuals affected by homelessness or housing precarity. I have worked with SHN since its inception in 2007. I also joined HAMSMaRT at its formation in 2016.

3. I have been asked to review the July 31, 2024 Affidavit of Roberto Mastroianni. I have reviewed the affidavit and offer the following comments in reply.

4. In paragraph 47, Mr. Mastroianni states that "The Applicant, Ammy Lewis, is presently housed and has been since October 1, 2021, according to City records".

5. From my records, Ms. Lewis was briefly in a Residential Care Facility briefly in the spring of 2021, accessed the shelter system in November of 2022, and was housed in February of 2023. Beyond those instances, Ms. Lewis lived unsheltered during the time that I have known her (since March 2021). I see Ms. Lewis regularly in clinic and we routinely discuss her housing situation.

6. I make this Affidavit for no improper purpose.

Affirmed remotely by Dr. Timothy O'Shea stated as being located in the Town of Parry Sound, before me at the Town of New Tecumseth in the County of Simcoe, on August 12, 2024, in accordance with O. Reg 431/20, Administering Oath or Declaration Remotely.

.....

Commissioner for Taking Affidavits

Michelle Sutherland LSO#70159T

Timothy O'Shea

Heegsma et al
Applicants

-and-

CITY of HAMILTON
Respondents

Court File No. CV-21-00077187-0000

Ontario
Superior Court of Justice

PROCEEDING COMMENCED AT HAMILTON

Affidavit of Dr. O'Shea dated August 12, 2024

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Counsel to the Applicants

COURT FILE NO. CV-21-77187

ONTARIO

SUPERIOR COURT OF JUSTICE

BETWEEN:

KRISTEN HEEGSMA, DARRIN MARCHAND, GORD SMYTH, MARIO MUSCATO, SHAWN ARNOLD, BRADLEY CALDWELL CHRISTINE DELOREY, GLEN GNATUK, TAYLOR GOGO-HORNER, CASSANDRA JORDAN, JULIA LAUZON, AMMY LEWIS, ASHLEY MACDONALD, COREY MONAHAN, MISTY MARSHALL, SHERRI OGDEN, JAHMAL PIERRE, LINSLEY GREAVES and PATRICK WARD

Applicants

-AND-

CITY OF HAMILTON

Respondent

The Cross-Examination of Dr. Timothy O'Shea, on an Affidavits dated June 7, 2024 and August 12, 2024, taken upon affirmation in the above action this, 6th of September, 2024, conducted via videoconference hosted by the offices of Nimigan Mihailovich Reporting Inc.

APPEARANCES:

For the Applicants:

For the Hamilton Community Legal Clinic:

SHARON CROWE

For the Community Legal Clinic of York Region:

MICHELLE SUTHERLAND

NONYE OKENWA

BENJAMIN HOGNESTAD

For the City of Hamilton:

JORDAN DIACUR

JOJO JOHNSON

Gowling WLG (Canada) LLP

I N D E X

PAGE

WITNESS: DR. TIM O'SHEA

Cross-Examination by MR. DIACUR 5
Re-Examination by MS. CROWE 43

EXHIBITS

GUIDE TO UNDERTAKINGS, ADVISEMENTS, and REFUSALS:

This should be regarded as a guide and does not necessarily constitute a complete list:

UNDERTAKINGS:

(None noted).

UNDER ADVISEMENTS:

(None noted).

REFUSALS:

[2] 10/4, 10/22.

--- Commencing at 1:45 p.m.

DR. TIM O'SHEA,

THE WITNESS HEREINBEFORE NAMED,

Having been duly sworn by me to testify to the truth,

testified on their oath as follows, to wit:

CROSS-EXAMINATION BY MR. DIACUR:

1 Q. Thank you. So, Doctor, I have questions for you today about your two affidavits provided in this matter. They are dated June 7, 2024, and August 12th, 2024.

Do you have copies of those affidavits available to you?

A. I do have them on my computer, yes.

2 Q. Okay. My intention would also be to put copies of them up on the screen when I'm asking about them.

A. Sure.

3 Q. So that you can look at either version, but there will be a copy that's on the screen for you.

A. That's perfect, thank you.

4 Q. I will put that up and make sure that you can see it to begin with.

So on the screen now is your first affidavit, June 7, 2024.

You can see that, okay?

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A. Yes, sir.

5 Q. Okay. So to begin with, you have not provided a copy of your CV or curriculum vitae in this matter; correct?

A. I don't think so.

6 Q. And you have not provided any studies or evidence regarding the capacity or the sufficiency of the shelter system in the City of Hamilton?

A. As far as I know, I have not.

7 Q. And you've not signed a document called an "Acknowledgement of Expert's Duty" or sometimes called a Form 53 in this matter; right?

A. I don't believe so.

8 Q. So, Dr. O'Shea, do you consider yourself independent in this matter?

A. What I consider is I provided my findings with respect to my patients. I'm independent as a medical practitioner in terms of assessing my patients.

9 Q. By "independent", I mean that you do not favour one side or the other?

A. My intention isn't to favour one side or the other, but to provide information about my patients.

10 Q. Understood. And you prepared the medical letters that are attached to your affidavit; is that right?

A. Correct.

11 Q. And you did so at the request of the lawyers for the Applicants; is that correct?

A. Correct.

12 Q. And they are addressed, in fact, to the Hamilton Community Legal Clinic; correct?

A. I can have a look and see. I don't --

13 Q. I'm putting the first of them dated June 13, 2022, on the screen.

A. Yeah.

14 Q. With reference to Kristen Heegsma. It says:

"To whom it may concern[...]"

And the address is the Hamilton Community Legal Clinic.

A. Yes, I agree.

15 Q. These letters, they were prepared around the time that this litigation began. Were they prepared, to your knowledge, after this litigation began?

A. I honestly don't know the timeline.

16 Q. Yes. You have not included in your affidavit the request or instructions you received from the Applicants' lawyers in preparing these medical letters; correct?

A. Correct.

17 Q. And is the any additional correspondence; emails, letters, notes of calls between you and the Applicant lawyers regarding the preparation of your medical letters?

A. From what I recall I was requested to provide information about my patients' health status as it relates to their housing status.

18 Q. Did you prepare these medical letters that are attached on your own or did you applicants' lawyers assist you?

A. I prepared these on my own.

19 Q. Did you review a draft of the Notice of Application in this matter prior to preparing the medical letters?

A. I don't believe I did. It's been a long time, but I don't believe I saw such a thing.

20 Q. Have you seen a Notice of Application in this matter at all?

A. To my knowledge, I have not.

21 Q. Did you speak with the applicants who are referenced in your medical letters prior to preparing your medical letters?

A. I see the Applicants on a regular basis so I spoke to them -- I speak to them frequently, multiple times a month.

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Q. Okay. Did you speak with any of the applicants about the medical letters prior to preparing them?

A. I don't believe I did beyond getting their consent which was provided to me.

Q. Did you review the Applicants' own affidavits in any form prior to preparing the medical letters?

A. I did not.

Q. Have you reviewed those affidavits since?

A. I have not.

Q. And are you aware that a Dr. Koivu gave evidence in this matter?

A. I was given a list of people being cross-examined and I saw Dr. Koivu on that list so that is the extent of my knowledge of her involvement.

Q. Okay. But you would confirm that you've not provided any reply evidence responding to the affidavit or evidence of Dr. Koivu; right?

A. Correct.

Q. Would you agree that homelessness itself causes poor sleep, stress, anxiety, new medical conditions, worsening of existing medical conditions, and generally poor health outcomes in those experiencing homelessness?

A5251

MS. CROWE: I'm going to object to that. That is beyond the scope of what he is here to testify about.

---REFUSAL

MR. DIACUR: Well, again, that is not the test in terms of what can be asked of these witnesses. Anything relevant to this matter can be posed to them. It's not limited to what he states in his affidavit.

MS. CROWE: Well, he's here is a fact witness and not here to give opinion evidence about these issues at large.

MR. DIACUR: Well, that's also not something that has been settled. The's opinion in the affidavits that we've received so my question stands. If it's a refusal then, for the record, I would like for you to state that.

MS. CROWE: It's a refusal.

BY MR. DIACUR:

Q. Would you agree, Doctor, that homelessness as a general proposition is bad for you?

MS. CROWE: It's a refusal.

---REFUSAL

BY MR. DIACUR:

Q. Would you agree that in treating a patient it's important to obtain an accurate medical history?

A. Yes, of course.

Q. It is important that the medical history be comprehensive?

A. Yes.

Q. In the sense that it doesn't leave out anything significant?

A. I don't understand the question, I'm sorry.

Q. Well, I'm trying to get at what comprehensive means in terms of a medical history. A medical history would not be comprehensive --

A. I can give you a bit of an idea.

Q. A medical history wouldn't be comprehensive if it leaves out something significant; is that fair?

A. Yes. And I think the test of significance is dependent on the presentation of a patient. So I wear a number of different hats as an infectious disease physician. If I'm assessing somebody for HIV, for instance, then a different set of questions and a set of things that might be considered significant then if I'm assessing for an ingrown toenail or something else.

So certainly, a careful medical history should be taken on every assessment, and depending on what the purpose of the visit is, that will guide what types of questions I'm asking and what type of information I'm gathering.

Q. Understood. So the nature of the medical history that's required is something that the expertise of a physician allows them to determine?

A. Correct.

Q. Would you agree that getting a baseline for patient is important in terms of being able to tell whether they are getting better or worse?

A. Yes.

Q. Would you agree that to say that a condition has worsened requires a significant level of investigation?

A. Again, dependent on the condition, sometimes it's quite obvious. Sometimes very detailed investigations are required to determine if something is worsening or improving.

Q. And, again, that something that's within the expertise of a physician to determine?

A. Correct.

Q. Would you agree that patient self-reporting about their condition can be challenging because it's not clear what parameters the patient is using?

A. I don't know if I agree with that entirely. I mean, a lot of times I rely on patient self-report around a lot of their conditions in terms of what's getting better and what's getting worse.

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Really, for me in a lot of cases what is most important is how the patient perceives their condition as improving or not improving. My goal is to make my patients feel better overall and so the self-report ends up being quite important in that instance.

39 Q. Would you agree that in inaccurate medical history could affect the reliability of an assessment or diagnosis?

A. Certainly. Yes.

40 Q. Would you agree that some patients, and some of your patients in particular, may not be able to give an accurate or comprehensive medical history for themselves?

A. I wouldn't qualify it as you did, as "my patients", in particular. I think, yes, I mean, patients have differing degrees of ability to recall, to report, et cetera.

I don't think it's better, worse, or other in the patients that I see. And, again, I see a lot of patients in different contexts so it's hard to generalize.

41 Q. Understood.

In taking a medical history from a patient, do you, as a physician, take any steps to account for the possibility that they may not be able to give you an

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accurate or comprehensive report of their medical history?

A. Certainly. I mean, the medical histories are a very important part of the assessment of my patients. And, again, the importance of that changes over time.

Most of my patients I see extremely frequently, and regularly, and have long-term relationships with; and so as I get to know somebody, I can kind of get a sense of how much trust I can put in the self-report, if you will, and how much I need to rely on other sources of information.

I think the question was whether I look for other sources of information and certainly we do. We have a network of other physicians that we consult with. We have access to extensive medical charts, including the hospital charts, that we can review and do review on a regular basis.

We get reports from community pharmacists who are interacting with the patients on a daily basis. That's a very important point of contact for our patients and source of information for us in terms of how things are going overall.

We are in contact with social service agencies including workers in the shelters, workers with the Social Navigator Program, and we work very closely

with patient advocacy groups as well who have fairly intimate knowledge of how people are doing, again, on a day-to-day basis because they see them on a day-to-day basis and can report that back to us.

42 Q. Okay. Well, thank you.

You wouldn't render a medical opinion without gathering a comprehensive medical history, reviewing necessary medical records, and carefully examining the patient in question; correct?

A. Correct.

43 Q. You would agree that a medical opinion rendered without taking those steps would not be valid?

A. I mean, again, I think it depends on the degree to how much investigation is required depends on the condition that is being looked at.

So if I see someone who comes in with an abscess on their arm, I'm not necessarily going to review their entire medical history on their hospital records to make a diagnosis of an abscess and treat that abscess.

If I'm seeing someone with more long-term condition that requires like I had mentioned a more detailed investigation and more detailed information, then I'm going to seek that information.

44 Q. No. I understood. I'm talking specifically about a medical opinion, not determining

whether treatment is appropriate. Determining, for example, the cause of an illness, it would require those steps to be taken in order to be valid?

A. The cause of an illness can be determined by -- yes. I mean, it depends again on the illness in question. Sometimes it take a lot of time and effort to figure out what caused a condition and sometimes it takes much less.

45 Q. Sure. And that something like reviewing the necessary medical records, what's necessary is within your expertise as a physician?

A. Correct.

46 Q. Diagnosis of things like PTSD and Substance Use Disorder would require a full assessment of the patient; correct?

A. Correct, yes.

47 Q. The expected progression of a patient who is addicted to opiates and who is not getting treatment is to worsen. Would you agree with that?

A. I don't know if there's an expected outcome in that situation. I would say most people would not improve if they weren't getting treatment. I don't know if --

48 Q. I'm not saying not improve. I'm saying worsen. So not that they would stay static, but that

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their condition would worsen.

Is that not the expected progression?

A. In my opinion, again, it would be hard to tell you what an individual patient's expected progression would be without treatment. It's, again, individual.

If you're asking me about a population level of what would generally happen, I think that what the evidence would show is that people would not generally improve without treatment I think. They would remain stable or worsen. I think those are both possibilities.

49 Q. Is it an accepted premise of addiction medicine that the goal is for the patient to stop using the drug?

A. I think in my practice of addiction medicine, the goal is to minimize the harms that are occurring to patients, and then to work with them to set their goals, and to help them achieve those goals.

50 Q. Now, opiate addiction can cause changes in the brain and affect executive function and decision-making; correct?

A. Opioid use can affect executive functioning and decision-making. If people are intoxicated with opioids, their executive function and decision-making would be impaired.

51 Q. And even when they are not using, the use

A5253

over a period of time can affect the brain in a negative way, affecting executive functioning and decision-making; correct?

A. I think depending on the situation, if people are experiencing withdrawal from not using that would affect their executive function decision-making.

I think if somebody is not using and has stopped using, I don't know that there is good evidence to support that their executive function decision-making wouldn't return to normal.

52 Q. Okay. An opiate-addicted patient may not be able to make decisions in their own medical best interests.

Would you agree with that?

A. I would object a little bit to the phrasing. I think that many different patients may not be able to make decisions about their own medical care regardless of whether our they are making substances or not. I think that is an individual assessment at the time of an interaction with a patient.

53 Q. All right. So I'd like to turn to your affidavit dated June 7, 2024, which I put back on the screen.

You do say at paragraph 2 that you are a physician with the Shelter Health Network, SHN, and the

Hamilton Social Medicine Response Team, HAMSMaRT. You indicate that you have worked with the SHN since its inception in 2007 and you also joined HAMSMaRT at its formation in 2016.

Is it fair to say that you are a founding member of both the Shelter Health Network and HAMSMaRT?

A. It would be fair to say that I'm a founding member of HAMSMaRT. I joined Shelter Health Network about two or three weeks after the founding members who are three family physicians started the organization.

54 Q. Okay. So essentially you joined a couple of weeks --

-- SIMULTANEOUS SPEAKERS --

BY MR. DIACUR:

55 Q. -- after its inception?

A. Correct.

56 Q. Okay. You are aware that HAMSMaRT previously sued the City of Hamilton alongside two of the current applicants, Mr. Caldwell and Ms. MacDonald, correct, in 2020?

A. Correct.

57 Q. Would you consider that HAMSMaRT is, among other things, an advocacy organization?

A. I think it is self-evident from our

website, et cetera, that one of the things that we do participate in is advocacy for patients according to what their needs and desires are in terms of where they want advocacy to be directed.

58 Q. But also by participating in litigation.

A. If needed, yes.

59 Q. All right. So I'm going to scroll down to Exhibit B to your affidavit. You mentioned it in paragraph 4 is a report that relates to Ammy Lewis. You also indicate that this report is undated and that you endorse the contents of it.

Do you recall when this report at Exhibit B was prepared by you?

And I will scroll down to it. It's on the screen now and I will try to make a bigger so that you can see it there.

A. Yes, thank you very much. I don't recall the exact date. It would have been around the same time that I provided the letter for Ms. Heegsma.

60 Q. Thank you.

And you do state in this letter in the last sentence of the first paragraph:

"To the best of my knowledge, Kristen has been homeless for at least the past three years."

A969

Given that you referred to Ammy Lewis as Kristen here, is it possible that you prepared the letters at exactly the same time; so the Kristen Heegsma letter and this Ammy Lewis letter?

A. It's likely that I -- and apologies for the typo -- it's likely that I, yes, prepared them around the same time. I don't know if it was like the same day, but it would have been a similar timeframe.

61 Q. Okay. Thank you. So you do mention that Kristen has -- and, again, you say "Kristen" but meaning Ammy; is that right?

A. Yes, correct.

62 Q. And you do say that:

"She has the following medical conditions, the first being HIV infection[...]"

Do you know long Ms. Lewis has been HIV-positive?

A. I do. And I can get that information, the exact date if you like, because I was the person who made the diagnosis. It would have been I believe, it would have been late -- well, when did I first meet her? March of 2021. So it would have been late 2021.

63 Q. That's I think close enough for our purposes.

A5254

Have you provided any treatment to Ms. Lewis as a result of her HIV infection?

A. I have.

64 Q. Okay. And what treatment have you provided to her for that?

A. Would you like the name of the medication?

65 Q. Yes. The name of the medication or any other treatments that you provided.

A. Yes. So she's been on antiretroviral therapy since the time of her diagnosis. She's been taking medication called Biktarvy.

66 Q. The next item in the list is Opioid Use Disorder. Also Stimulant Use Disorder.

Did you diagnose those conditions?

A. She came with me -- sorry, to me with those conditions diagnosed, but I can confirm the --

67 Q. Okay.

A. -- diagnosis of both of them.

68 Q. Have you provided treatment for those two conditions?

A. I provided treatment for Opioid Use Disorder and continue to do so.

69 Q. And what treatment have you provided?

A. She's been on opioid substitution therapy with Methadone and Kadian and she's been on safer supply

prescribing with Dilaudid tablets.

70 Q. Understood. Thank you.

The last on the list is Post-traumatic Stress Disorder. How long has Ms. Lewis had PTSD to your understanding?

A. To my understanding, it's been longstanding. And, again, this would be a diagnosis that I didn't make myself but one she came to me with and which has been confirmed through our in-house psychiatry services.

71 Q. And have you provided treatment to her for her PTSD?

A. Only insofar as referring her to our psychiatrist.

72 Q. And she has received treatment via that psychiatrist?

A. Presumably.

73 Q. You do reference trauma that Ms. Lewis experienced as a direct result of her lack of housing. And at the top of page 2 you reference a criminal assault.

Now, I understand from Ms. Lewis that that criminal assault was perpetrated by a landlord. Is that your understanding?

A. That is my understanding, yeah.

74 Q. Okay.

A. She's reported to me more than one assault. The initial assault when I first met her was perpetrated by a landlord.

75 Q. Okay. And that's the one that is referenced in this letter?

A. Can I just read through?

76 Q. Yes. Of course. It's at the top of page 2. You mentioned the rooming house in Hamilton.

A. Correct.

[Reading].

Yes, agreed.

77 Q. And Ms. Lewis has provided evidence in this matter. She was also cross-examined. She had indicated that she was homeless for about five months as of June 2022. And prior to that she had been renting an apartment which she left because she felt unsafe.

You don't have any reason to contradict Ms. Lewis' own evidence; right?

A. No. I don't.

78 Q. Under cross-examination, Ms. Lewis indicated that she first became homeless when released from a penitentiary in Kitchener. She can't remember that when that occurred. You indicate here in Exhibit B that it may have been within the spring of 2020, however you also say that you first met Ms. Lewis in March of 2021.

A970

That's correct; that you first met her then?

A. Correct.

79 Q. So you would agree that you can't be sure what her housing status was before you met her?

A. Again, that was from her self-report to me.

80 Q. No. Understood.

A. Which I don't have any reason not to --

81 Q. So that's the only reason. You can tell us what she told you, but you can't confirm what her housing status was before you met her?

A. Agreed, correct.

82 Q. She also indicated under oath that she became homeless at that time because her mother kicked her out of the house on the first day she was released from the penitentiary.

She stated that she tried to access a shelter but no one would take her on as she had a dog. She stated that she stayed with her daughter who is also experiencing homelessness. She was first at a place called her -- that she referred to any way as "The Underground", but was told it was not safe there.

She then indicated she moved to a park or building at Barnesdale and Barton in Hamilton. She then went on to a place behind No Frills or a Fortinos near

A5255

train tracks for a few months.

You don't have any evidence to contradict any of Ms. Lewis' evidence on any of those points?

A. I do not.

83 Q. Ms. Lewis also testified that the apartment she's living at now, 95 Hess in Hamilton, was obtained for her while she was staying at Mary's Place and that she went there after her dog was placed with a foster. She also indicated that she has now been living in that same apartment with her dog for over two years and that she pays market rent at that apartment.

You don't have any evidence to contradict that either?

A. I'm just trying to think of the timeline because I'm fairly clear on the timeline of when she got into that apartment and that was according to my medical records.

84 Q. I'm sorry? Does that timeline fit with what you know or not?

A. I don't have the dates in front of me. If you'd like, I can check. I've got my medical record here.

85 Q. I'm sorry, I can't have you referring to documents that haven't been produced to us.

A. Yes, no problem.

86 Q. So the question is about your recollection.

So do you have any evidence to contradict Ms. Lewis' evidence?

A. Can you repeat when she said she was housed?

87 Q. Yes, of course. So and then, in fact, I'm coming to that because Ms. Lewis was cross-examined on August 14, 2024. And at that time --

A. Yes.

88 Q. -- she testified that the apartment she is living at now, 95 Hess in Hamilton, had been her residence for over two years. So --

A. I don't believe --

89 Q. By my calculation --

A. -- that's accurate from my record.

90 Q. -- that would be at least August 2022.

A. Yeah.

91 Q. Do you have any reason to dispute or contradict that timeline?

A. That is different than my records. So yes, I would dispute that.

92 Q. I'm sorry, are you referencing your medical record?

A. No. I have nothing else on my screen. But I know for certain that in the summer -- I know for certain in the summer -- that she was outside into the

winter, because I recall the time when we did finally get her into Mary's Place, the main reason why she finally agreed to let her dog get fostered was because of the extreme cold.

93 Q. Okay. Well, would you agree that Ms. Lewis could have sought to place her dog with a foster sooner than she did?

A. We tried multiple, multiple times to be honest with you and weren't successful. So it was only through the efforts of Dr. Lamont that we were able to get a foster for her dog.

94 Q. So it was Dr. Lamont who was successful in doing that?

A. Correct.

95 Q. And in terms of your recollection when did Ms. Lewis obtain housing?

A. My sense, if I had to guess without consulting my records, would be that it would have been early in 2023 or late in 2022. I believe I provided an affidavit to that effect at some point.

96 Q. Well, we do have your further affidavit dated August 12th, 2024. I understand that you did prepare a second affidavit after reviewing evidence that was provided by Rob Mastroianni of the City.

That's accurate?

A971

A. Correct.

97 Q. So Mr. Mastroianni's evidence indicated that city records indicate that Ms. Lewis has been housed since October of 2021?

A. Yes.

98 Q. Is that your recollection?

A. Is that my recollection of the affidavit?

99 Q. Well, yes. Of the affidavit that you reviewed and then responded to.

A. That sounds correct. I don't have the dates off the top of my head, but if you're telling me that's what's in the affidavit, I believe you.

100 Q. Well, understood. You would agree that October of 2021 would align with Ms. Lewis' own evidence that she had been in her present apartment for over two years? October 2021 is over two years ago, in other words.

A. It is over two years ago. I would agree with your math.

101 Q. During the period that Ms. Lewis has been stably housed, what improvement has her condition seen?

A. So a couple of things I would point to. The main thing, again, the two main things that I'm treating her for would be her HIV infection and her Opioid Use Disorder.

With regard to her HIV infection, she's been more consistent in taking her medications; and from that perspective, we have seen a stabilization of her infection through her viral load being consistently suppressed.

The second thing for her Opioid Use Disorder is us being able to see her on a more consistent basis has been helpful in adjusting and titrating her doses; and so we've been able to get to a more stable dose that has led to her decrease use of opioids.

And then finally, again, from my perspective, Ammy suffers from a lot of mental health issues and so being able to engage consistently with Dr. Lamont has been a major benefit to her.

And I would say all of those have improved as her housing status has been more stable, with the caveat that she's gone through a lot of other social upheaval even while she's been housed, including the death of her mother and so there's been periods of time, again, where she's continued to struggle.

102 Q. Would you agree that between obtaining shelter and having a pet, medical priority must be given to obtaining shelter due to the dangers of remaining outside without shelter?

A. I don't think that I am in a position to say what was best for Ammy in terms of those two choices.

103 Q. Well, I'm not asking specifically about Ammy. I just want to be clear I'm asking about what should be given medical priority.

So as a general proposition would you agree that between obtaining shelter and having a dog, medical priority for any individual must be given to obtaining shelter due to the dangers of remaining without shelter?

A. I would say in my practice, I rely on my patients to make decisions about what's best for them. We talked to Ammy consistently about the benefits of her being housed and our concerns about her being unhoused.

She was not willing to part with her dog because the dog provided her with a lot of emotional support; and given her mental health issues, she identified her dog as being extremely important to her mental health. I have no reason to doubt that, or disbelieve it, as it was her -- in my opinion, her prerogative to make decisions about what's most important to her.

104 Q. I understand that. But as soon as the dog was put into a foster, she obtained shelter and then subsequently permanent stable housing; you would agree with that?

A. In fact, the only thing that allowed her to take that step of fostering her dog was the fact that she would be able to obtain shelter and housing, correct.

105 Q. All right. So I would like to turn now to Exhibit A to your first affidavit. This is the letter with reference to Kristen Heegsma, dated June 13, 2022.

I've got it on the screen now. Can you see it?

A. Not yet.

106 Q. Actually I can make it a bit bigger than that even.

A. Okay.

107 Q. So this letter has a number of similarities to the letter regarding Ms. Lewis that we just reviewed. The first paragraph is very similar in both, save for the length of time that you have seen the patient and the patient's name, as well as your understanding of how long they have experiencing homelessness.

Would you agree with that?

A. I would agree.

108 Q. The second paragraph is the list of medical conditions which is tailored to the patient.

You would agree with that?

A. I agree.

109 Q. The third paragraph, other than the name of

the individual, is identical for both. It states:

"It is my opinion that [...]"

-- each of the patients --

[...]Medical conditions have been negatively impacted by her lack of access to stable housing."

Is that correct?

A. Agreed, yes.

110 Q. There are then some sentences tailored to the patient. But then, both state, quote:

"Furthermore, the trauma that she experienced outlined below as a direct result of her lack of housing has further exacerbated her underlying mental health conditions to a severe extent."

That was stated about both patients; is that right?

A. Agreed.

111 Q. And then in the third paragraph, the last sentence in both letters is very similar. And I will put that just in the centre of the screen here. So the last sentence here starting, "despite". They state:

"Despite her being able to see me on a fairly regular basis over the past six months[...]"

A5257

Then you identify the patient. And you state that:

"Ammy's overall condition has overall deteriorated but our progress has been far below what I would expect if she were stably housed."

With respect to Ms. Heegsma, on this screen now, you state:

"Kristen's overall condition continues to fluctuate, and our progress has been far below what I would expect if she were stably housed."

Is that correct?

A. I can see the one on the screen and I can confirm that that's what it says in this letter. I don't have the other one in front of me.

112 Q. Okay. Well, I can go to the other one. There might be a little bit of switching back-and-forth required. But here. I will put on the screen now the letter to do with Ammy Lewis. And it says:

"Despite her being able to see me on a fairly regular basis over the past six months, Ammy's overall condition has overall deteriorated, and our progress has been far below

what I would expect if she were stably housed."

So that is what was written about Ammy and Kristen; correct?

A. I'm sorry, it might be my Internet. I just got Ms. Lewis' up now; and yes, I agree that that is what that says.

113 Q. And then in both letters there's a section that's tailored to each patient. So looking at Exhibit B, being the Ammy Lewis letter, there is a paragraph about her background and information to do with her.

Scrolling up to Exhibit A, there are two paragraphs about Ms. Heegsma's status.

Then the last two paragraphs in each letter are essentially identical, save for the patient's name at the very beginning. The one that's on the screen now is to do with Kristen Heegsma. And so, for example, it says here:

"Kristen's health has clearly suffered to a significant extent due to her homelessness and housing precarity."

If we scroll down to Exhibit B, the Ammy Lewis letter, the second-last paragraph is:

"Ammy's health has clearly suffered to a significant extent due to her homelessness and housing precarity."

The rest of the paragraph is identical in both letters. I will let you look at those.

But this is Exhibit B that is on the screen now. Can you let me know when you are done reading that paragraph?

A. [Reading].

Yep, all good.

114 Q. And I'm going to scroll up to the Exhibit A letter to do with Kristen Heegsma. The second-last paragraph. The rest of it is identical.

Could you just confirm that?

A. Correct.

115 Q. And then the last paragraph in both letters says:

"I would be happy to answer further questions as required."

Can you confirm that too?

A. Yes, sir.

116 Q. Okay. Well, this appears to me to be a form letter with some areas that allow for personal details for each patient to be added.

A973

Would you agree with that?

A. It's not a form letter. I would disagree with that.

117 Q. Well, the letters ultimately reach the exact same conclusions about the patients.

Would you agree with that?

A. There's a similar conclusion in terms of how homelessness has affected their health. I would agree with that. But there's differences in terms of their individual circumstances.

118 Q. Yes. And as we've seen, the individual circumstances are listed.

But you would agree that the same conclusions are reached about both of the patients?

A. I think there are conclusions that go beyond the last paragraph, sir. So the last paragraph is similar in terms of the conclusions that are in that. But I think that there's differences in terms of the individual patient circumstances.

119 Q. Well, I think we've established that the last paragraph is identical --

A. Agreed.

120 Q. -- except for the name.

Would you agree with that.

A. Agreed, yes.

A5258

121 Q. And you first?

A. I don't think --

122 Q. Sorry, I didn't mean to cut you off.

A. Go ahead, please.

123 Q. Please, go ahead.

A. No, no. Pardon me.

124 Q. I didn't mean to cut you off.

A. No. Go ahead.

125 Q. Okay.

A. I'm just establishing that there's nothing in that last paragraph that says "in conclusion" or says "this is the end" or that this is the entire opinion.

I think there's reports throughout the entire letter that talk about facts.

126 Q. I would certainly agree that there's opinion throughout the letter.

You first met Ms. Heegsma in July of 2021; is that right?

A. I believe that's what it says -- states in the --

127 Q. Yes.

A. -- in the, yeah.

128 Q. I'll scroll up to the top. It says there in the first paragraph that you first met her in July of 2021.

That's accurate?

A. Correct.

129 Q. Do you still provide Kristen Heegsma with medical treatment today?

A. I do.

130 Q. And you indicate in your medical letter that to the best of your knowledge Kristen has been homeless for at least the past four years.

And that would be as of the date of this letter in June of 2022?

A. Correct.

131 Q. Okay. And Kristen Heegsma gave an affidavit and was cross-examined in this matter.

She testified that she was living with her grandparents in 2019, and that after that she stayed in a City of Hamilton hotel space on-and-off, for roughly one year total, as well as two other shelters. One was identified as Mary's Place in Hamilton, and one she mentioned was Burlington.

She also indicated she was employed by a temp agency during this period and that she stayed at the Ferguson encampment in Hamilton until October of 2020 as well as encamping at several locations in Hamilton; including Jackie Washington Park, Beasley Park, and Woolverton Park.

You don't have any evidence to dispute that; correct?

A. Sorry, can I pause for just a quick second I'm borrowing an office because I don't have an office at this hospital. I am just going to grab something for somebody so that they are not in the room at the same time.

132 Q. Absolutely take care of that it. We will go off the record for a moment.

---OFF THE RECORD

BY MR. DIACUR:

133 Q. So Kristen Heegsma gave an affidavit and was cross-examined in this matter. She testified to several things. She indicated she was living with her grandparents in 2019. She indicated that after that, she stayed in a City of Hamilton-funded hotel space on-and-off for roughly one year total, as well as staying in two other shelters; one was Mary's Place in Hamilton, and one other that she mentioned was in Burlington.

She indicated that she was employed for a period of time by a temp agency during the period after 2019. She also testified that she stayed at the Ferguson encampment in Hamilton until October of 2020, and then encamped at several locations in Hamilton, including Jackie Washington Park, Beasley Park, and Woolverton Park.

A974

You don't have any evidence to dispute any of that that was testified to by Kristen Heegsma?

A. I do not.

134 Q. Ms. Heegsma also testified that she was provided with a mental health crisis bed for a period of time at the Hamilton Barrett Centre; that she was enrolled in the Hamilton YWCA's transitional living program for about four months until September of 2021, but was terminated from that program when she made what she called "a dumbass decision" involving breaking into the YWCA staff office.

You don't have any evidence to dispute any of that testimony of Ms. Heegsma?

A. I do not.

135 Q. Ms. Heegsma also testified that after being terminated from the YWCA's transitional housing program, she obtained housing at 123 Bold Street in Hamilton in January of 2022.

You don't have any evidence to dispute that?

A. I do not.

136 Q. She also indicated that later in 2022, roughly June, she moved to Oakville for a time and then spent some time in jail in Milton for breaking into cars.

You don't have any evidence to dispute that

A5259

testimony of Ms. Heegsma?

A. I don't.

137 Q. Ms. Heegsma also indicated that she spent some time in Toronto. And then in December of 2023, she moved to a residence at 9 Faircourt Drive in Stoney Creek to live with her father.

I realize that that postdates your medical letter. But given that you have continued to treat her, can you confirm that you have no evidence to dispute that testimony of Ms. Heegsma?

A. I can confirm that.

138 Q. Oh, you can confirm that that is actually the case?

A. No, no.

139 Q. That she moved in to an apartment with her dad?

A. No. No, I'm sorry. I said, "Can I confirm that?" I don't have any evidence to dispute that.

140 Q. Thank you.

I understand that. Yes, the question has to be asked in that way.

Ms. Heegsma also testified that she occasionally travels to and from London, Ontario by bus or train to stay with her mother and daughter. You don't have any evidence to dispute that testimony of

Ms. Heegsma?

A. Correct.

141 Q. To the extent that Ms. Heegsma was truthful, you would agree that she has spent a significant amount of time over the past six years with various forms of indoor shelter; some with family, some in various programs; and some in housing that she, herself, obtained?

A. I agree that she has spent time indoors, significant time indoors.

142 Q. No. But would you agree that some of it was with family; some of it was in housing programs; and some of it was in housing that she, herself, obtained?

A. Based off of her testimony, I would agree with that.

143 Q. Okay. All right. Well, thank you very much, Doctor. I appreciate you attending and answering those are all my questions.

MS. CROWE: Thank you, Dr. O'Shea. I think I just have one redirect question actually if you will give me a moment to screenshare.

RE-EXAMINATION BY MS. CROWE:

144 Q. Dr. O'Shea, you should be seeing the August 12, 2024, affidavit. Can you see that on your screen?

A. Yes, I can.

145 Q. Okay. I want to scroll down to paragraph 5. Mr. Diacur had asked you about your knowledge of the timing for Ms. Lewis' housing. And in this paragraph you indicate that based on your records she was housed as of February 2023.

Can you just clarify what records and how did you come to that conclusion?

A. Yes. Sorry, that was based off of my medical records. So, again, in our medical records, and at each visit, we document the patient's housing status; and so I reviewed those records back to the time that I wrote the letter, and before, and obtained those dates from that.

Beyond that, as well, both Dr. Lamont and I were fairly closely involved in her placement at Mary's Place initially and onwards from there. And so I would say the notes were more detailed than the typical in Ammy's case because of our direct involvement in her obtaining the space at Mary's Place initially.

146 Q. Okay. So to the best of your knowledge is February 2023 the date that Ms. Lewis was, in fact, housed?

A. Correct.

147 Q. Thank you. Those are my questions.

--- The examination concluded at 2:30 p.m.

A975

I hereby certify the foregoing is a full, true, and correct transcription of all of my oral stenographic notes to the best of my ability so taken at the Cross-Examination of DR. TIM O'SHEA, given under oath before me on the 6th of September, 2024.

Amy Armstrong, CVR-RVR

Certified Realtime Verbatim Reporter #7305

Certified Commissioner of Oaths

Certified this 7th of September, 2024

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Court File No. CV-21-00077817-0000

ONTARIO

SUPERIOR COURT OF JUSTICE

BETWEEN:

KRISTEN HEEGSMA et al.

Applicants

-and-

CITY OF HAMILTON

Respondent

AFFIDAVIT OF Medora Uppal

(Sworn July 17, 2023)

I, Medora Uppal, of the City of Hamilton in the Province of Ontario, AFFIRM AND STATE:

1. I have personal knowledge with respect to the facts set out below, except where stated otherwise. Where the information is not based on my personal knowledge, it is based upon information provided by others which I believe to be credible and true.

Credentials and Nature of Work

2. A copy of my Curriculum Vitae is attached hereto as **Exhibit "A"** to my affidavit.

3. I am the Chief Executive Officer of the YWCA Hamilton and have held this role since December 2022. I was previously Director of Operations of the YWCA from Hamilton from September 2011 until December 2022.

4. As Director of Operations, I led the development and expansion of women's housing, shelter and gender-based violence services within the YWCA Hamilton. I conceptualized, developed, and launched Carole Anne's Place, a low-barrier drop-in for unsheltered women and non-binary individuals in Hamilton that opened in 2016. From 2016 until April 2022, I was the overseeing Director of Carole Anne's Place staff (including serving as on-call for management when needed), provided advice to staff on challenging client issues, secured external funding, and met reporting requirements to funders. From April 2022 until present, the overseeing Director reports directly to me and I continue to lead on funding development and expansion of the program.

5. Individuals accessing Carole Anne's Place are provided with meals, access to showers and basic needs, low barrier health care, harm reduction and withdrawal management services, safe drug use space from 10 PM to 9 AM, systems navigation and shelter referrals, advocacy, care planning and coordination. Staff provide support within a trauma-informed lens that incorporates a gender-based analysis of homelessness and harm reduction. External services attend on a weekly basis to provide access to additional services including access to housing supports, outreach, mental health, legal and peer support. Access to low barrier sexual and reproductive health care needs are available onsite as well as through the Shelter Health Midwifery team on an on call / as needed basis. Carole Anne's Place provides these services in partnership with St. Joseph's WomanKind Addiction Services, HAMSMaRT, Shelter Health Network and Keeping Six. Carole Anne's Place is located within YWCA Hamilton's MacNab Street location. Clients are admitted from 10 PM to 1 PM daily on a first come, first served basis. As CEO of the YWCA Hamilton, I retain ultimate responsibility for Carole Anne's Place. I still receive daily emails with updates on intakes, and regular reports.

6. In addition to my specific responsibilities for Carole Anne's Place, over the course of my 25-year career in the non-profit sector in Hamilton I have worked extensively on the issue of women's shelters in Hamilton. Much of this work has been through the Women's Housing Planning Collaborative ("WHPC"), which I co-founded as a Good Shepherd representative. I stayed on as a representative for YWCA Hamilton on WHPC when I joined the organization in September 2011. WHPC's member organizations include YWCA Hamilton, Mission Services of Hamilton, Good Shepherd Centres Hamilton, Native Women's Centre, St. Joseph's Healthcare Hamilton – Womankind Addiction Service, Interval House Hamilton, Wesley Centre, Hamilton Regional Indian Centre, The Elizabeth Fry Society – Hamilton. *Ex-officio* partners of WHPC who

attend meetings and / or receive minutes are the Social Planning and Research Council of Hamilton, Service Canada, the City of Hamilton Housing Division, the Ministry of Community and Social Services (MCCSS), and the McMaster University – Community University Policy Alliance (CUPA). I have sat on the Steering Committee of the WHPC since it was founded, and currently serve as Chair.

7. WHPC was created in 2010 to address the challenges facing shelters, transitional housing and other service providers assisting women who are unhoused in Hamilton. Our intention was not to expand shelter beds, as additional shelter beds had just been added to Good Shepherd Mary's Place and Martha House. Rather, our goal was to address expanding support services and funding to help women access housing, address the issues contributing to their homelessness and to bring a gender perspective to planning for housing and homelessness that was largely absent.

8. Finally, I have worked with YWCAs across Canada working with federal, provincial and municipal governments, aligned stakeholders, and people with lived and living experience in women's shelters.

Women's Shelter System in Hamilton

9. Despite best attempts to provide accommodation, there were frequently no shelter beds for women who needed them. Moreover, it is and was common for women to be turned away from shelter if the shelter has an inability to meet the women's needs. These women often presented with complex needs that the space would be unable to adequately address, as they are only funded for minimal staffing for their shelter beds.

10. By 2016, WHPC recognized that despite the increase in shelter beds there were still women who were not being admitted. At the recommendation of WHPC, YWCA Hamilton opened Carole Anne's Place for the winter months to prevent women from sleeping outside in the cold from December to March.

11. Notwithstanding the City of Hamilton's awareness of need in the women's shelter sector, funding continued to be only temporary and not always available through the City. WHPC members sought various sources of funding each year through proposals and advocacy as the problem of women's homelessness persisted.

12. I attach the "2019-2020 Carole Anne's Place Impact Report" as **Exhibit "B"** to my affidavit, and "From Homelessness to Hope: Support for Carole Anne's Place November 7, 2019" as **Exhibit "C"** to my affidavit. These are official YWCA Hamilton publications whose preparation I oversaw and ultimately approved, and for which I was ultimately responsible.

13. In the Carole Anne's Place Winter 2020 Research Findings, the researcher used a point-in-time ("PiT") analysis popular in data collection on homelessness used by the Federal, Provincial and Municipal governments to provide an example that can be used to represent the status of homelessness across a community. She compared January 23, 2018, 2019 and 2020 to identify the increase in demand for service and the continuing number of turnaways. In this report, women who are unsheltered share their experience of seeing more homeless women in Hamilton and reasons why women cannot access shelters. The women also present solutions which include expanding beds and remodelling the services delivered to meet women's needs. I adopt this report as part of my opinion in this matter.

14. The increase in demand for shelter for women from 2019 onwards is clear. From December 2018 to March 2019, Carole Anne's Place supported 260 unique women. We reopened December 2019 and up to March 2022, Carole Anne's Place supported 660 unique women.

15. Carol Anne's Place had to turn away people 636 times between December 2019 and March 2022, due to a lack of capacity. This is significant because Carol Anne's Place is the last resort for a woman attempting to get into shelter because it is the overflow space women can attend when they cannot access the standard shelters.

16. In December of 2019, the City of Hamilton approved one-time funding to re-open Carole Anne's Place with a maximum capacity of 22 beds. In the face of the pandemic, in March 2020 the City asked YWCA Hamilton to keep Carole Anne's Place open during the pandemic and increased funding recognizing the need for shelter beds.

17. In 2021, Mission Services was funded by the City of Hamilton to open Emma's Place, a 15-bed shelter for women. In addition, a hotel was funded by the City in 2020 for single women experiencing homelessness which shifted over to Cathedral and has a maximum capacity goal of 100 beds. A second hotel, originally intended for men experiencing homelessness, began opening rooms for women due to the continued demand for shelter.

18. Throughout the pandemic, despite the increase in shelter capacity for women, Carole Anne's Place continued to bring women in overnight because shelters and hotels were full or could not accommodate and turned women away because of capacity limitations or for safety reasons.

19. The women's shelter sector continues to advise the City of capacity limitations of the shelter system and the need for expanding housing and shelter. I organized weekly triage meetings on behalf of the women's sector during the pandemic to address pressures in women's shelters and hotels. These meetings included City staff. Despite best efforts during triage meetings, with current resources the service providers were unable to confirm shelter or bed space for all the women presented weekly during these meetings.

20. I attach the PiT count from 2021 as **Exhibit "D"** to my affidavit. It indicates that there are more homeless women than men but the increase in shelter beds to date, temporary or permanent, has not resolved this problem.

21. As of March 2022, there were 96 shelter beds designated by the City of Hamilton to Women and 212 for Men. The Emergency Overflow beds have not been broken down by gender and account for an additional 251 beds. Prior to this, the women's beds varied from 26 to 46 and men's beds were as a high as 245 and as low as 115 beds.

Violence Against Women

22. Women are at risk of being victims of assaults and sexual assaults even while attempting to access and while accessing women's shelters.

23. During the pandemic I received an increase in reports from staff of violent incidents, stalking and harassment of women at YWCA Hamilton's Transitional Living and Carole Anne's Place at a volume and degree of risk unlike any incidents I previously managed at YWCA or in my career in the women's shelter sector in Hamilton. Both Transitional Living and Carole Anne's Place provide residential services to women and gender diverse people experiencing homelessness.

24. I have received reports of women being sexually assaulted during daylight and evening hours around the building of these services. This includes two incidents where women were being raped in public spaces near the building and on the property. One incident was witnessed and reported by a client and the other by a staff member. One woman was lured by a man when she

was waiting at the door to get into Carole Anne's Place for the night. He took her to a nearby alley and assaulted her.

25. Men have attended the YWCA building searching for women known or unknown to them. In one case, a man was coming to the building, handing out flyers searching for a woman he said he wanted to punish for leaving him. This same man returned to the site multiple times handing out flyers looking for a woman to live with him and provide in home services. I reported the incidents to the police and staff and clients provided statements.

26. I received reports from staff of street level harassment against them as they entered and exited the building. Men were circling the building at different hours asking women to get into their cars. The women approached included staff and clients. I have received reports of staff disrupting these attempts and helping women get out of the vehicles. Many of the women targeted are in visible distress, impaired from drugs or alcohol, and / or presented with mental health or cognitive disabilities.

27. I was contacted by staff twice when women outside the building have been attacked with bear mace. Both incidents were witnessed, and multiple people were affected by the attacks. Emergency services attended the scenes.

28. I have received reports of men chasing women down the street and into the building. Men have attempted to enter the building by breaking in. One broke through the doors and entered. Several have smashed the windows or glass doors. One staff vehicle was targeted. Police were contacted in all instances.

29. I have received reports from staff of men loitering around the building with weapons including steel poles and blow torches and threatening and wielding the weapons. These incidents were reported to the police. One man approached a mother and child attending our childcare centre, threatening to kill the child. The mother did not know the man and the incident was reported to the police by the mother and the staff.

30. In 2021, I contacted Hamilton Police Services to discuss the rising incidents of violence occurring by men targeting women around our building. The Hamilton Police developed a Problem Oriented Policing Project ("POPP") for the 75 MacNab Street South Hamilton area, which is where the YWCA is located. In the Women's Services Advisory Committee to the Chief of Police on

December 7, 2021 which I attended, Hamilton Police Services explained they had tracked a rise in calls to the police from YWCA Hamilton over the year. Hamilton Police Services reported receiving calls from 75 MacNab Street South Hamilton as follows: 89 calls in August 2021, 59 calls in September 2021, 76 calls in October 2021, 58 calls in November 2021. With the POPP active, they reported that by December 6, 2021 there had been 162 calls, 179 proactive calls, 25 individuals asked to leave, 9 individuals arrested, 6 charges laid, and 8 provincial offences. At the recommendation of police and with funding through the City, YWCA Hamilton initiated hiring a security company to monitor the exterior of the building and to prevent violent incidents, redirect men who are loitering and to contact police when needed.

"Service Restrictions": a Term used by Shelters

31. A "shelter restriction" may be issued against a service user during their stay or can be issued and then remain in place subsequent to their stay. They are issued to shelter users if their behaviours violate shelter policy.

32. The intent in Hamilton's women's shelters is that these restrictions only be used when necessary to protect the safety of others.

33. There is not a uniform shelter restriction policy for women's shelters in Hamilton. There are no mandated standards for women's shelters in managing service restrictions for a variety of reasons including different funders for shelters, different mandates of shelters, and the different infrastructure, design and physical space of shelters.

34. Historically, women's shelters have developed their own restriction standards of practice. In 2021, WHPC voluntarily developed with members and in consultation with City staff the "Service Restriction Framework or Services and Shelters Serving Women," attached hereto at **Exhibit "E"**. It was agreed by members that this document would inform policies, procedures and practices developed by each organization.

35. The length of time people are restricted from shelter services varies based on the specific situation, incidents, and resources available to the shelter.

36. The men's shelter system has their own service restriction standards with the City.

Carol Anne's Place

37. Carole Anne's Place operates as a low barrier overnight program which only opens from

10 PM to 1 PM daily. Low barrier means that it is easy to access, in particular for woman presenting with high acuity needs. This requires women to relocate for the day and return at night to secure a bed if they still need a safe place to sleep.

38. Most women's shelters in Hamilton provide 24/7 service and women secure their bed until they discharge from the program. The length of the shelter stay is determined by the woman and the shelter.

39. For Carole Anne's Place, the closing of the program each day forces a natural break that reduces the risk of behaviors escalating into violence that can lead to a service restriction. In shelters, like Carole Anne's Place, there are few staff to support all the residents but more challenges to managing risks in 24/7 congregate care settings.

The System – Design and Intent

40. Women's shelters and drop-ins are not funded or designed to provide intensive services for people with highly acute needs. For this reason, we often see women with the highest need turned away because their needs exceed what can be provided and/or they are service restricted because their high acuity needs result in behaviors that violate policies.

41. Substance use in shelters has presented challenges to shelter operations. Carole Anne's Place is the only shelter with a legal safe use drug space in Hamilton, which was introduced in April 2022.

42. Without a safe use drug space, women are discouraged or not allowed to use drugs in the shelter. This can result in a number of situations that cause women to lose access to beds. They may leave to use drugs and not return by curfew or for several days, at which point the bed would be turned over because of demand. They may return to the shelter under the influence and not present in a condition where shelter staff feel they can safely bring them into the shelter. The woman then may not return or may lose her bed. They may use drugs with others or distribute drugs that could cause the shelter to discharge the women. They may also leave needles and other drug paraphernalia out, exposing risk to staff or others in the facility.

43. The tolerance to manage drug use in the women's shelter system is dependent on the design, mission, staffing levels and skills, and the composition of the resident group in the shelter.

44. There are women and gender diverse people in Hamilton who have limited or no access to

shelter or overnight beds. They may move from shelter to shelter, spending time on the street, in encampments, in hospital, incarcerated or with acquaintances who pose a danger. These women present behaviors that shelters will try to manage for limited or extended periods but may result in an early discharge or a discharge without secured housing because the shelter does not have the resources to manage the needs of the individual. These cases have been presented regularly through the weekly women's sector triage meetings which includes women's shelters, drop-ins and the City. They have also periodically been presented at the Complex Care System Planning Table, which I chair, that includes shelters, housing, city, hospitals and health care. During the pandemic, the Triage group has attempted to capture this list through the Drop-In services who encounter women who experience the most service restrictions. While this list is fluid and is challenging to maintain with limited resources, I can confirm that at times we have had over 50 women on the list. However, this does not account for the total number of women we continue to see experiencing homelessness for years.

45. I attach the report "[in]visible: Single Women's Experiences of Chronic Homelessness in Hamilton*"* 2018 as **Exhibit "F"** to my affidavit. I refer to this report as the "Invisible Project". I adopt to the "Invisible Project" as part of my opinion in this case. The WHPC commissioned this the "Invisible Project" while I was on the Steering Committee and I approved the researcher to meet with YWCA residents. 70 women and gender diverse people in Hamilton who experienced homelessness were interviewed for the "Invisible Project". The report found that 34% of women had experienced 4 or more years of homelessness and 15% reported 25 or more years of homelessness.

46. From a philosophical and values perspective, the WHPC members who operate women's shelters and drop-ins believe women need to have the autonomy to choose where they want to live. When women are with an abusive partner or fleeing abuse many women's shelters and YWCA programs across Canada encourage women's autonomy to define and determine her next steps to help her regain a sense of control over her life that was denied by her partner. For this reason, we philosophically respect the choice made by a woman to sleep in an encampment.

47. Prior to the pandemic and increasing during the pandemic, staff have reported to me on women who do not want to move into women's shelters or Carole Anne's Place. In these cases, women have identified themselves to staff a variety of reasons. For some women, they prefer the

services of some shelters and drop-ins over others and will not access beds in locations because of past experiences regardless of where they are required to sleep as an alternative.

48. Sometimes women come into Carole Anne's Place to take a break from sleeping "rough," meaning without shelter, out in the open on the street. Some women prefer to stay with male partners or friends who are living outdoors. Several women YWCA Hamilton has supported choose to sleep outside with their male partners during their pregnancies.

49. For some women, women's shelters and / or drop-ins feel too invasive, unsafe and they feel put them at risk. This might be due to past experiences, their own beliefs or fears of others. Service providers may attribute this to mental health or past trauma, but each individual is unique. Women who have been institutionalized or are coping with past trauma may find that shelters interfere with their autonomy as all these spaces have some rules and require some congregation. Some shelters offer less privacy and some spaces have limited or no storage for belongings. There are limitations to how residents move through the space, rules governing resident conduct, and the requirement to meet with staff and share their information.

50. While providers try to work around people's individual needs, there are limitations. In a temporary housing environment, there are limitations as to how long people can be permitted to remain if they refuse to participate in basic requirements that maintain the safety of the other people in the facility, especially when only 1 or 2 staff are available to support 15 to 30 people.

51. Many women whom we encounter in the homeless system for many years have been in hospitals, or first experienced homelessness before the age of 18, grew up in group homes or foster care, and may have been incarcerated. This experience is validated in much research including "The Invisible Project" in Hamilton. For these women, their desire for permanent, independent housing does not always mean that they are comfortable or willing to endure the compromises of living in a women's shelter or sleeping in an overnight drop-in.

52. Supporting women's right to choose helps us as shelter and housing providers to build trust and pushes services to provide solutions that more appropriately meet the needs of women.

53. The invisibility of women's homelessness has led to an underfunding of services historically. In past point-in-time counts, women have represented under 25% of the homeless population. This is in part to several factors including: women having fewer shelter beds available

to them; women staying in violence; women being excluded from shelters; couch surfing; exchanging sex for shelter; or returning to abusive people. Years of advocacy work from women's organizations have gone into making the case to increase investments in women's homelessness.

54. At national conferences, women's homelessness has been sidelined to special population workshops and sessions. Because the Violence against Women's shelters funding is managed through the Province and homelessness shelter funding was downloaded to the Municipalities, the Violence against Women's shelters were utilized as an alternate resource to offset the lack of beds in the homeless system for women. As long as Violence against Women shelters could open their doors to women experiencing homelessness the sector did not need to acknowledge unique and specific needs of women who are homeless. Pressure began to emerge in the system when Violence against Women's shelters were consistently full or could not manage the high needs women were presenting in congregate living with children.

55. The COVID-19 pandemic, according to the World Health Organization, brought with it the "Shadow Pandemic" increasing pressure on Violence against Women shelters as more women are experiencing gender-based violence. The pressure in the Hamilton system came long before the pandemic and has only been exacerbated by the Shadow Pandemic, as male perpetrated violence is increasing in homes and on the street.

56. When women do not have any overnight beds they can access that they feel are safe, they may decide their only choice is to sleep or set up living accommodations outdoors.

57. Women choose hidden spaces or very public spaces to increase their safety.

58. I have witnessed women actively trying to use space around the YWCA building to create temporary homes or beds. This does not provide the dignity or safety they deserve. Staff have reported to me that women visiting Carole Anne's Place who stay in tents identify they can create more secure and comfortable spaces. Some join communities or stay with men who help them feel safe outdoors. Staff have reported to me that displacing these women from their outdoor space with or without a tent leads those women to feel afraid and at risk. Displacement denies their right to choose and define their living conditions. If women have no access to permanent housing, then the only alternative should not be limited to a shelter or drop-in bed.

Sworn remotely by Medora Uppal at the City of Hamilton, in the Province of Ontario, before me on July 17th, 2023 by "zoom" videoconference, in accordance with O. Reg. 431/20, Administering Oath or Declaration Remotely.

Mohamad Bsat

Commissioner for Taking Affidavits

Mohamad Bsat 75897L, LSO

Medora Uppal

THIS IS EXHIBIT “A” TO THE
AFFIDAVIT OF MEDORA UPPAL
AFFIRMED REMOTELY BEFORE ME AT
THE CITY OF HAMILTON DURING A “ZOOM” VIDEOCONFERENCE
IN ACCORDANCE WITH O.REG. 431/20,
ADMINISTERING OATH OR DECLARATION REMOTELY
THIS 17th day of July, 2023

Mohamad Bsat

Mohamad Bsat
LSO NO. 75897L
Commissioner for Taking Affidavits, etc

MEDORA UPPAL

88 Delmar Drive, Hamilton, L9C 1J7
Medora.uppal@gmail.com
905 719 9133

A5274

EXPERIENCE

DIRECTOR OF OPERATIONS • YWCA HAMILTON • 2011 - PRESENT

Leading the operations of a multi-service, non-profit organization with 350 employees and a $25 million budget, reporting directly to the CEO. Developing and implementing the strategic plan, organizational policies, budgets, and capital development. Guiding relationships with government, funders, community partners and developing proposals. Supporting advocacy and community relationships locally and coordinating with YWCA Canada to advance the rights of women, girls, and gender diverse people through community planning tables and government relations. Responsible for developing anti-racism / anti-oppression framework, policies and implementation. Oversight of all programs, services and infrastructure acting as the direct report for management and senior management: child & youth programs, social enterprise, housing and shelter, developmental services, youth programs, parenting supervision services, violence against women services, senior's programs, health and wellness, employment and training, immigration and settlement, and the center for innovation, human resources, facilities management, fund development, IT, and administration.

DIRECTOR OF WOMEN'S SERVICES • GOOD SHEPHERD • 2006 – 2011

Responsible for operations of two emergency women's shelters, one transitional housing programs, second stage, and counselling programs for women and children. Managed labour relations with union. Leader at community planning tables. Secured new funding for legal advocacy program, increased counselling and case management services, second stage housing with 40+ units, major capital funding. Design and develop new and expanded shelter and community facilities for a +$10 million capital build. Led the implementation of operations in an innovative new facility to provide shelter and programs to women experiencing homelessness and women and children fleeing violence.

ASSISTANT DIRECTOR OF WOMEN'S SERVICES • GOOD SHEPHERD • 2004 - 2006

Reported to the Director and supported management of women's shelters, transitional housing, and counselling programs for women and children. Supported program design, participate in planning tables, and

WOMAN ABUSE EDUCATION & SUPPORT PROGRAM • GOOD SHEPHERD MARTHA HOUSE• 2001 – 2004

Supportive counselling, safety planning and group facilitation programs for women experiencing gender- based violence. Developed workshops, curriculum and public education to address violence against women in community and worked directly with survivors. Community advocacy and organized events and led committees. Coordinated camp programs for 100+ women, children and youth survivors annually and facilitated adventure-based counselling.

CASE MANAGER • Good Shepherd WOMEN'S SERVICES • 1997 – 2001

Case management with women experiencing homelessness at Mary's Place and women (and their children) fleeing violence at Martha House. Advocacy and planning with hospital, housing providers and mental health and addiction services for women. Crisis intervention support to women experiencing violence, suicidality and other mental health and safety issues.

A990

MEDORA UPPAL

88 Delmar Drive, Hamilton, L9C 1J7
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905 719 9133

A5275

VOLUNTEER & COMMUNITY LEADERSHIP

BOARD MEMBER•2019–PRESENT • TODAY'S FAMILY

BOARD MEMBER•2005 – 2007 & BOARD CHAIR• 2007 – 2013 • SACHA (SEXUAL ASSAULT CENTRE HAMILTON)

ACTIVE COMMITTEES • 2022
Co-Chair, Women's Housing Planning Collaborative
Chair, Complex Care System Planning Table
Chair, Equity and Engagement Advisory Group – City of Hamilton Early Years
Member of Women's Services Advisory Committee to the Hamilton Chief of Police
Member of Equity Advisory Council - Greater Hamilton Health Network
Member of City of Hamilton Housing and Homelessness Planning Group
Member of Hamilton is Home

YWCA CANADA • NATIONAL / INTERNATIONAL ENGAGEMENT
United Nations Commission on the Status of Women, 2012
YWCA World Council, Thailand, 2015 – Observer & Workshop Presenter
YWCA World Council, South Africa 2019 – Observer
Member of YWCA Canada Advocacy Committee
Member of YWCA Canada – Housing, Community of Practice

AWARDS
Leadership Award, Good Shepherd, 2009
Woman of Distinction, YWCA Hamilton, 2010
YWCA Canada, 2019

EDUCATION & TRAINING

WOMEN'S STUDIES & PHILOPSOPHY• MCMASTER UNIVERSITY • 1996 – 2000
ADVENTURE BASED PROGRAMMING & COUNSELLING • 2002
ANTI-RACISM / ANTI-OPPRESSION TRAINER • 2010
GRADUATE LEADERSHIP PROGRAM • QUEEN'S UNIVERSITY • 2014
INDIGENOUS CANADA COURSE • UNIVERSITY OF ALBERTA • 2021
SAN'YAS INDIGENOUS CULTURE SAFETY TRAINING • 2022

A991

THIS IS EXHIBIT “B” TO THE
AFFIDAVIT OF MEDORA UPPAL
AFFIRMED REMOTELY BEFORE ME AT
THE CITY OF HAMILTON DURING A “ZOOM” VIDEOCONFERENCE
IN ACCORDANCE WITH O.REG. 431/20,
ADMINISTERING OATH OR DECLARATION REMOTELY
THIS 17th day of July, 2023

Mohamad Bsat
_____
Mohamad Bsat
LSO NO. 75897L
Commissioner for Taking Affidavits, etc

YWCA HAMILTON

A5277

2019-2020 IMPACT REPORT

A993

YWCA HAMILTON

BOARD OF DIRECTORS

Charaya Thach, President
Terri Johns, Vice President
Victoria Walzak-Mosca, Treasurer
Charlotte Yates, Past President
Anna D'Angela, Secretary
Alison Horton
Dr. Carys Massarella
Jesse Elders
Lydia Kapiriri
Pauline Taggart
Sue Bennison

> *To me it seemed like a good opportunity to show that transgender people belong, and we have the capability to achieve the same things as anyone else."*
>
> *– Dr. Carys Massarella on joining YWCA Hamilton's Board of Directors*

EXECUTIVE LEADERSHIP

Denise Christopherson, CEO
Janet Arsenault, Director of Finance
Maisie Raymond-Brown, Director of Employment and Training Services
Medora Uppal, Director of Operations
Sandra Parker, Director of Child and Youth Services
Sarah Ernest, Director of Development
Tricia Thomson, Director of Building Services
Winnie Linker, Director of Human Resources

SENIOR LEADERSHIP

Alisha Mociak, Human Resources Advisor
Amy Deschamps, Manager, Transitional Housing
Carol Fraser, Manager, Developmental Services – Community Supports
Daniella Bozur, Manager, Family Access Services
Deborah Schwientek, Manager, Employment and Training Services
Heather Barkley, Campaign Officer
Hillary Banks, Human Resources Advisor
Jennifer Andreoli, Head Chef, At the Table Social Enterprise Café
Jennifer Noel, Manager of Children's Services
Joanne Gneth, Manager of Building Operations
Marnie Warman, Manager, Health and Wellness
Neanette Atanas, Senior Analyst, Programs & Training
Nermine Yousseff, Manager, I.T. Systems
Sandra Litster, Finance Officer
Sarah Borde, Project Officer, Building Services
Shannon Cummings, Manager, Enterprise Centre
Sheryl Nadler, Manager, Media and Communications
Tracey Helwig, Manager, Developmental Services
Violetta Nikolskaya, Senior Analyst, Programs and Advocacy

A MESSAGE OF THANKS FROM OUR BOARD PRESIDENT & CEO

This fiscal year was one to remember. In partnership with our community and friends of our mission, we celebrated 130 years of changing the lives of women, girls and families in Hamilton.

Together, we have made major progress in many of our key priority areas identified within our 2018–2022 strategic plan. As an organization, we have officially begun building for our future on Ottawa Street and we have made huge strides within our capital campaign, closing this fiscal year with over $2 million raised.

In the spring of 2020, we were – and continue to be – tested as an organization, as we faced a global pandemic head on. We are reminded of our legacy of resilience, as YWCA Hamilton has stood the test of time, serving our community for over a century. We will continue to do so, regardless of what this ever-changing world throws at us.

Our mission is tried and true. We were there for those who needed us during the global pandemic of 1918 and we provided services and supports to those impacted during both World War I and World War II. One thing is evident – YWCA Hamilton has been there – and will always be there – for those who need us most.

Each time we are faced with adversity, we come out stronger.

We are fueled by a deep-rooted passion for justice, equality, and making change for the 10,000+ individuals we serve each and every year. Listening to these diverse voices will continue to inform our work, our priorities, and our path forward as we embark on this new fiscal year and the remaining two years of our strategic plan.

Together, we've set some bold goals that are backed by our desire to impact, influence and to innovate. These three pillars will continue to drive our work to make more meaningful change in the lives of those we serve. The work of YWCA Hamilton would not be possible without the tireless dedication and passion of all YWCA Hamilton staff, volunteers and supporters.

Together, we're inspiring change. And, we are creating a community where women, girls and families thrive.

Charaya Thach,
Board President

Denise Christopherson,
Chief Executive Officer

AT OUR CORE

130+
years serving women, girls & families in Hamilton

10,000+
people impacted through **60+** programs & services

30+
community based locations

396 staff & **250+** volunteers
championing our mission

330,000+
women & girls supported by YWCAs across Canada

We believe that women and girls must have the rights, resources and opportunities to shape their own lives and define their communities. YWCA Hamilton is part of a global movement connecting over 25 million women in 125 countries.

Our impact is made possible on the lands of the traditional territory of the Haudenosaunee and Anishnaabeg. This territory is covered by the Upper Canada Treaties, within the lands protected by the "Dish With One Spoon" wampum agreement, and is directly adjacent to Haldimand Treaty territory. We respect the longstanding relationships with the local Indigenous communities, the Mississaugas of the Credit First Nation and the Six Nations of the Grand River, and are committed to the recommendations of the Truth and Reconciliation Commission Report.

IMPACT REPORT 2019/2020 | **YWCA Hamilton**

A5280

WE BUILD STRONG LEADERS.

We know that to build a strong community, you must build strong leaders. At YWCA Hamilton, we're intentional about developing a workplace culture that prioritizes development opportunities, inclusivity, equity and balance. We invest in all of our employees.

5,988
hours of training provided to **976** staff – that's an increase of **2,508** hours over last year

307
staff trained in Health & Safety

239
staff trained in Non-Violent Crisis Intervention & Crisis Prevention

82
staff trained in First Aid & CPR

79
staff trained in Applied Suicide Intervention Skills & SafeTalk

68
staff trained in Truth & Reconciliation

67
staff trained in Anti-Racism Anti-Oppression

41
staff trained in Trans Inclusion

34
staff trained in Mental Health First Aid

16
staff trained in opioid overdose response

YWCA HAMILTON

THE PUTMAN FAMILY YWCA

The newly-reimagined Ottawa Street YWCA will be named The Putman Family YWCA, thanks to a $1 million donation from Hamilton's Putman family, known locally as the founders of Ancaster-based Everest Toys.

The Putmans approached YWCA Hamilton after reading a newspaper story about the lack of funding to Carole Anne's Place, our emergency overnight shelter for women experiencing homelessness during the winter months.

Doug Putman announces a $1m donation at the 2020 Women of Distinction Awards

"We've been at the forefront of addressing the affordable housing crisis in Hamilton," says Denise Christopherson, CEO YWCA Hamilton. "The Putman family contribution will significantly support our efforts to eradicate women's homelessness in this city."

"We wanted to be part of the solution," says Doug Putman, who credits his mother Karen with bringing the media story to the attention of the close-knit family. "I obviously have a very strong mother and a very strong sister. I've got a very strong wife and I hope I've got a very strong daughter as she grows up. I see the impact of a mother on the kids, the family. What better place to support than mothers and families, because you can actually impact that next generation?"

The Putman family, including Bob and Karen, Doug, his wife Kerri Putman and daughter Hadley, as well as Bob and Karen's daughter Jennifer Putman, her husband Pablo Roque and their daughter Anna Roque took stage at the 2020 Women of Distinction Awards to announce their donation and urged the crowd of 1,000+ guests to invest in women, girls and families in Hamilton.

A996

THE PUTMAN FAMILY YWCA AT A GLANCE

HOUSING FOR WOMEN & CHILDREN

50 affordable apartments

- 28 one-bedroom units
- 6 barrier-free one-bedroom units
- 10 two-bedroom units
- 6 three-bedroom units

15 of which are dedicated for adults with developmental disabilities

In-residence counselling

Wraparound support for residents, including goal-planning, skill-building, resource navigation and supportive counselling

Rooftop garden and community spaces

Passive House design ensuring high levels of comfort

INNOVATION, COMMUNITY & SENIORS SPACES

Innovation Centre dedicated to providing employment training, social enterpriseand microlending, new apprenticeships and business start-up support

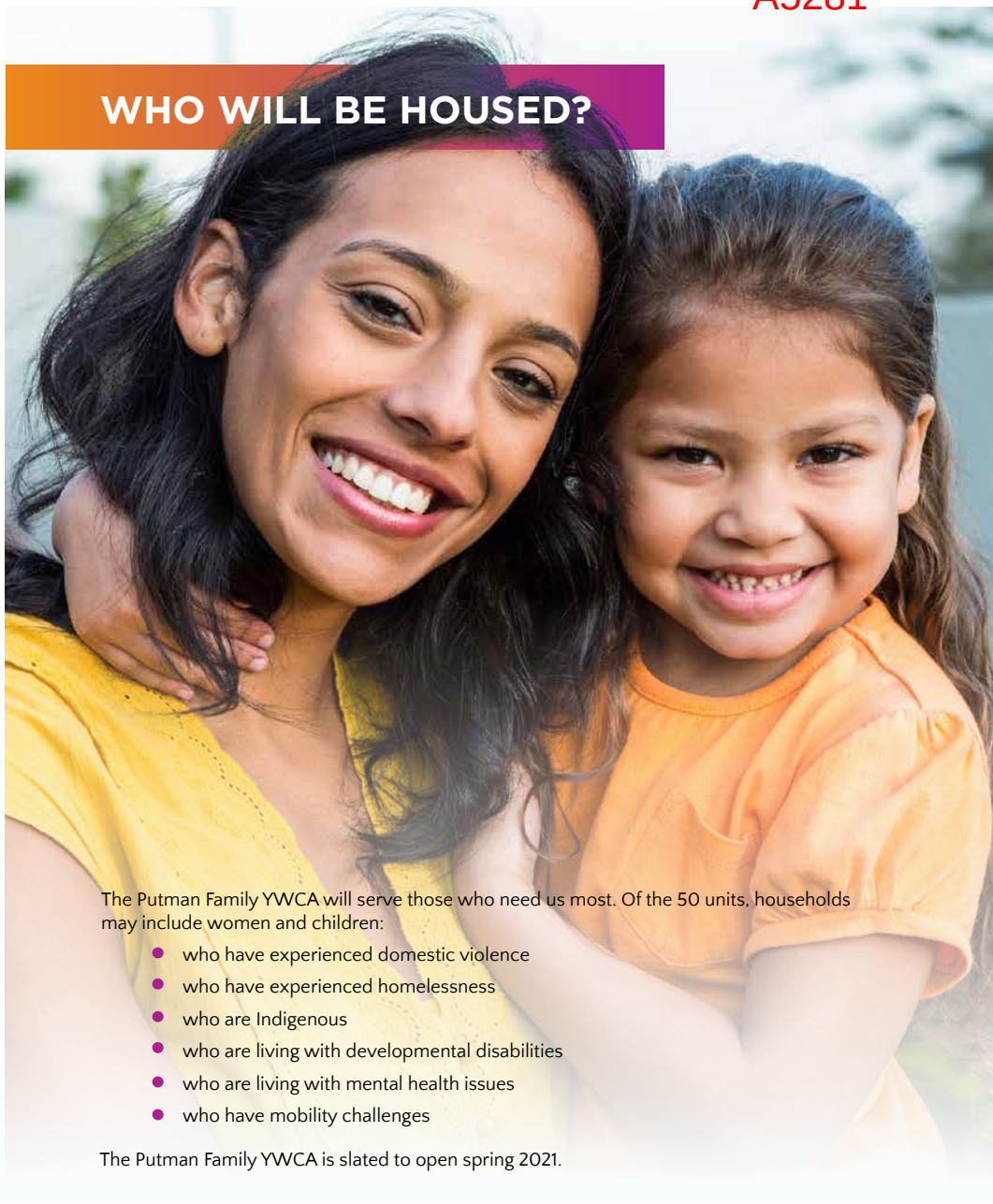
Seniors Centre encouraging active living and engagement for citizens 55+

Health and wellness programming including fitness, yoga and more

Community Atrium promoting neighbourhood connections and youth programming

Non-YWCA programs and flexible rental spaces for community partner use

WHO WILL BE HOUSED?



The Putman Family YWCA will serve those who need us most. Of the 50 units, households may include women and children:

- who have experienced domestic violence
- who have experienced homelessness
- who are Indigenous
- who are living with developmental disabilities
- who are living with mental health issues
- who have mobility challenges

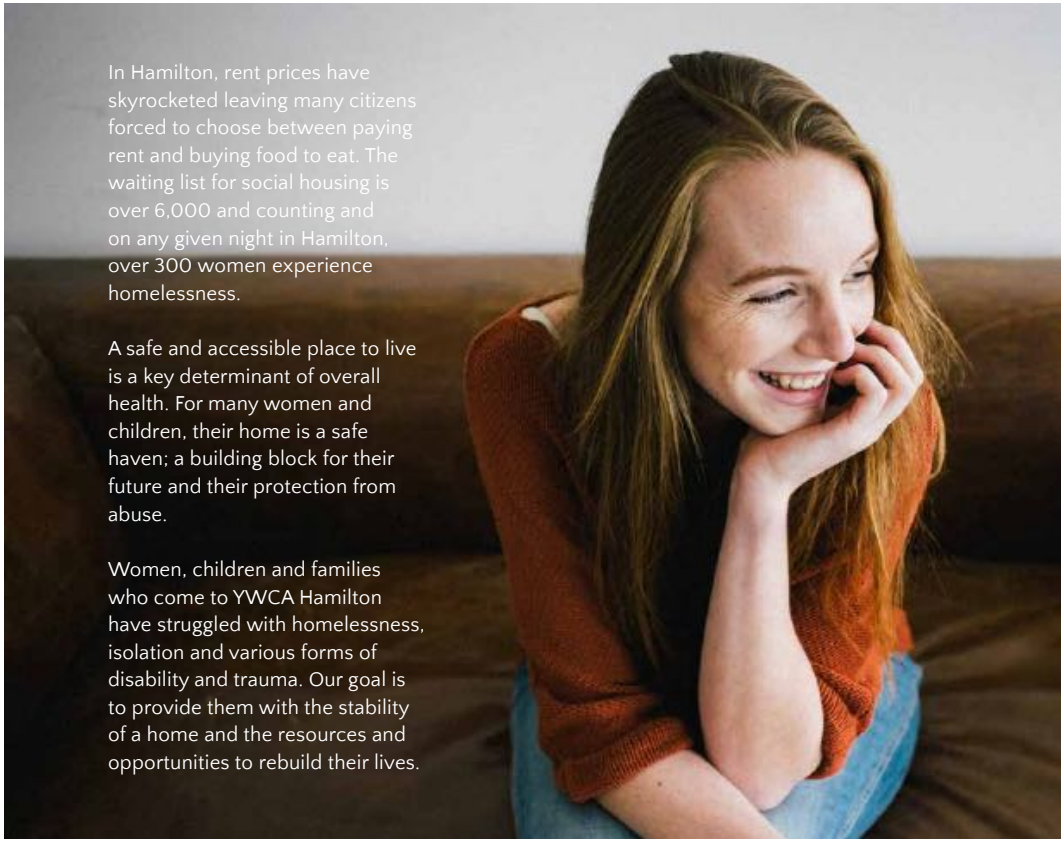
The Putman Family YWCA is slated to open spring 2021.

A5282

WE ELIMINATE FOOD INSECURITY AND INCREASE SKILLS.

Many of the individuals we serve struggle with food insecurity. Access to nutritious food is a basic need and a requirement for empowering women and families. In partnership with local restaurants and supporters, we're tackling food insecurity head on and making an immediate difference through providing dignified access to healthy options.

WE PROVIDE SOLUTIONS TO ENDING HOMELESSNESS.



In Hamilton, rent prices have skyrocketed leaving many citizens forced to choose between paying rent and buying food to eat. The waiting list for social housing is over 6,000 and counting and on any given night in Hamilton, over 300 women experience homelessness.

A safe and accessible place to live is a key determinant of overall health. For many women and children, their home is a safe haven; a building block for their future and their protection from abuse.

Women, children and families who come to YWCA Hamilton have struggled with homelessness, isolation and various forms of disability and trauma. Our goal is to provide them with the stability of a home and the resources and opportunities to rebuild their lives.

140

women struggling with poverty, homelessness and violence received safe, affordable housing through Transitional Living and Phoenix Place

212

women had a safe place to rest **3044** times times during winter's coldest months at CaroleAnne's Place, our out-of-the-cold emergency shelter – an increase of **62%** from last year

47

women moved on from Transitional Living and into independent housing

352

women safely housed

A998

A5283

WE SUPPORT SURVIVORS OF VIOLENCE.

Gender-based violence is the leading cause of women's homelessness and globally, 243 million women and girls age 15-49 have experienced some form of physical or sexual violence perpetrated by an intimate partner in the past 12 months.

Domestic violence rates have skyrocketed across Canada as a result of the pandemic and in Hamilton, we've already seen a 4.6 per cent increase in calls to police about violence in the home.

We are on the frontlines of the fight against violence against women. We are dedicated to ensuring the safety of women and families fleeing violence and offer safe, supportive housing for those escaping violence as well as individualized support, counselling and skill-building to recover from trauma and start anew.

150+
hours of counseling, abuse education, advocacy, legal advice and parenting support to women experiencing violence

39
safety plans completed to support survivors leaving their abusers

40
group sessions providing support to 150+ women fleeing violence through Phoenix Place

145
women, youth and newcomers with limited exposure to the digital world gained digital literacy skills, knowledge and confidence to safely navigate the internet and online communities through the Digital Smarts program

WE ADVANCE WOMEN'S ECONOMIC JUSTICE AND INDEPENDENCE.

Women face unique barriers to accessing gainful employment and are engaged in more precarious work and minimum wage jobs than men. Newcomer women and women of colour experience an even greater earning gap.

Women hold less than 4.5 per cent of all skilled trades jobs across Canada, and in Hamilton, there is a skilled labour shortage of women accessing technical fields and skilled trades.

We are working hard to put women on a path of well-paying growth careers, exploring opportunities within non-traditional occupations and achieving financial independence.

When women have access to training and opportunities, they thrive. And our economy thrives too.

883 individuals supported through Employment and Training Programs with 14 women-led businesses launched through Business Out of the Box, a shipping container reimagined as a storefront for women entrepreneurs

200 young women and non-binary youth ages 15-30 gained meaningful employment after 16 weeks of employability training, 4 weeks of paid in-class training, 7 certification trainings and 12 weeks of paid on the job experience through the SISTER Program

161 female students grades 9-12 across 9 Hamilton high schools explored careers in skilled trades and technical fields and met female mentors to help pave their path forward in non-traditional and STEM fields

300+ clients supported in job search, resume building and increasing employability

30 women are ready to take on the world as trained General Machinists and Electricians through the Pre-Apprenticeship Program in partnership with Mohawk College and Niagara College

"Overall, it was a really great experience and it brought me to where I am today."

- Shannon, Program Graduate

A999

A5284

WE PROMOTE THE HEALTH AND WELLNESS OF ALL PEOPLE.

Robin Mech, Supervisor of 55+ Active Living Centre hand delivering care packages to seniors during the pandemic.

Canadians of low income report the highest rates of food insecurity and those at greatest risk of isolation include seniors with physical and mental health issues, low income seniors, Indigenous seniors and those who are newcomers to Canada.

In Hamilton, over 12,000 seniors are known to be isolated, contributing to increased cognitive decline and depression. Senior women become especially vulnerable to isolation due to taking on the bulk of caregiver responsibilities.

We are focused on promoting the physical and emotional well-being of all Canadians. With our network of volunteers, we're providing in-home social support to isolated seniors, encouraging the full participation of newcomers, supporting new moms and cancer survivors, and providing subsidies to remove barriers for women and families in accessing health and wellness opportunities.

977 patients served through the Shelter Health Clinic at YWCA Hamilton, a health care service designed to reach high-risk populations of people who do not have stable housing and complex health issues

2,309 men, women and children engaged in health and wellness programming

2,347 hours of home visits made to 574 isolated seniors with 445 new connections made to community programs and services through the Senior Peer Connector Program

60 new moms, **74** babies and **36** siblings supported in the comfort of their homes to strengthen bonds and reduce the risks of postpartum depression through Good Beginnings Program

344 women who face financial barriers accessed wellness programming through Women Alive!

4,141 hours of South Asian Punjabi programming provided to 105 senior Punjabi women

55 survivors of breast cancer participated in specialized programming to promote healing, recovery and connectedness among survivors

I have made new friends and enjoy the social component as much as the yoga and exercise. For me, the positive impact is immeasurable. I am grateful for the teachers, my fellow classmates and especially for the individuals involved in creating such a wonderful program for us seniors. Thank you from the bottom of my heart."

– Santokh, YWCA Health & Wellness member

WE STAND FOR DIGNITY AND RESPECT.

A woman with a developmental disability is three times more likely to experience violence. The employment rate of adults aged 16 to 64 with a developmental disability was 22%, less than one-third of the rate for people without a disability and the lowest employment rate of any disability type.

Individuals may also experience isolation within their homes and communities due to mobility challenges and barriers to transportation and care.

We have been serving the needs of youth and adults with developmental disabilities for over 40 years. With a team of dedicated staff, we provide 24-hour support and supervision to adults with differing levels of independence and provide the training, support and care to access meaningful employment opportunities.

342 individuals with developmental disabilities supported through YWCA Hamilton Developmental Services

46 adults provided with 27/7 compassionate care through group living homes and supportive apartment environments

148 people empowered to move, build confidence and increase their self-esteem through Developmental Services day programming

33 individuals with self-identified disabilities prepared for workforce entry with jobs secured in IT, Food Service, Transportation, Non-profit and the Health Care sector through The Opportunities Program (TOP).

A positive affirmation created and shared by folks within Developmental Services.

A1000

A5285

WE BELIEVE IN QUALITY, AFFORDABLE CHILD CARE AND SAFE ACCESS.

Court ordered non-custodial parental visits and exchanges through our Family Access Centre have an 18-24 month wait list. Without a funding increase since 2008, women continue to experience unsafe situations. Unsupervised custodial exchanges in parking lots and within homes where abuse was once perpetrated increases the risks of child abduction and violence against mom.

The need for quality, affordable child care and safe access is greater than ever. With the onset of the pandemic, women have been expected to work full time from home while caring for their children. Child care services in Canada remain inadequate and investments in child care are proven to enhance economic security for all women and communities across Canada.

YWCAs are the second largest provider of licensed child care in the country. We advocate tirelessly to invest in quality, affordable and universal child care across all levels of government. Child care is the ramp to women's equality and integral in women's economic empowerment.

555
non-custodial parental visits at our Family Access Centre to ensure safety where domestic violence, mental health, substance abuse or risk of abduction is of concern

130+
children and youth received subsidy to participate in swimming lessons and Youth Fitness Programs

16,100
hours of quality, inclusive programming delivered to 500+ children through YWCA Hamilton Child Care Centres

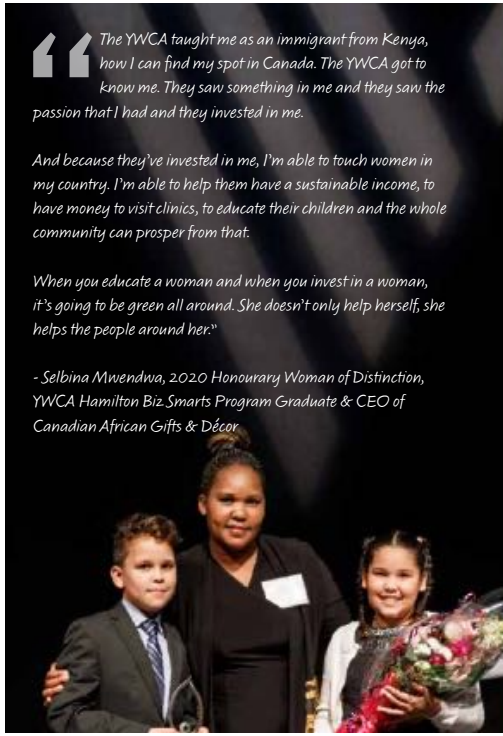
213
children had a summer to remember at YWCA Hamilton Summer Camps

WE ADVOCATE FOR CHANGE.

At our core, we are social innovators and are part of an international network for Gender and Equity. We were there when women were advocating for the right to vote, for reproductive rights and for maternity leave.

We were there when the first shelters opened. YWCA Hamilton has and continues to be a strong voice dedicated to advancing social justice for women, girls, non-binary and gender fluid folks through our programs, services and advocacy.

We work from an anti-racism anti-oppressive, intersectional feminist framework to understand and challenge power structures, address the root causes of systemic racism and amplify the voices of Black, Brown and Indigenous people in our community. We believe in creating safe, inclusive spaces and are invested in building the leadership potential of young women and non-binary youth to carry the torch in the creation of a just and equal society.



610+ youth engaged through youth-led programs, workshops and events that centres the voices of young women, non-binary and gender fluid youth in Hamilton

541 youth across 24 schools attended the Totally Awesome Young Women's Breakfast and left feeling inspired and ready to take on the world

24 girls grades 1-6 empowered through GirlSpace, a free after school program devoted to increasing self-confidence and empowering girls to live healthy, safe lives

15 young women and non-binary individuals identifying as Black, Indigenous, Persons of Colour (BIPOC) claimed power and place in politics to effect change through the Reaching for Power workshop series

A1001

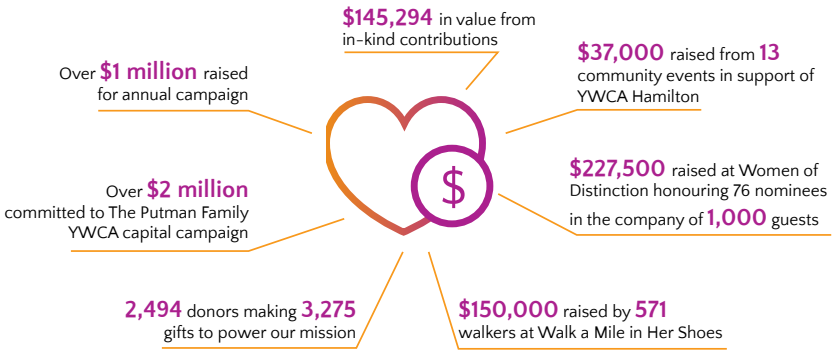
A CULTURE OF PHILANTHROPY.

Your 2020 YWCA Hamilton Women of Distinction Winners.

Bottom (L to R): Dr. Heather Sheardown (Science|Technology|Trades), Chyler Sewell (Young Trailblazer), Blueberry Therapy, Owner Kristen Parise (Outstanding Small Business), Dr. Audrey Hicks (Health)

Top (L to R): Monique Lavallee (Community Leadership), Kayonne Christy (Young Woman of Distinction), Emily O'Brien (Business Leadership|Entrepreneurship), Diana Weir (Arts|Culture|Design), Lena Sutton (Lifetime Achievement)

Fundraising is critical in ensuring the ongoing operations of our programs and services. With the support of our community, partners, funders and generous donors we continue to change the lives of the women and families we serve.



IT WASN'T OUR FIRST PANDEMIC

In March 2020, our organization – like many others – grappled with a new challenge. Covid-19 took our country by storm and we ended our fiscal year navigating the unchartered waters of a global pandemic. But it wasn't the first time.

We were there for the women and families during the global pandemic of 1918, providing supports and services for those in need. And we're still here – supporting and advocating for women and communities disproportionally affected by the pandemic.

With a nimble, passionate team our pandemic response was swift. Together, we:

- ✓ **pivoted our programs** and services to be delivered online where possible;
- ✓ **continued service delivery** within all essential service areas including Transitional Living, Carole Anne's Place, Phoenix Place and all Developmental Services residences;
- ✓ **expanded our women's housing services** in partnership with The City of Hamilton to ensure that women experiencing homelessness had a safe roof over their head and a space to self-isolate;
- ✓ **led the way in developing a virtual visitation** provincial standard to enable safe, virtual court ordered visitations for families through our Family Access & Access Alternatives programming;
- ✓ **stayed connected with isolated seniors** through telephone calls, virtual check-ins and delivering care baskets;
- ✓ **launched a Covid-19 response campaign** raising over $24,000 to support our pandemic response along with over $15,000 worth of in-kind donations for programs and collecting 7,000+ pieces of personal protective equipment to ensure the ongoing safety of our staff and clients.

The effects of the pandemic will be felt for years to come. From massive layoffs to increased unpaid work to the surge in domestic violence, women have been disproportionally impacted by Covid-19. **We are dedicated to advancing Canada's first Feminist Economic Recovery Plan and will work tirelessly with YWCAs across the Country to see this through.**

REMEMBERING MILLI GOULD

(L to R): Ben Gould, Milli Gould, Mark Gould, Denise Christopherson

Our CEO Denise Christopherson remembers Milli as a woman who seldom wanted to talk about herself or her own accomplishments, and instead wanted to focus on making the community a better place for women and children.

"I just remember the joy in her eyes as women talked about the businesses they were planning," Denise said. "She always believed that because someone invested in her potential, she would pay it forward and invest in the potential of other women."

YWCA Hamilton is deeply grateful for the support and friendship of Milli Gould who was a catalyst for change in the lives of so many women. When you invest in a woman, it has a ripple effect across the community, a concept Milli understood more than most. And her legacy will live on in the women entrepreneurs she supported and who, in turn, supported themselves, their families and helped build Hamilton.

YOU POWER OUR MISSION.

Our heartfelt thanks and appreciation goes out to all supporters of our mission. From our staff team to our volunteers, funders and individual donors, we all contribute our unique offerings to enable our shared success and collective impact. Because of you, women, children and families are thriving.

Government Funders

City of Hamilton
Employment & Social Development Canada
Federal Economic Development Agency
Health & Social Services Haldimand & Norfolk
Immigration, Refugees and Citizenship Canada
Innovation, Science and Economic Development Canada
Ministry for Seniors & Accessibility
Ministry of Attorney General
Ministry of Children, Community and Social Services
Ministry of Education
Ministry of Heritage, Sport, Tourism, Culture
Ministry of Training, Colleges & Universities
Ontario Trillium Foundation
Women and Gender Equality Canada

Foundation & Corporate Supporters

ACCESS Community Capital Fund
Alectra Utilities
Alice Jean Ainsworth Memorial Fund through the Hamilton Community Foundation
Ancaster Lions Club
ArcelorMittal Dofasco Employee Donations Fund
ArcelorMittal Dofasco Inc.
Arvin Air Systems
Atomic Spark
BDO Canada LLP
Bestco Construction Ltd
Beth Jacob Synagogue
Body Shop – Eastgate Square
Boehringer Ingelheim
Brabant Foundation
Brownlow Partners
Burnt Tongue
Cable 14
Cake and Loaf Bakery
Canadian Tire Jumpstart Foundation
Cancer Assistance Program
Carmen's Group
Cavalier Clothing
Centre de santé communautaire Hamilton/Niagara
Children's Aid Society of Hamilton
CHML Children's Fund
CIMA Enoteca
City of Hamilton – Economic Development
Coke Canada
Cogeco Connexion
Collyer Benson Capital Inc.
Community Arts Fund through the Hamilton Community Foundation
Congregation of the Sisters of St. Joseph in Canada
Coreslab Structures
Council for Canadian Urbanism
Councillor Nrinder Nann
Court Holdings Limited
COVID-19 Emergency Fund through the Hamilton Community Foundation
CrossFit Opus
CURE Foundation
Datcor Mechanical a Division of 1826298 Ontario Inc.
De dwa da dehs nye's Aboriginal Health Centre
Deloitte LLP
Dewildt Honda
Dr. Ravinderpal Singh Ohson Medicine Professional Corporation
Dundas Lioness Club Charity
Edith H. Turner Foundation Fund through the Hamilton Community Foundation
Empower Strategy Group
Enbridge Gas Inc.
Energy Advantage Inc.
Estate of Elizabeth Love
Gallagher
Gentherm
Genworth Canada
Givesome Foundation
Gowling WLG
Graceworks Baptist Church
Grant Thornton LLP
Green Benefits Group
H. Fred Janson Fund

IMPACT REPORT 2019/2020 | **YWCA Hamilton**

A5288

Hamilton Community Foundation
Hamilton Etsy Handmade
Hamilton Fire Fighters Assistance Fund - Local 288
Hamilton Jewish Family Services
Hamilton Out of the Cold
Hamilton Police Service
Hamilton Romanian Community
Hamilton Spectator Summer Camp Fund through the Hamilton Community Foundation
Hamilton Tiger-Cats Football Club
Hamilton-Wentworth Catholic District School Board
Hamilton-Wentworth District School Board
Hamilton-Wentworth Elementary Teachers' Local
Healthcare & Municipal Employees' Credit Union
IBEW Local 105
Intact Insurance
Jackman Foundation
Kabuki Spa & Skin Care Centre
Karen & Peter Turkstra Family Foundation through the Hamilton Community Foundation
KMSalter Design
KPMG Foundation
KPMG LLP
Labourer's International Union of North America (LIUNA) 837
Lamont Law
Lean In Wealth Management
MacKay CEO Forums
MacNeill Baptist Church
Malarkey Kids Inc.
Malloch Foundation Fund through the Hamilton Community Foundation
Maple Leaf Sports and Entertainment
Marz Homes
Martin Foundation Fund through the Hamilton Community Foundation
Mastectomy Lingerie and More
Maxims Limited Partnership (Aird & Berlis LLP)
McCallum, McBride Fund through the Hamilton Community Foundation
McGowan Insulations Ltd.
McMaster University
Meals with Purpose
Mercedes-Benz Burlington
Meridian Credit Union
MERIT Brewing
Mohawk College
MPP Andrea Horwath
MP Filomena Tassi
National Steel Car Limited Employees Charitable Donations
Neighbour to Neighbour Centre
New Horizon Development Group
Nique Restaurant Inc.
Niwasa Kendaaswin Teg
Odds Bar
Ontario Indigenous Centre of Excellence
Ontario REALTORS Care Foundation
Pearson Dunn Insurance Inc.
Pelmen Foods
PV&V Insurance Centre Ltd.
Q Spa
Radius
RBC Royal Bank
Rexall Pharmacy Group Ltd.
Ross McBride LLP
Royal LePage Shelter Foundation
RWAM Insurance Administrators Inc.
Schilthuis Construction Inc.
Scotiabank
Sheraton Hamilton Hotel
SimpsonWigle LAW LLP
Sisters of Charity
Solee Shoes
Sony Music
Soundbox Productions
Starward Homes
Sunrise Records
Superior Boiler Works and Welding Limited
T. Johns Consulting Group Ltd.
Tandia
TD Commercial Banking
The Body Shop - Eastgate Square
The Generator Inc
The Hamilton Spectator
The Mule
The Other Bird
The Shoebox Project
Thier + Curran Architects
TPH The Printing House
TradeLink International Ltd.
United Steelworkers
United Way Halton & Hamilton
Unity Spiritual Centre
VIA Rail Canada Inc.
2WA Consulting
Women 4 Change Fund through Hamilton Community Foundation

Individual Donors (Donating $500+)

Aaron Gillespie
Albina Veltman
Alexis Fletcher
Allison Nielsen
Amy Campbell
Andrew Vanderhout
Ani Kaluzny
Ann McLaughlin
Anna D'Angela
Anne Tennier
Annette Hamm
Annette Verschuren
Archie Merigold
Beatrice and Romeo D'Angela
Bianca Bruzzese
Bob Aron
Brenda Vrkljan
Brenda Yates
Brooke Eady
Carm Bozzo
Carm Vespi
Carmela Trombetta
Catherine Miller
Cathy MacKenzie
Charaya Thach
Chelsea Kirkby
Chris Rigby
Christina DelBello
Claire Kislinsky
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Debra Kumita
Deidre Henne
Denise Christopherson
Earle O'Born
Eileen Campbell
Felicia Van Dyk
Gabriela Covaci
Gillian Webster
Graham Crawford
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Hoda Kamel
Jane Allison
Janet Arsenault
Janet Rush
Jean MacKinnon
Jeff Dowding
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Jo-Ann Savoie
Joanne McCallum
Juliet Daniel
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Patricia Saunders
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Pauline Taggart
Pearl Veenema
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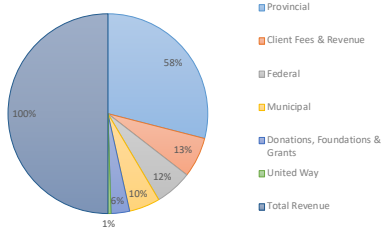
Sue Bennison
Sue Ramsay
Susan Reid
Suzanne Bauman
Suzanne Gibson
Suzanne Mammel
Suzanne Zandbergen
Tanweer Abbas
Tara Townson
Ted Stark
Theresa Picone
Thomas Corradetti
Winnie Linker
Yulena Wan
Ziad Reda

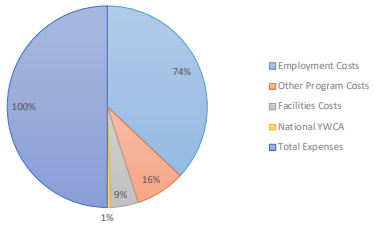
Financial Highlights

Financial information is extracted from the financial statements audited by Deloitte LLP. Anyone requiring a copy of the audited financial statements and financial notes disclosure may contact us.

Revenue



Expenses

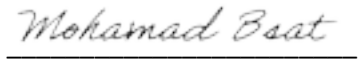


IMPACT REPORT 2019/2020 | **YWCA Hamilton**

A1004

A5289
PUTMAN FAMILY YWCA
A1005

THIS IS EXHIBIT “C” TO THE
AFFIDAVIT OF MEDORA UPPAL
AFFIRMED REMOTELY BEFORE ME AT
THE CITY OF HAMILTON DURING A “ZOOM” VIDEOCONFERENCE
IN ACCORDANCE WITH O.REG. 431/20,
ADMINISTERING OATH OR DECLARATION REMOTELY
THIS 17th day of July, 2023



Mohamad Bsat
LSO NO. 75897L
Commissioner for Taking Affidavits, etc

A5291

YWCA HAMILTON

FROM HOMELESSNESS TO HOPE

Support for Carole Anne's Place

Submission to Emergency and Community Services Committee – City of Hamilton

November 7, 2019

A1007

A5292

NO PLACE TO CALL HOME – A CRISIS IN HAMILTON

Women are turned away from shelters over 300 times every month.

But all they want tonight is a safe place.

YWCA Hamilton's Carole Anne's Place keeps women who are homeless warm and safe during Canada's coldest winter months.

Every day over the winter, YWCA opens the MacNab Street site at 10pm where staff from St. Joseph Healthcare Centre and YWCA provide overnight space for 10 - 20 women.

Carole Anne's Place closes at 8am and women are given bus tickets to go to Willow's Place. Mission Services extends the hours of Willow's Place, so that women have a place to go when Carole Anne's Place is closed.

A request to fund Carole Anne's Place has been submitted to the Housing Services Department for future years (April 2020 – 2023).

There is no funding for this Winter.

A1008

A5293

CAROLE ANNE'S PLACE

Carole Anne's Place offers women a safe, warm place to rest overnight during winter's coldest months. And, our partners at Willow's Place offer daytime drop-in and support until doors open at Carole Anne's Place.

Carole Anne's Place and Willow's Place provides access to hot meals, housing assistance, and winter clothing for women struggling to cope with homelessness or precarious housing situations.

2018/2019:

4583 visits — December 1st, to March 31st, 2019

260 women — accessed safe space at Carole Anne's & Willow's Place

79% overnight guests — required substance use monitoring (March 2019)

33 days — that were below -10 degrees

A1009

A LACK OF FUNDING FOR CAROLE ANNE'S PLACE

Without access to emergency shelter, women in Hamilton risk death and injury this winter.

Since 2016, Carole Anne's Place has evolved to create a service that is responsive and helps keep women safe in the winter. Carole Anne's Place relies on the coordination of services between YWCA Hamilton, Mission Services, and St. Joseph Healthcare Centre to respond when the shelters are full or cannot support the women who require a low-barrier option.

The funding gap is **$228,000**, which supports opening Carole Anne's Place and extending hours at Willow's Place. Contributions of **$30,000** have already been committed to Carole Anne's Place from St. Joe's, Out of the Cold, and Sisters of Charity.

The Women's Housing Planning Collaborative (WHPC) endorses Carole Anne's Place as a necessary response until other permanent solutions can be established.

Overflow shelter Carole Anne's Place will not be able to open this winter without new funding

The YWCA-run program provided a warm place to sleep for dozens of women turned away from full shelters last winter — but funding for the pilot project has run out.

NEWS 07:58 AM by Matthew Van Dongen The Hamilton Spectator

Carole Anne's Place has run the overflow shelter out of the downtown YWCA for three years between December and March. - The Hamilton Spectator file photo

An emergency overnight stay program for homeless women turned away from full shelters will not be able to open this winter without new funding, says the Hamilton YWCA.

A5295

FROM HOMELESSNESS TO HOPE: ONE WOMAN'S STORY

Cathy found a protected alcove near the GO Station, where she and her partner Lindsey could take shelter from the cold for the night. As she settled in and waited for Lindsey to join her, two men entered the small alcove and started using intravenous drugs.

"And here I am, freezing, almost in tears. Don't know what to do, don't know where to go. No money, no food, no drinks, no nothing. Absolutely nothing," says Cathy. "And I sat there and I watched it because I did not want to get beaten up, killed, robbed, raped, or anything. I didn't want any of that happening because that already happened to me before, years ago. But I was scared for my life."

A few weeks later, Cathy and Lindsey would find Carole Anne's Place, where they slept every night from December to March. With support from YWCA Hamilton staff, they were eventually set up with a permanent apartment, a safe place they could finally call home.

"I'm starting to get our life back together. And you know, if it wasn't for Carole Anne's Place pushing us and giving us that support and all the positivity that they have, I honestly don't believe that I would be here."

Carole Anne's Place evolved from the Women's Housing Planning Collaborative (WHPC) in 2016 and has relied on contributions from Out of the Cold, a non-profit, and the LHIN to operate. Out of the Cold has had to reduce the amount of donated dollars they can contribute and the LHIN has not been able to re-fund the program in 2019/20. To date, the City of Hamilton has not contributed any funding to this crisis response for women.

A1011

THIS IS EXHIBIT “D” TO THE
AFFIDAVIT OF MEDORA UPPAL
AFFIRMED REMOTELY BEFORE ME AT
THE CITY OF HAMILTON DURING A “ZOOM” VIDEOCONFERENCE
IN ACCORDANCE WITH O.REG. 431/20,
ADMINISTERING OATH OR DECLARATION REMOTELY
THIS 17th day of July, 2023

Mohamad Bsat
_____
Mohamad Bsat
LSO NO. 75897L
Commissioner for Taking Affidavits, etc

A5297

City of Hamilton

Point in Time Connection Results 2021

Housing Services Division – April 2022

A1013

The 2021 Point in Time Connection (PiTC), a joint planning effort with City of Hamilton's Housing Services Division and the Coalition of Hamilton Indigenous Leadership (CHIL), was made possible through the support of a wide range of community partners who assisted greatly in its planning and implementation. The Housing Services Division would like to specifically acknowledge and thank every single survey participant whose contributions allow us to more deeply examine the impact of our ongoing work to end homelessness.

The partnership with, and leadership of, CHIL remain central in efforts to prioritize Indigenous led solutions to homelessness. Recommendations from the Indigenous community guide efforts to ensure that the PiTC is conducted in a way that is safe and culturally appropriate, acknowledging autonomy and self-determination as key pillars of engagement.

For the first time, Hamilton's PiTC was led on the ground exclusively by community partners and City staff without the support of volunteers; these efforts were critical in prioritizing the health and safety of all involved throughout the survey week. Building on this initiative, we continue to strive to centre the voices of unhoused residents to work toward ensuring that their needs are directly prioritized in approaches taken and decisions made in the context of local planning, policy and investment.

Land Acknowledgment

The City of Hamilton is situated upon the traditional territories of the Erie, Neutral, Huron-Wendat, Haudenosaunee and Mississaugas. This land is covered by the Dish With One Spoon Wampum Belt Covenant, which was an agreement between the Haudenosaunee and Anishinaabek to share and care for the resources around the Great Lakes. We further acknowledge that this land is covered by the Between the Lakes Purchase, 1792, between the Crown and the Mississaugas of the Credit First Nation.

Today, the City of Hamilton is home to many Indigenous people from across Turtle Island (North America) and we recognize that we must do more to learn about the rich history of this land so that we can better understand our roles as residents, neighbours, partners and caretakers.

Coming Together to End Homelessness: Hamilton's Systems Planning Framework outlines our strategic local approach to preventing and ending homelessness, which must account for the systemic over-representation of Indigenous persons experiencing homelessness. The Housing Services Division is committed to ongoing coordination with urban Indigenous leadership to ensure that approaches to service coordination and provision are culturally appropriate, safe and built on principles of relationship, trust and informed consent.

Table of Contents

Summary and Key Findings 3
Snapshot of Homelessness in Hamilton on November 19, 2021 4
Introduction 4
COVID-19 Context 4
Overview of Homelessness in Hamilton 5
Sheltered Homelessness 5
Unsheltered Homelessness 6
Shelter System Flow Data 7
Methodology 9
Snapshot 10
Survey Participation 11
Profile of Respondents Experiencing Homelessness 11
Age 11
Gender Identity 12
Indigenous Identity 12
Migration to Canada 13
Racial Identity 14
Length of Time in Hamilton 14
Family Homelessness 15
Sexual Identity 15
Veteran Homelessness 16
Health 16
Sources of Income 17
Homelessness History 18
Length of Homelessness in Past Year 18
Age of First Homeless Experience 19
Experience with Foster Care 19
Reasons for Homelessness/Housing Loss 20
Barriers to Finding Housing 21
Service Use Patterns 21
Shelter Use in the Last Year 21
Interaction with the Health Care & Criminal Justice System 22
Conclusion and Next Steps 23
Appendix A: 2021 PiTC Survey 24

Summary and Key Findings

Hamilton's most recent PiTC survey of individuals experiencing homelessness in the city highlights a shift in the demographic profile of those experiencing homelessness, identifies key barriers to maintaining or obtaining housing, and shows specific groups are overrepresented in their experience of homelessness.

Held November 15 to 19, 2021, and jointly planned by the City's Housing Services Division and CHIL, it is the third nationally-coordinated Point-in-Time Count since 2016. The information collected complements existing local efforts to collect and report on key data on the state of homelessness and helps to ensure available resources are used as efficiently and effectively as possible to prevent and end homelessness.

Service staff from community-based social service organizations conducted 545 surveys over the five-day period at emergency shelters, drop-in programs, community agencies, and in unsheltered locations to better understand the needs of people experiencing homelessness in our community.

Results of the survey highlight:

- the overrepresentation of Indigenous peoples, as 23% of all respondents identified as Indigenous or as having Indigenous ancestry;
- a shift in the demographic profile of those experiencing homelessness throughout the COVID-19 pandemic, including an increase in the percentage of respondents who identify as a woman (53%), which was higher than in 2018 (32%) and 2016 (28%);
- key barriers to maintaining or obtaining housing, such as impacts from the COVID-19 pandemic, housing affordability, low income/low income assistance, landlord/tenant conflict, poor housing conditions and discrimination;
- a majority of respondents reported they had most recently stayed in an emergency shelter or a City funded hotel/motel; and,
- the 2021 PiTC engaged a larger number of people staying in outdoor unsheltered locations and encampments (95) compared to 2016 and 2018 (In 2016, 34 survey respondents were unsheltered and/or in encampments compared to 25 survey respondents in 2018).

In keeping with the principles of Indigenous data sovereignty, as directed by the Indigenous Community Advisory Board (ICAB), CHIL has led the analysis of Indigenous respondent data and the City of Hamilton has not and will not use this data without the approval of the ICAB. Housing Services Division continues to prioritize collaborative work with local Indigenous leadership to develop connections to housing and supports

that are culturally appropriate, rooted in the spirit and actions of reconciliation that recognize the values of autonomy and self-determination.

Snapshot of Homelessness in Hamilton on November 19, 2021

- Shelters were at 93% capacity during the period of November 15-19, 2021
- 748: the number of unique individuals that stayed in an emergency shelter during the period of November 15-19, 2021
- 1426: total number of people on the City of Hamilton's By-Name List on November 12, 2022

Introduction

From November 15 to 19, 2021 the City of Hamilton participated in Everyone Counts, the third nationally coordinated Point-in-Time Count in Canada. Completion of the PiTC fulfilled requirements of both the Federal government's Reaching Home: Canada's Homelessness Strategy and the Ontario Ministry of Municipal Affairs and Housing.

Point-in-Time Counts have historically been used to help communities better understand the nature and extent of homelessness and the circumstances of the people experiencing homelessness, while providing information to help shape ongoing system and service responses. Point-in-Time Counts can assist in identifying how many people in a community experience homelessness at any given time; however, it is not an exhaustive count. Through the accompanying survey, the initiative provides information on the demographics and service needs of the local population experiencing homelessness.

545 surveys were completed during the week at emergency shelters, provincially administered Violence Against Women shelters, drop-in programs, community agencies, and in unsheltered locations including encampments. An Indigenous led magnet event was also held in Beasley Park on November 17, 2021 to provide an opportunity for Indigenous community members to be surveyed by Indigenous surveyors.

COVID-19 Context

Investments specifically targeted towards housing-focused interventions in Hamilton to prevent and end people's experience of homelessness total approximately $25 M annually in regular funding. In addition, since the beginning of the COVID-19 pandemic, the City has sustained an emergency response across the homelessness-serving system directing more than $60 M in additional pandemic response funds. These funds ensured for a responsive and flexible response throughout the evolving demands of the pandemic.

Through the pandemic, additional investments have enabled the temporary expansion of shelter space across the system from 341 beds up to 548 beds at the highest point plus additional overflow space, as well as a new temporary women's shelter. In addition, these investments supported the expansion of the City's Housing Focused Street Outreach team and have also enabled community drop-in programs to expand and

maintain services for vulnerable residents, including: meals, showers, harm reduction supplies, and overnight access to drop-in services. These investments and the dedicated efforts of agency staff provided additional settings and opportunities for engagement through the PiTC.

Overview of Homelessness in Hamilton

Sheltered Homelessness

Emergency shelters are a critical first-line response to ensure people experiencing homelessness have a safe place to stay while they pursue stable housing. The City's outreach staff work on a daily basis to engage individuals experiencing unsheltered homelessness to offer shelter space and work with them to find safer, humane, and supportive housing options.

There has been growing pressure within the shelter system throughout the course of the pandemic. In 2020, emergency shelter average length of stay increased 18% and the women's system was particularly over-capacity. From 2020 to 2021 there has been an increasing trend in number of unique individuals accessing shelters by month.

Figure 1: Unique Individuals in Shelter by Month

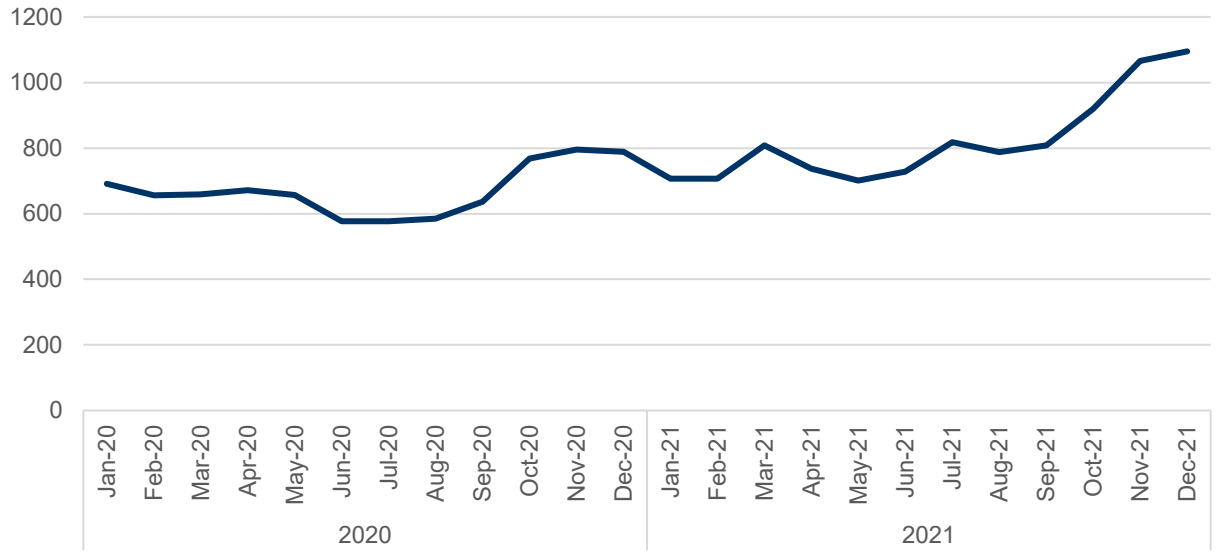


Figure 2: Monthly Shelter Bed Usage and Max Capacity by Month

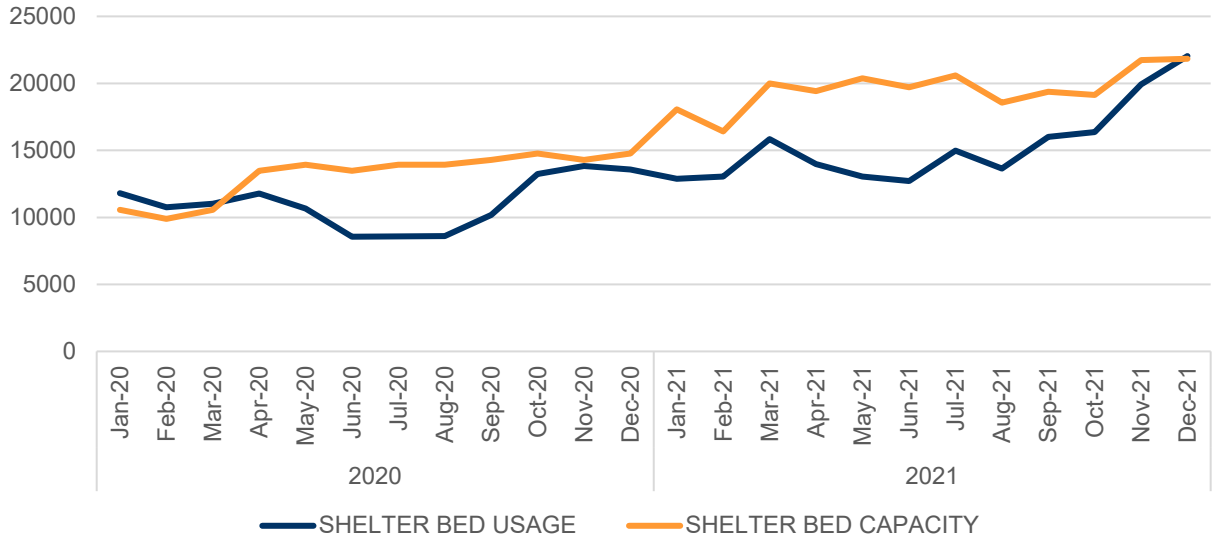
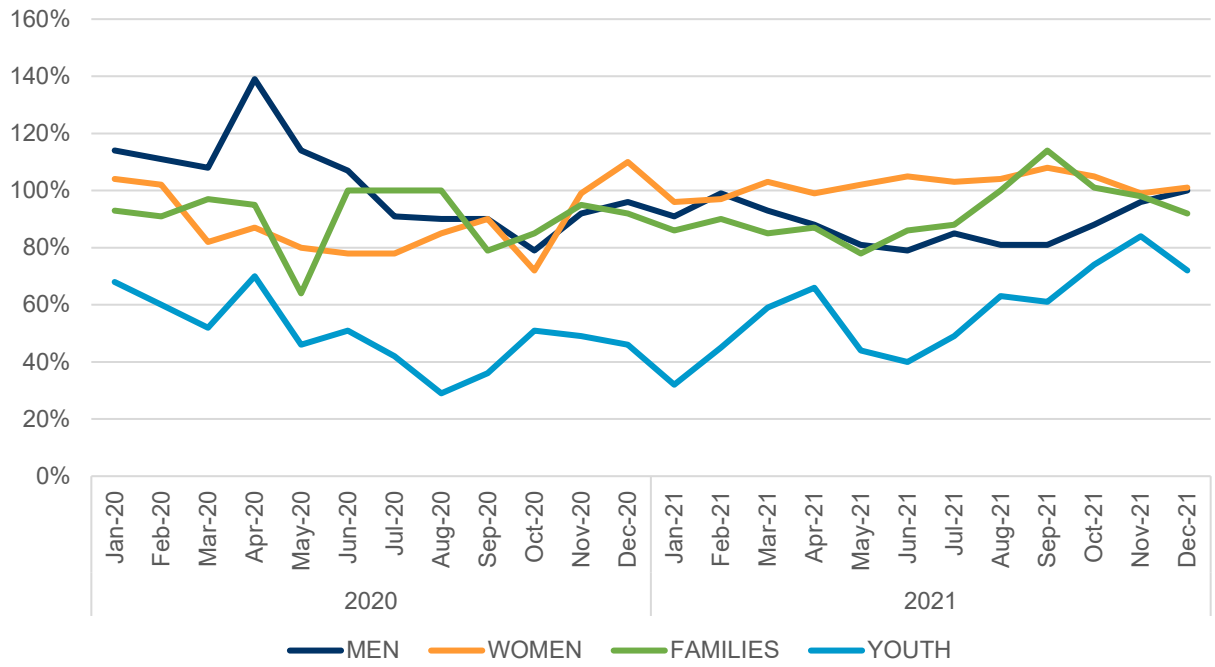


Figure 3: Shelter Occupancy by Sector and Month



Unsheltered Homelessness

During the week of the PiTC (Nov. 15-19, 2021), the City's Housing Focused Street Outreach team reported that there were approximately 90 unique individuals staying in unsheltered locations, including encampments. The rise in, and visibility of, unsheltered

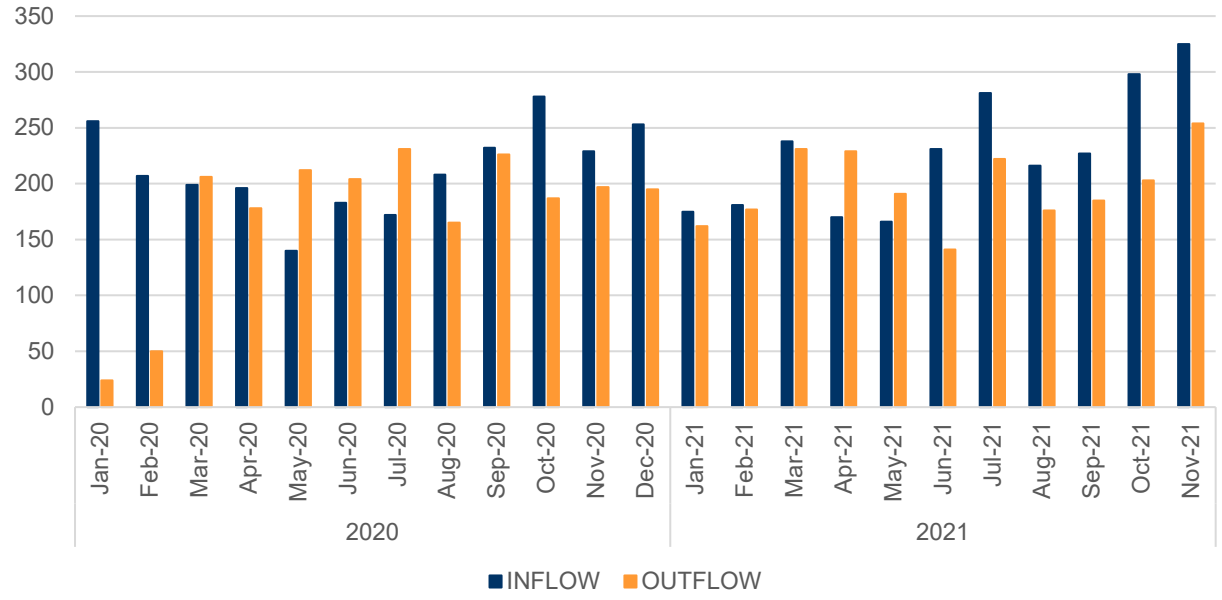
homelessness and encampments throughout many Canadian cities continues to demonstrate how the COVID-19 pandemic persists in exacerbating ongoing systemic challenges and inequities as it relates to housing and homelessness. While the City has worked to develop new strategies and approaches to address these issues locally, unsheltered homelessness remains a persistent reality in Hamilton along with structural barriers to accessing adequate housing and supports.

Shelter System Flow Data

Inflow and outflow are two of the most important measures for monitoring progress towards the goal of ending homelessness. The goal towards ending homelessness is to see outflow exceed inflow. When this happens, it means that more people are exiting from homelessness than are entering the homeless-serving system. As of the end of November 2021, there have been two months where outflow exceeds inflow. In 2020, there were four months where outflow exceeded inflow. Note that outflow data was limited for the first two months of 2020.

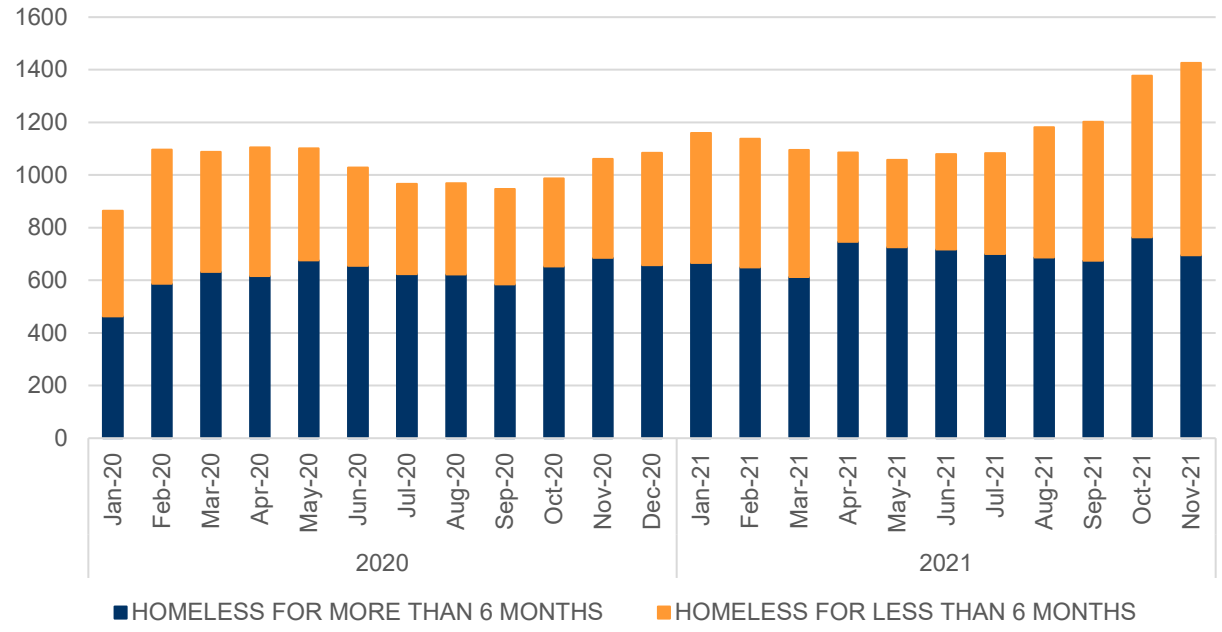
INFLOW	OUTFLOW
Represents the number of individuals: • newly identified as homeless, • returned to homelessness from housing, • returned to homelessness from inactive status.	Represents the number of individuals: • who have moved from housing to housed, • those who have moved to inactive status (meaning they have not interacted with the homeless-serving system for 90+ days).

Figure 4: Individuals (shelter stayers) entering (inflow) or exiting (outflow) homelessness by month



The number of people actively experiencing homelessness is based on data collected by homeless-serving shelters through the Homeless Individuals and Families Information System (HIFIS). Individuals on the By Name List (BNL) who have been engaged only through Outreach and Drop-in programs are not included in this depiction at this time as we look to improve our data reporting.

Figure 5: Individuals (shelter stayers) experiencing homelessness for less than six months and more than six months, by month



Methodology

The nationally coordinated Point-in-Time Count approach includes a set of core standards for the methodology that guide how the counts are conducted in participating communities across Canada. The core standards, identified by Federal and Provincial governments, identify common screening and survey questions that are asked in all participating communities. The approach does give some flexibility for communities to adapt methodology, and Hamilton's survey design and implementation was guided by local partners, including consultation with Indigenous partners through CHIL.

Given the COVID-19 pandemic, adaptations to methodology were made available to communities to support the implementation of Point-in-Time Counts to reduce risks and burden on participants and staff in the homeless serving sector. Adaptations to the 2021 PiTC included:

- expansion of surveying timeline to five days, creating additional flexibility to participate and complete surveys, while avoiding large gatherings to reduce the risk of infection and community spread of COVID-19;
- no additional assessment tool included for 2021, as the survey consisted of only the core anonymous questions;
- 24-hour online survey submission, completed through the Homeless Individuals and Families Information System (HIFIS);
- no additional community volunteers recruited - surveying was conducted exclusively by community social-service agency and City of Hamilton staff;
- full training module completed online; and,
- focus on sheltered sites (emergency shelter, drop in, etc.) and a targeted approach to connect with unsheltered individuals and families in the community in known locations through the City's Housing Focused Street Outreach team, alongside partners from local Indigenous housing organizations.

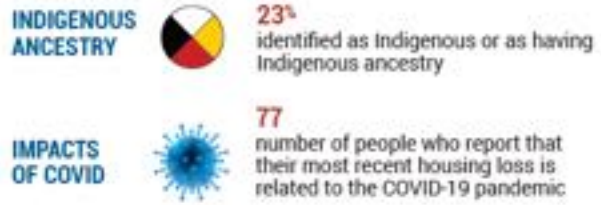
As in 2016 and 2018, an Indigenous led magnet event was held during the week to provide an opportunity for Indigenous community members to be surveyed by Indigenous surveyors. All survey participants of the PiTC were provided a $15 gift card honorarium upon completion of the survey.

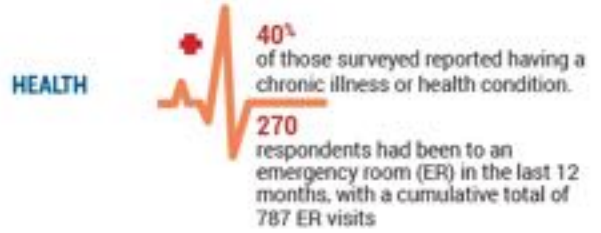
While a number of strategic decisions allowed for increased engagement through the PiTC, there remains limitations in the methodology. In the 2018 PiTC, Hamilton had expanded survey sites to include additional drop-in programs focused on youth, as well as including the Central Library location as a survey site. As a result of enhanced COVID-19 health and safety regulations and limitations on volunteer recruitment, staff were unable to include these additional spaces and build upon learnings and reflections from these survey sites in 2018.

Snapshot

Comparison and analysis of detailed results across multiple PiTC initiatives remains a challenge given the varying contextual factors from year to year. Between PiTC initiatives, the Housing Services Division has worked with community partners to strengthen local reporting on key data related to the state of homelessness and actions towards preventing and ending it. As a part of these broader efforts, the PiTC remains a valuable tool to further support evidence-informed action and improvement within Hamilton's Housing and Homelessness Serving System.

A total of 545 individuals completed voluntary surveys during the 2021 Hamilton Point in Time Connection. Here is a snapshot of the survey results:





Survey Participation

The following chart provides a summary of where the 545 survey respondents reported staying the night before completing the survey:

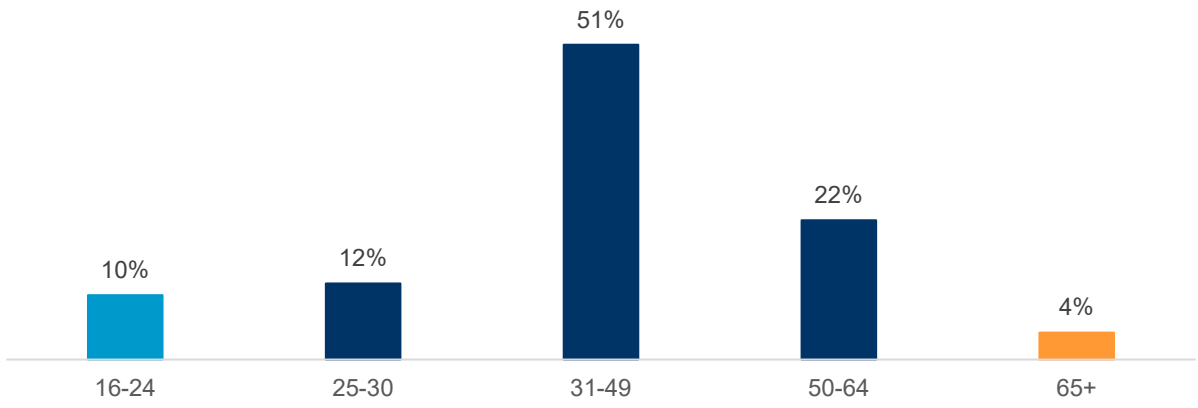
Location	Total	Description
Emergency Shelters	366 (67%)	An emergency shelter, hotel or motel, and domestic violence shelters for emergency accommodation.
Unsheltered	61 (11%)	An unsheltered location in a public space, such as a park, vehicle, or other place not intended for human habitation.
Encampment	35 (6%)	A group of tents, makeshift shelters, or other long-term outdoor settlements.
Couch Surfing	15 (3%)	Staying with a friend, family member, or stranger.
Transitional Housing	52 (10%)	Housing which is a temporary type of accommodation meant to bridge the gap from homelessness to permanent housing.
Motel / Hotel (Self-funded)	1 (0.2%)	Staying in a motel / hotel that was paid for by the individual or family.
Location undetermined	15 (3%)	Location was not reported.

Profile of Respondents Experiencing Homelessness

Age

The average age of respondents was 35 years. Respondents ranged in age from 16 being the youngest and 79 as the oldest. Most respondents (73%) were between the ages of 31 and 64.

Figure 6: Age of Respondents



Gender Identity

A key demographic shift in 2021 results was the percentage of respondents who identified as a woman (53%), which was higher than in 2018 (32%) and 2016 (28%). There are contributing factors to keep in mind when considering this shift in respondent profile, including intentional adaptations to methodology, and where surveys were administered in 2021 in comparison to previous years.

Although not required, Hamilton continues to include people who may be experiencing "hidden homelessness" into the PiTC survey. This has been a standing recommendation by our community to ensure that we better represent populations who may typically not be as highly represented in the mainstream emergency shelter system. Enhanced gender-specific responses during COVID-19, including an expanded emergency shelter system and enhanced drop in locations, along with the option to complete surveys 24 hours a day through the entire duration of the initiative may have also contributed to a shift in response rate.

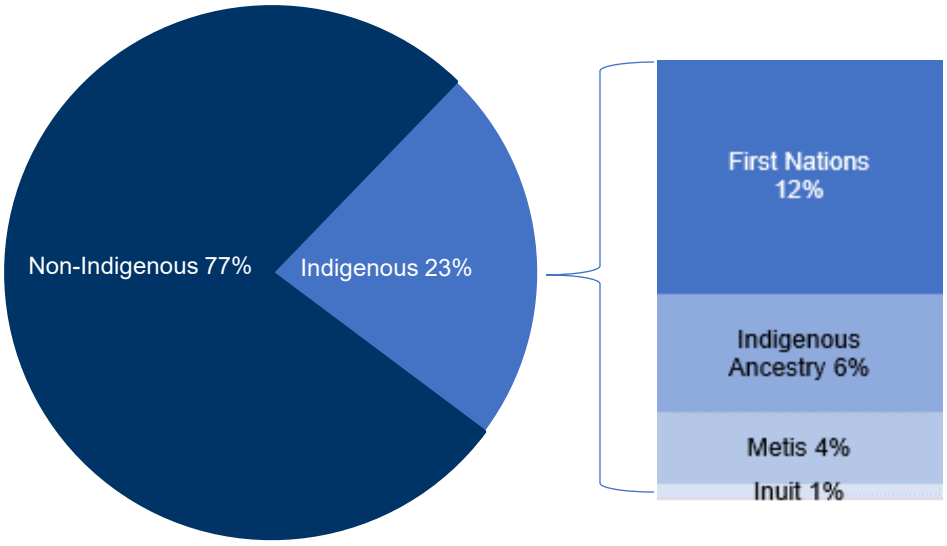
Table 1: Gender Identity of Respondents

Gender	Percentage
Woman	53%
Man	45%
Non-Binary	2%
Trans, Two-Spirit	<1%

Indigenous Identity

In 2021, the PiTC continues to highlight the overrepresentation of Indigenous persons experiencing homelessness in Hamilton (23% of all respondents). A full analysis of Indigenous respondent data can be found in Appendix "B" to Report HSC22021 - 2021 Point in Time Count (Hamilton, Ontario): Indigenous Responses, submitted by CHIL and approved by the ICAB.

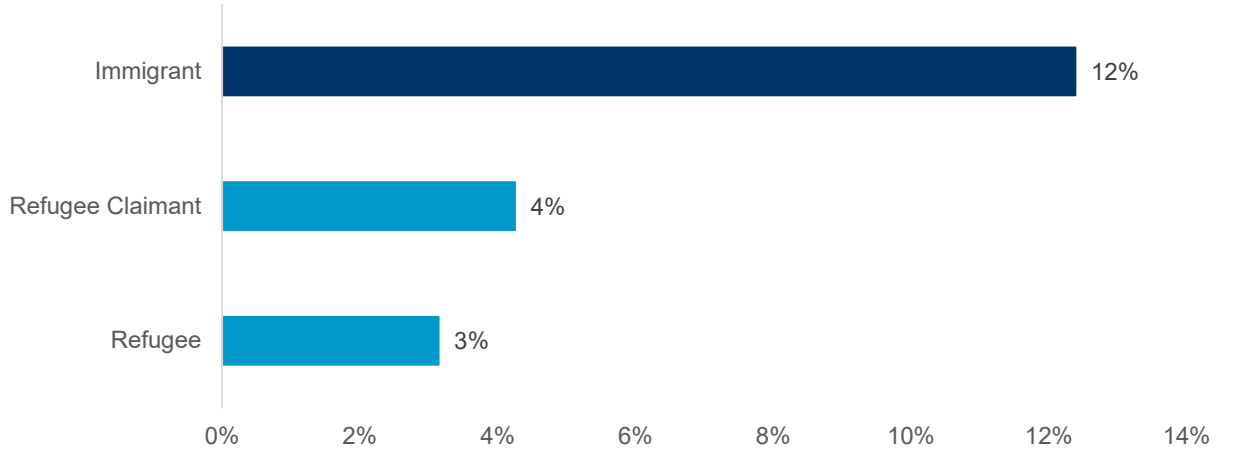
Figure 7: Indigenous Identity of Respondents



Migration to Canada

One-fifth of respondents identified as an immigrant or refugee. A total of 91% reported having been in Canada for one year or more, and 9% reported being in Canada for less than six months.

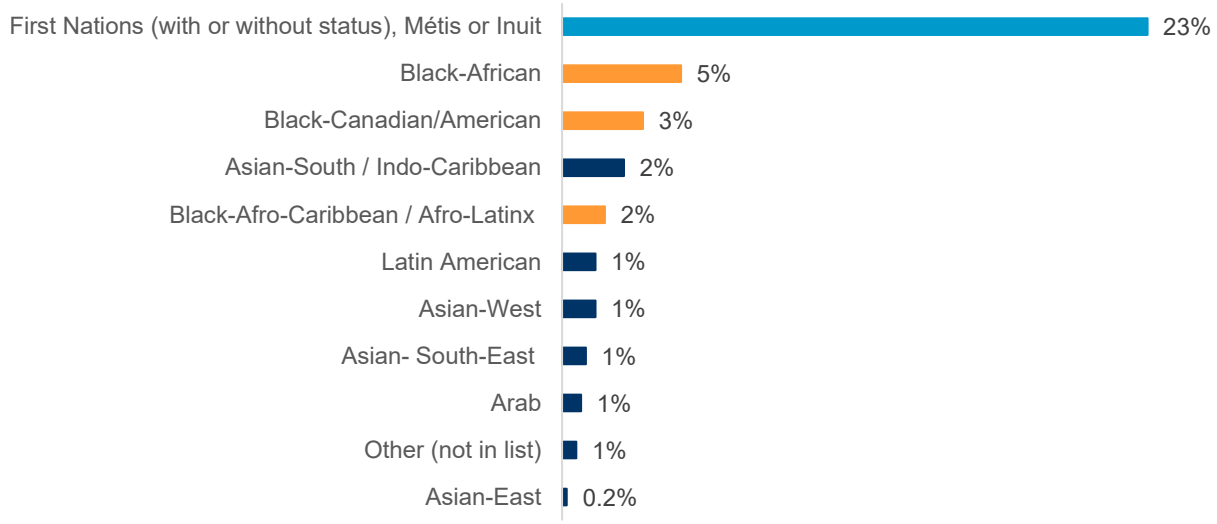
Figure 8: Respondents Migration to Canada



Racial Identity

In 2021, 39% of respondents identified as members of racialized groups, with the largest percentage identifying as First Nations (with or without status), Métis or Inuit (23%). Also, 10% of respondents identified as Black.

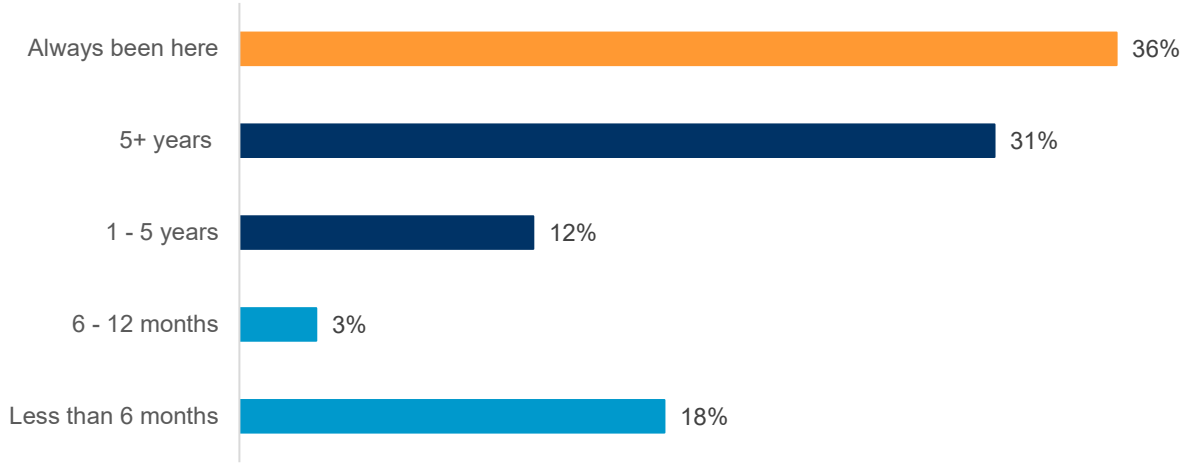
Figure 9: Racial Identity of Respondents



Length of Time in Hamilton

A total of 79% of respondents identified having been in Hamilton for one year or more, including those who reported as always been in Hamilton (36%). 21% of individuals reported being in Hamilton for less than one year.

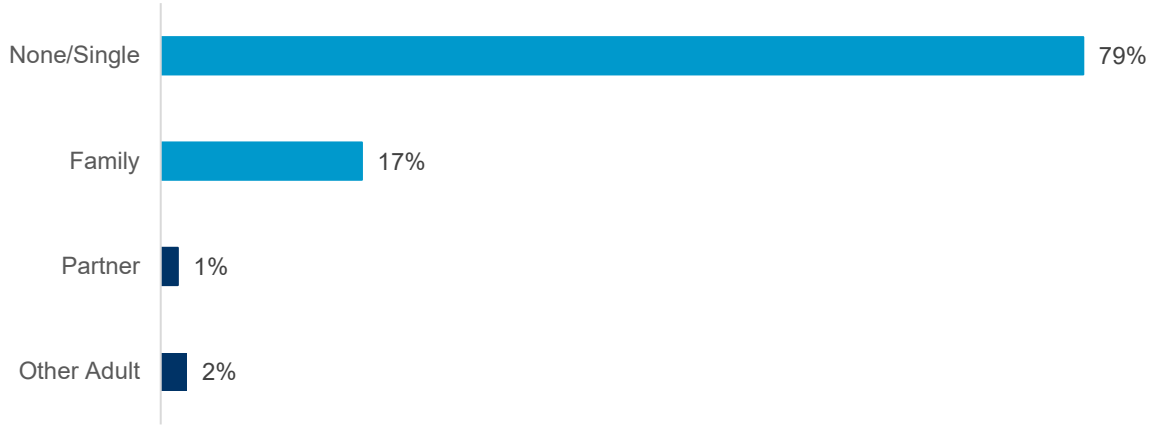
Figure 10: Respondents Length of Time in Hamilton



Family Homelessness

The majority of respondents identified that they were staying alone when surveyed (79%); 21% reported that they had either a partner, other adults or non-adult dependents staying with them that night.

Figure 11: Persons Staying with Respondent on Night of PiTC Survey



Sexual Identity

A total of 10% of respondents identified as 2SLGBTQ+ (Two-spirit, lesbian, gay, bisexual, transgender, queer, questioning, + refers to sexual and gender identities not represented in the acronym). Of those who identified as 2SLGBTQ+ (50), 16% (9) were youth between the ages of 16 and 24.

Figure 12: Sexual Identity of Respondents

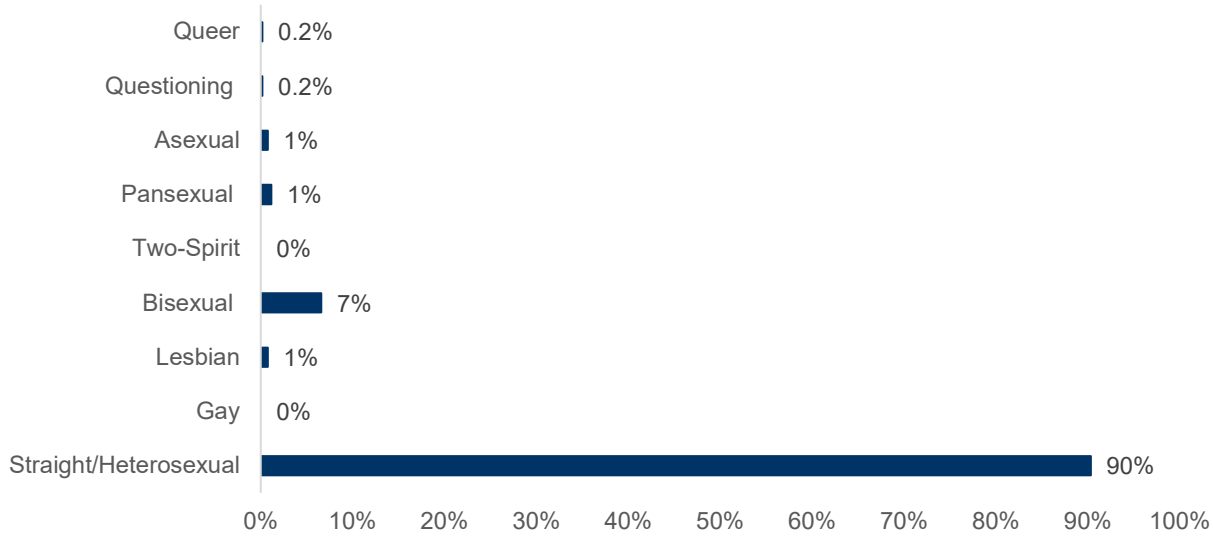
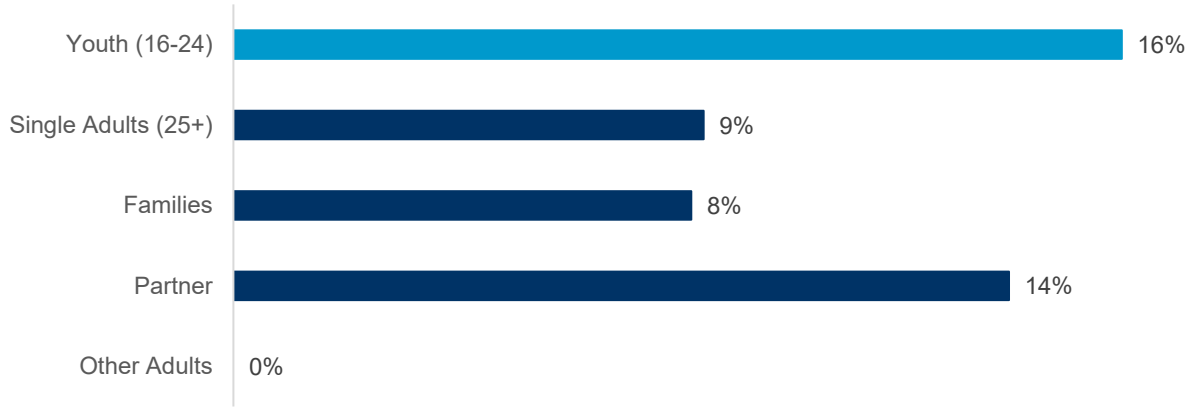


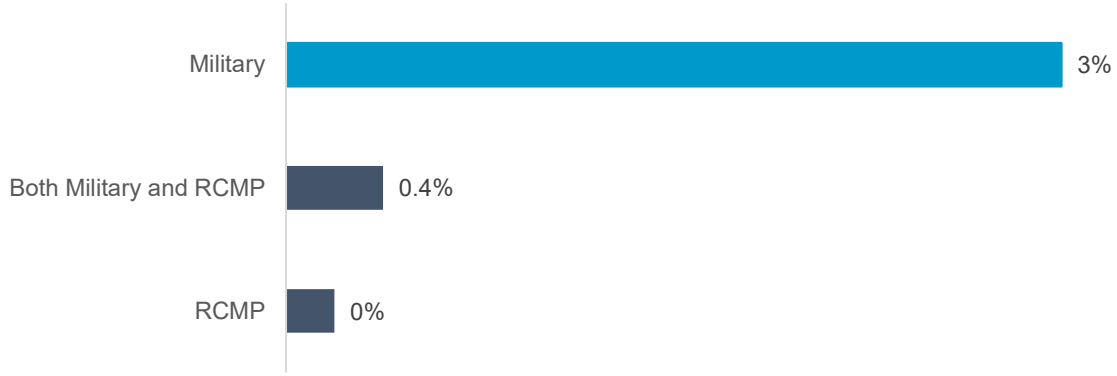
Figure 13: Respondents Identifying as 2SLGBTQ+ by Surveyed Group



Veteran Homelessness

In 2021, 3% of all respondents experiencing homelessness reported having served in the Canadian Military or RCMP.

Figure 14: Respondents Reporting Ever Serviced in the Military or RCMP



Health

Respondents were asked if they had any of the following types of health challenges:

- mental health issue [diagnosed or undiagnosed] (e.g. depression, PTSD, bipolar disorder),
- substance use issue (e.g. tobacco, alcohol, opiates),
- illness or medical condition (e.g. diabetes, arthritis, TB, HIV),
- physical limitation (e.g. challenges with mobility, physical abilities or dexterity),
- learning or cognitive limitations (e.g. dyslexia, autism spectrum disorder, or as a result of ADHD or an acquired brain injury).

A total of 457 respondents identified having at least one health challenge. More than half of respondents indicated having a health challenge relating to mental health (60%)

and substance use (59%). A total of 40% of those surveyed reported having a chronic illness or health condition.

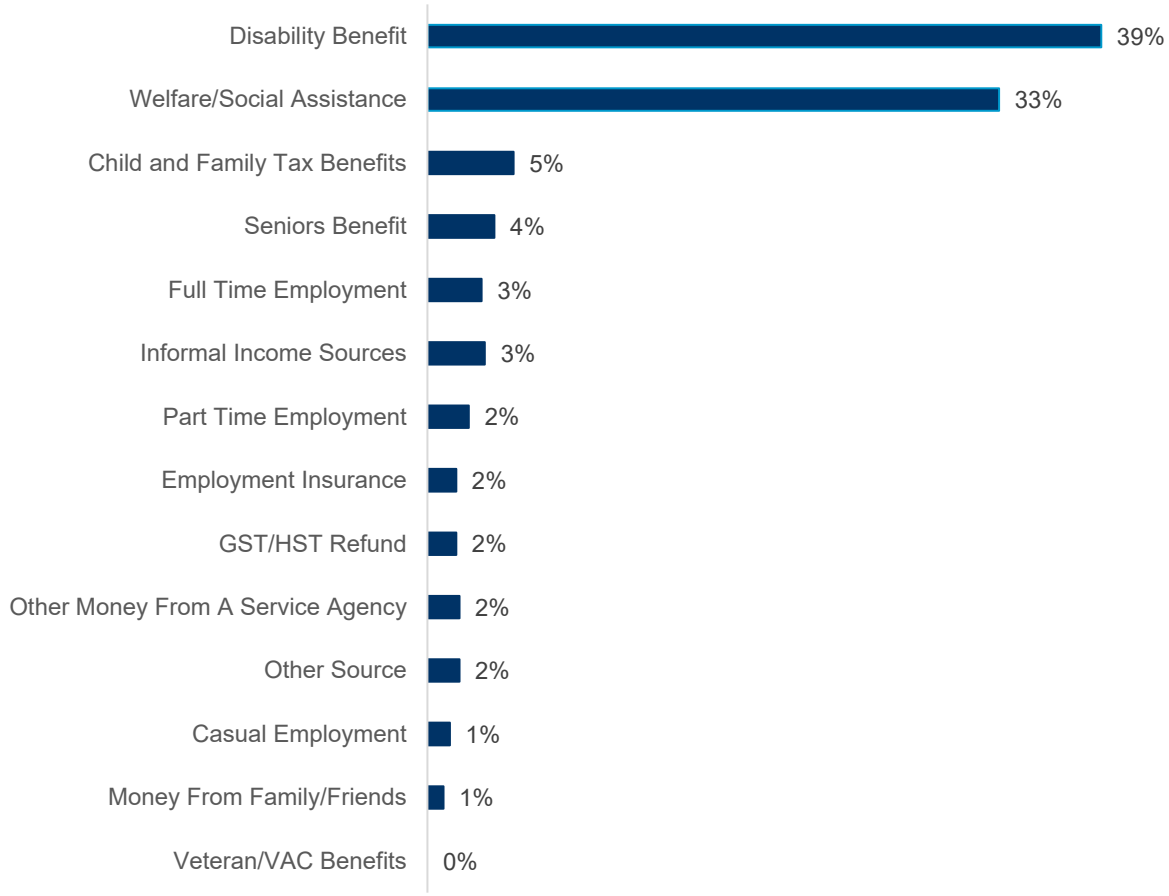
Figure 15: Health Challenges Identified by Respondents

Figure 16: Multiple Types of Health Challenges Identified by Respondents

Sources of Income

The majority of respondents (87%) reported having at least one source of income. The most common sources of income reported in 2021 were disability benefit (39%) and welfare/social assistance (33%). All other sources of income were reported by less than 5% of respondents.

Figure 17: Respondents Source of Income

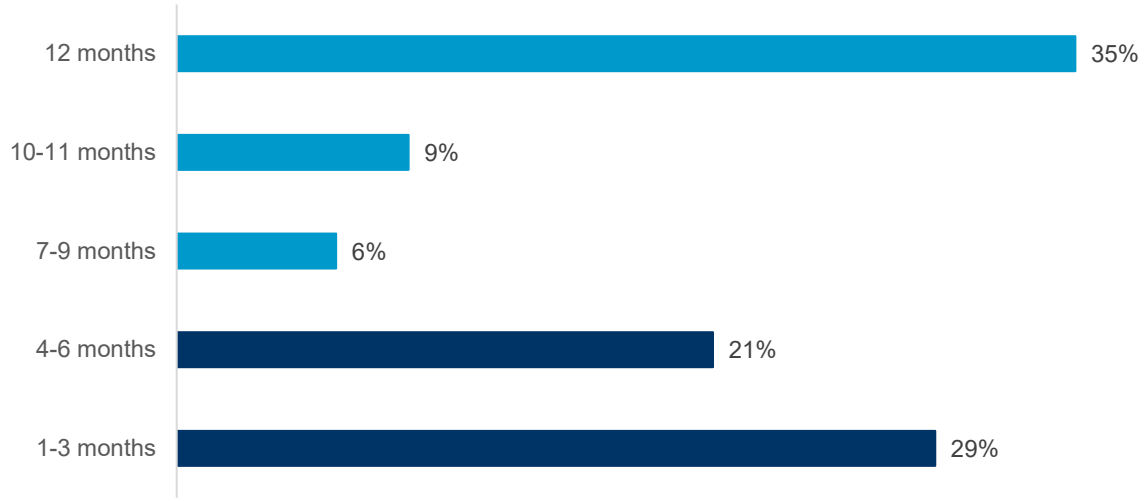


Homelessness History

Length of Homelessness in Past Year

The average reported length of homelessness in the past year was seven months. For the purposes of coordinated point-in-time counts, the federal definition of chronic homelessness is experiencing homelessness for six months or more in the past year. A total of 50% of respondents reported being homeless for more than six months over the past year. 65% of both youth and families identified as being homeless for less than six months in the past year. 57% of single adults identified as being homeless for more than six months in the last year.

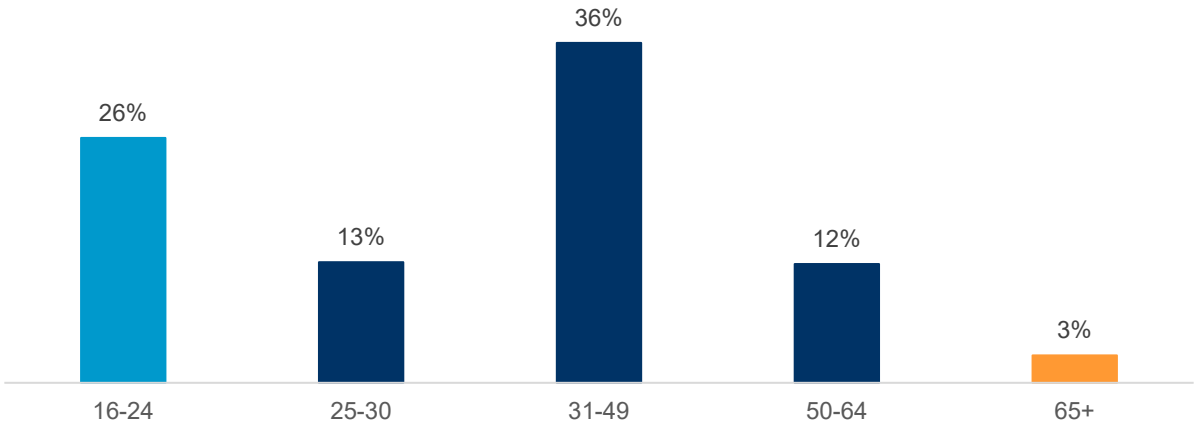
Figure 18: Length of Homelessness in the Past Year



Age of First Homeless Experience

Respondents were asked how old they were the first time they experienced homelessness. A total of 26% of respondents reported being between 16-24 years old the first time they experienced homelessness; 61% were between the ages of 25 and 64.

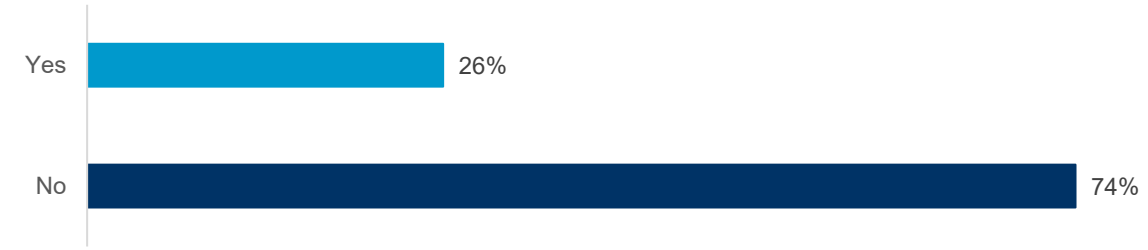
Figure 19: Respondents Age of First Homeless Experience



Experience with Foster Care

A total of 26% of respondents indicated that they had previous experience being in foster care or a youth group home.

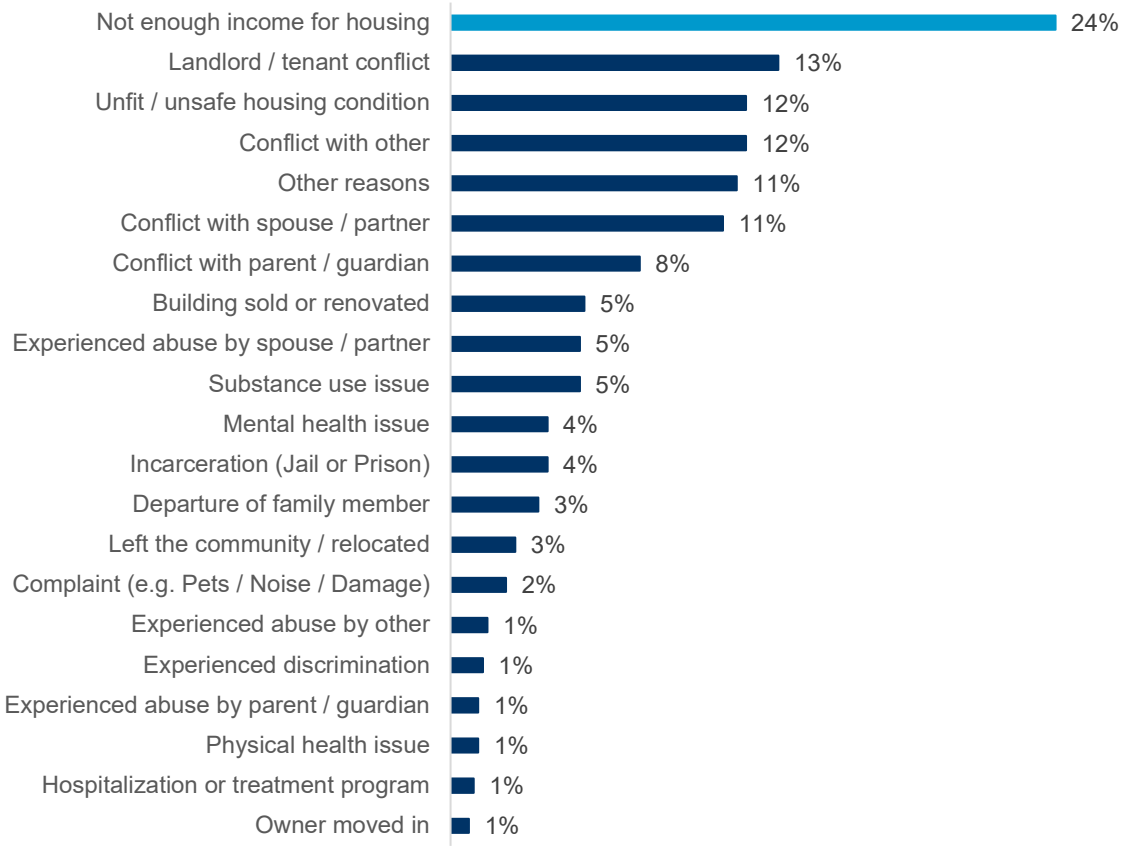
Figure 20: Respondents with Foster Care Experience



Reasons for Homelessness/Housing Loss

When asked what is necessary to maintain and/or find new housing, respondents consistently and clearly identified the need for enhanced income supports and spoke to ongoing challenges with housing affordability. The top reasons for most recent housing loss identified included: not enough income; landlord/tenant conflict; unfit/unsafe housing conditions and conflict with someone other than spouse/partner or parent/guardian.

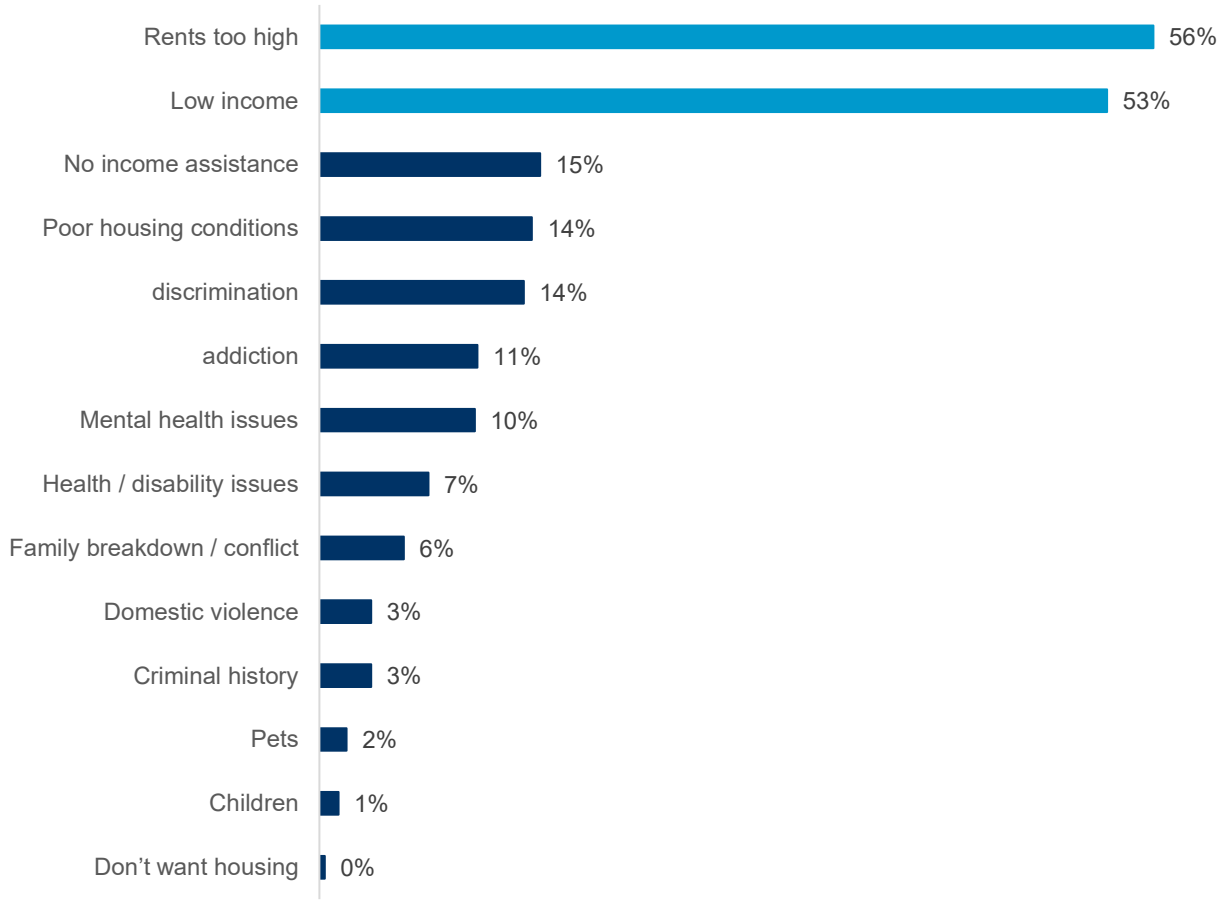
Figure 21: Respondents Reasons for Homelessness



Barriers to Finding Housing

The top barriers and challenges to finding new housing identified by respondents include: rents too high; low income; no income assistance; poor housing conditions; and, discrimination. Additionally, 67 respondents identified having a low credit score as a barrier as well.

Figure 22: Respondents Barriers to Finding Housing

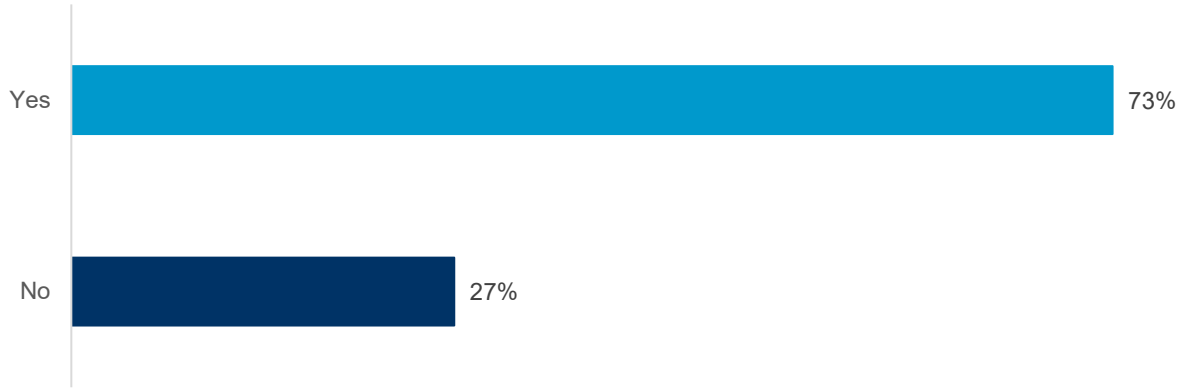


Service Use Patterns

Shelter Use in the Last Year

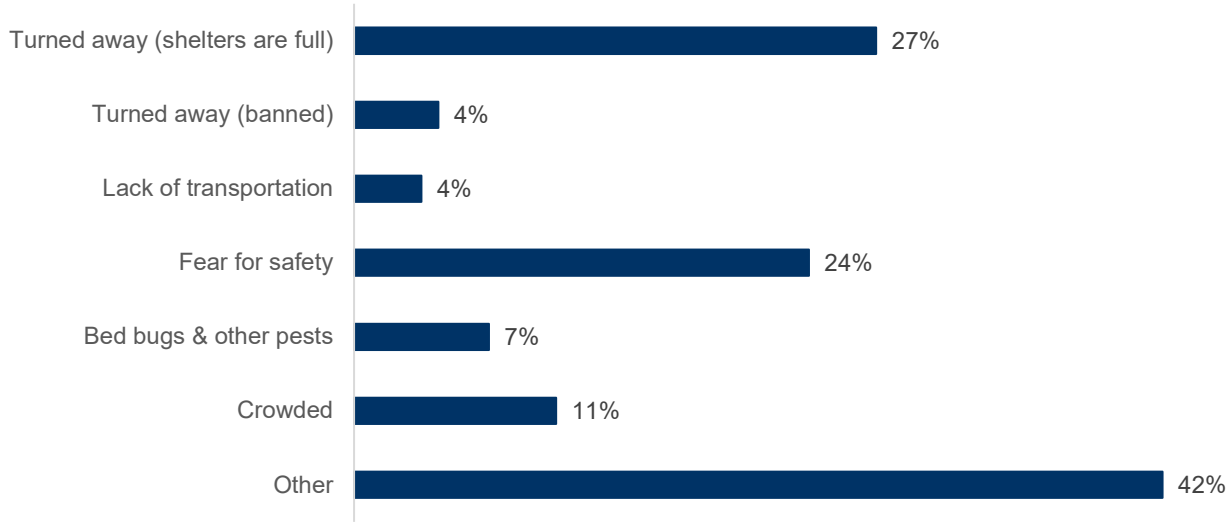
When asked if they have stayed in a shelter in the last year (including emergency and extreme weather shelters), 73% of respondents reported that they had.

Figure 23: Respondents Reporting Staying in Shelter in the Last Year



When individuals were asked about why they decided not to stay in a homeless shelter in the last year, 27% reported that they were turned away because the shelter was full, 24% feared for their safety in a shelter, and 11% expressed concerns about crowding.

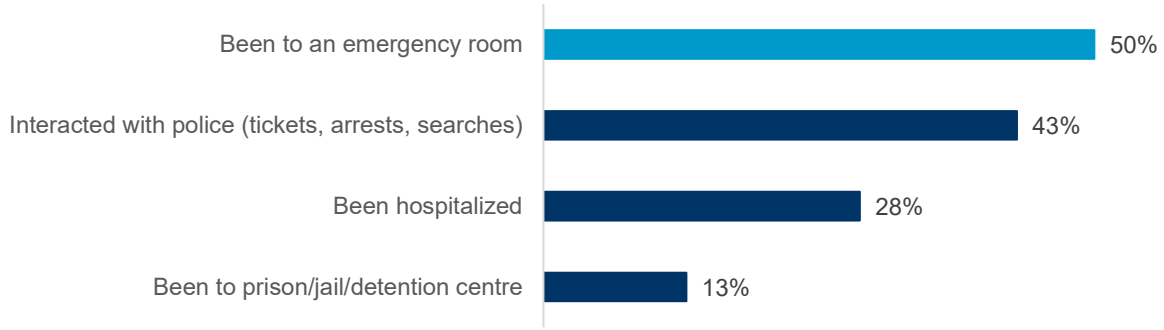
Figure 24: Respondents Reporting Staying in Shelter in the Last Year



Interaction with the Health Care & Criminal Justice System

A total of 270 respondents (50%) reported that they had been to an emergency room (ER) in the last 12 months, with a cumulative total of 787 ER visits. Approximately 61% of those who visited the ER in the last year had been there more than once.

Figure 25: Respondents Interaction with the Health Care and Criminal Justice System



Conclusion and Next Steps

The PiTC remains an important local initiative and a demonstration of Hamilton's commitment to work collaboratively to prevent and end homelessness. As Service System Manager and Designated Community Entity for the provincial and federal funding respectively, the Housing Services Division remains committed to working in partnership with urban Indigenous leadership to build a coordinated housing and homeless-serving system in deep collaboration with community partners to ensure everyone in Hamilton has a home.

In addition, enhanced gender-specific responses and housing options for women, trans-feminine, trans-masculine and non-binary adults remain an important local priority. The Housing Services Division continues to consult with the sector planning tables including the Women's Housing Planning Collaborative, the Street Youth Planning Collaborative and the membership of the Men's Emergency Services Coordination Committee. Through this ongoing engagement and collaboration, it is our goal to continue to share the results and further analysis of the PiTC, while discussing next steps to further centre the voices of unhoused residents in our collective responses.

In the ongoing development and adaptation of systems-level responses, it remains essential that people with living/lived experience are empowered to inform services and hold the homelessness-serving system accountable for delivering on its promise of housing and supports. A distinct focus on Indigenous rights should be prioritized in these efforts, guided by the obligation to respect, protect and fulfil the distinct rights of Indigenous peoples through engagement with unhoused residents. Underpinning further strategic coordination efforts remains the collective obligation to ensure that people experiencing homelessness have access to long-term, adequate housing that meets their needs.

Appendix A: 2021 PiTC Survey

SCREENING TOOL

Hello, my name is _____ and I'm a volunteer for the **Hamilton** Point in Time Connection – a housing needs survey. We are conducting a survey to provide better programs and services to people experiencing homelessness. The survey takes about 10 minutes to complete.

- **Participation is voluntary** and **your name will not be recorded –** participation will not affect the services you receive.
- You can choose to **skip any question** or to **stop the interview at any time**.
- Results will contribute to the understanding of homelessness across Canada, and will help with research to improve services.

A. Have you answered this survey already this week?
[YES: Thank and tally] **[NO: Go to B]**

B. Are you willing to participate in the survey?
[YES: Go to C] **[NO: Thank and tally]**

C. Where did you stay last night? [DO NOT READ CATEGORIES – circle response]

a. DECLINE TO ANSWER b. OWN APARTMENT / HOUSE	**[THANK & END SURVEY]**
c. SOMEONE ELSE'S PLACE d. MOTEL/HOTEL (SELF-FUNDED) e. HOSPITAL f. TREATMENT CENTRE g. JAIL, PRISON, REMAND CENTRE	**C1. Do you have access to a permanent residence where you can safely stay as long as you want?** a. Yes **[THANK & END]** b. No (not permanent AND/OR not safe) **[BEGIN SURVEY]** c. Don't Know **[BEGIN SURVEY]** d. Decline to answer **[THANK & END]**
h. HOMELESS SHELTER (EMERGENCY, FAMILY OR DOMESTIC VIOLENCE SHELTER) i. HOTEL/MOTEL (FUNDED BY CITY OR HOMELESS PROGRAM) j. TRANSITIONAL SHELTER/HOUSING k. UNSHELTERED IN A PUBLIC SPACE (E.G. STREET, PARK, BUS SHELTER, FOREST OR ABANDONED BUILDING) l. ENCAMPMENT (E.G. GROUP OF TENTS, MAKESHIFT SHELTERS OR LONG-TERM OUTDOOR SETTLEMENT) m. VEHICLE (CAR, VAN, RV, TRUCK, BOAT) n. UNSURE: INDICATE PROBABLE LOCATION _____	**[BEGIN SURVEY]**

- You will receive a $15 gift card as a thank you for your participation.

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Survey Number: _____

Location: _____ **Time: _____AM/PM**

Interviewer: _____ **Contact #: _____**

BEGIN SURVEY

1. **Did you have any family members or anyone else who stayed with you last night?** [Indicate survey number for partners. Check all that apply]

☐ NONE
☐ PARTNER - Survey #: ___ ___ ___ ___
☐ OTHER (Can include other family or friends)
☐ DECLINE TO ANSWER

☐ CHILD(REN)/DEPENDENT(S) [indicate gender and age for each]		1	2	3	4	5	6	7	8
	GENDER								
	AGE								

2. **How old are you? [OR] What year were you born?** [If unsure, ask for best estimate]

○ AGE _____**OR** YEAR BORN _____ ○ DON'T KNOW ○ DECLINE TO ANSWER

➔ **For this survey, "homelessness" means any time when you have been without a permanent and secure place to live, including sleeping in shelters, on the streets, or living temporarily with others without having your own permanent housing (e.g. couch surfing).**

3. **How old were you the first time you experienced homelessness?**

○ AGE_____ ○ DON'T KNOW ○ DECLINE TO ANSWER

4. **In total, for *how <u>much time</u>* have you experienced homelessness over the PAST YEAR (the last 12 months)?** [Does not need to be exact. Best estimate.]

○ LENGTH _____ DAYS | WEEKS | MONTHS ○ DON'T KNOW ○ DECLINE TO ANSWER

5. **Have you stayed in a homeless shelter in the past year? For example,** (*COMMUNITY NOTE: Include examples of emergency shelters and extreme weather shelters for interviewers to provide*).

○ YES ○ NO ○ DON'T KNOW ○ DECLINE TO ANSWER

5B➔ If not, what are the main reasons? [Do not read categories; select all that apply)

☐ TURNED AWAY (SHELTERS ARE FULL)	☐ FEAR FOR SAFETY	☐ OTHER: _____
☐ TURNED AWAY (BANNED)	☐ BED BUGS & OTHER PESTS	☐ DON'T KNOW
☐ LACK OF TRANSPORTATION	☐ CROWDED	☐ DECLINE TO ANSWER

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6. Did you come to Canada as an immigrant, refugee or a refugee claimant (i.e. applied for refugee status after coming to Canada)? A5323

○ YES, IMMIGRANT ---------->	**If YES:** **How long have you been in Canada?**
○ YES, REFUGEE---------->	○ LENGTH: _____ DAYS | WEEKS | MONTHS | YEARS
○ YES, REFUGEE CLAIMANT--------->	OR DATE: _____/_____/_____ DAY / MONTH / YEAR
○ NO	○ DON'T KNOW
○ DON'T KNOW	○ DECLINE TO ANSWER
○ DECLINE TO ANSWER	

7. How long have you been in Hamilton?

○ LENGTH _____ DAYS / WEEKS / MONTHS / YEARS	○ ALWAYS BEEN HERE ○ DON'T KNOW ○ DECLINE TO ANSWER
↳ Where did you live before you came here?	○ CITY: _____ | PROVINCE/TERRITORY/COUNTRY: _____ ○ DECLINE TO ANSWER

8a. Do you identify as First Nations (with or without status), Métis, or Inuit, or do you have North American Indigenous ancestry? [If yes, please specify]

○ YES, FIRST NATIONS	○ YES, MÉTIS	○ NO	○ DECLINE TO ANSWER
○ YES, INUIT	○ YES, INDIGENOUS ANCESTRY	○ DON'T KNOW	

8b. In *addition* to your response in the question above, do you identify with any of the racialized identities listed below? [Show or Read list. Select all that apply]

☐ ARAB (e.g., Syrian, Egyptian, Yemeni)	☐ BLACK-AFRO-CARIBBEAN OR AFRO-LATINX (e.g., Jamaican, Haitian, Afro-Brazilian)
☐ ASIAN-EAST (e.g., Chinese, Korean, Japanese)	☐ LATIN AMERICAN (e.g., Brazilian, Mexican, Chilean, Cuban)
☐ ASIAN- SOUTH-EAST (e.g., Filipino, Vietnamese, Cambodian, Malaysian, Laotian)	☐ WHITE (e.g. European, French, Ukrainian, Euro-Latinx)
☐ ASIAN-SOUTH OR INDO-CARIBBEAN (e.g., Indian, Pakistani, Sri Lankan, Indo-Guyanese, Indo-Trinidadian)	☐ NOT LISTED (PLEASE SPECIFY): _____
☐ ASIAN-WEST (e.g., Iranian, Afghan)	☐ IDENTIFY AS INDIGENOUS ONLY
☐ BLACK-CANADIAN/AMERICAN	☐ DON'T KNOW
☐ BLACK-AFRICAN (e.g., Ghanaian, Ethiopian, Nigerian)	☐ DECLINE TO ANSWER

9. Have you ever served in the Canadian Military or RCMP?
[Military includes Canadian Navy, Army, or Air Force]

○ YES, MILITARY	○ BOTH MILITARY AND RCMP	○ DON'T KNOW
○ YES, RCMP	○ NO	○ DECLINE TO ANSWER

10. As a child or youth, were you ever in foster care or in a youth group home (*COMMUNITY NOTE: include any other Provincial child welfare programs*)? [Note: This question applies specifically to child welfare programs.]

○ YES	○ NO	○ DON'T KNOW	○ DECLINE TO ANSWER

11. Do you identify as having any of the following health challenges at this time:

ILLNESS OR MEDICAL CONDITION [e.g. diabetes, arthritis, TB, HIV]	○ YES	○ NO	○ DON'T KNOW	○ DECLINE TO ANSWER

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PHYSICAL LIMITATION [e.g. challenges with mobility, physical abilities or dexterity]	○ YES	○ NO	○ DON'T KNOW	○ DECLINE TO ANSWER
LEARNING OR COGNITIVE LIMITATIONS [e.g. dyslexia, autism spectrum disorder, or as a result of ADHD or an acquired brain injury]	○ YES	○ NO	○ DON'T KNOW	○ DECLINE TO ANSWER
MENTAL HEALTH ISSUE [diagnosed/undiagnosed] [e.g. depression, Post traumatic stress disorder (PTSD), bipolar disorder]]	○ YES	○ NO	○ DON'T KNOW	○ DECLINE TO ANSWER
SUBSTANCE USE ISSUE [e.g. tobacco, alcohol, opiates]	○ YES	○ NO	○ DON'T KNOW	○ DECLINE TO ANSWER

12. What gender do you identify with? [Show list.]

○ WOMAN	○ TRANS WOMAN	○ NOT LISTED: _____
○ MAN	○ TRANS MAN	
○ TWO-SPIRIT	○ NON-BINARY (GENDERQUEER)	○ DON'T KNOW
		○ DECLINE TO ANSWER

13. How do you describe your sexual orientation, for example straight, gay, lesbian? [Show list.]

○ GAY	○ BISEXUAL	○ ASEXUAL	○ NOT LISTED: _____
○ LESBIAN	○ TWO-SPIRIT	○ QUESTIONING	○ DON'T KNOW
○ STRAIGHT/HETEROSEXUAL	○ PANSEXUAL	○ QUEER	○ DECLINE TO ANSWER

14a. What happened that caused you to lose your housing most recently?

[Do not read the options. Check all that apply. "Housing" does not include temporary arrangements (e.g., couch surfing) or shelter stays. Follow up for the reason if the respondent says "eviction" or that they "chose to leave".]

A: HOUSING AND FINANCIAL ISSUES	B: INTERPERSONAL AND FAMILY ISSUES	C: HEALTH OR CORRECTIONS
☐ NOT ENOUGH INCOME FOR HOUSING (E.G. LOSS OF BENEFIT, INCOME, OR JOB)	☐ EXPERIENCED DISCRIMINATION	☐ PHYSICAL HEALTH ISSUE
☐ UNFIT/UNSAFE HOUSING CONDITION	☐ CONFLICT WITH: SPOUSE / PARTNER	☐ MENTAL HEALTH ISSUE
☐ BUILDING SOLD OR RENNOVATED (RENOVICTION)	☐ CONFLICT WITH: PARENT / GUARDIAN	☐ SUBSTANCE USE ISSUE
☐ OWNER MOVED IN	☐ CONFLICT WITH: OTHER (_____)	☐ HOSPITALIZATION OR TREATMENT PROGRAM
☐ LANDLORD/TENANT CONFLICT	☐ EXPERIENCED ABUSE BY: SPOUSE / PARTNER	☐ INCARCERATION (JAIL OR PRISON)
☐ COMPLAINT (E.G. PETS/NOISE/DAMAGE)	☐ EXPERIENCED ABUSE BY: PARENT / GUARDIAN	
☐ LEFT THE COMMUNITY/RELOCATED	☐ EXPERIENCED ABUSE BY: OTHER (_____)	
	☐ DEPARTURE OF FAMILY MEMBER	

☐ OTHER REASON: _____ ☐ DON'T KNOW ☐ DECLINE TO ANSWER

14b. Was your most recent housing loss related to the COVID-19 pandemic?

○ YES ○ NO ○ DON'T KNOW ○ DECLINE TO ANSWER

14c. How long ago did that happen (that you lost your housing most recently)? (Best estimate)

○ LENGTH _____ DAYS | WEEKS | MONTHS | YEARS ○ DON'T KNOW ○ DECLINE TO ANSWER

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15. What are your sources of income? [Reminder that this survey is anonymous. **Read list** and check all that apply]

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☐ FULL TIME EMPLOYMENT	☐ EMPLOYMENT INSURANCE	☐ CHILD AND FAMILY TAX BENEFITS
☐ PART TIME EMPLOYMENT	☐ DISABILITY BENEFIT [Name of PROV. DISABILITY BENEFIT]	☐ GST/HST REFUND
☐ CASUAL EMPLOYMENT (E.G. CONTRACT WORK)	☐ SENIORS BENEFITS (E.G. CPP/OAS/GIS)	☐ OTHER MONEY FROM A SERVICE AGENCY
☐ INFORMAL INCOME SOURCES (E.G. BOTTLE RETURNS, PANHANDLING)	☐ WELFARE/SOCIAL ASSISTANCE [Prov. Benefit]	☐ OTHER SOURCE: _____
☐ MONEY FROM FAMILY/FRIENDS	☐ VETERAN/VAC BENEFITS	☐ NO INCOME
		☐ DON'T KNOW
		☐ DECLINE TO ANSWER

16. In the past year (12 months) have you: [Ask respondents to give their best estimate]

BEEN TO AN EMERGENCY ROOM ---------->	Y ____ N____	# _____ *Times*
BEEN HOSPITALIZED ---------->	Y ____ N____	# _____ *Times*
→DAYS YOU HAVE SPENT HOSPITALIZED		_____ *Days Total*
INTERACTED WITH POLICE (*Tickets, arrests, searches)* ---------->	Y ____ N____	# _____ *Times*
BEEN TO PRISON/JAIL ---------->	Y ____ N____	# _____ *Times*
→DAYS YOU HAVE SPENT IN PRISON/JAIL		_____ *Days Total*

17. What challenges or problems have you experienced when trying to find housing? [Select all that apply]

☐ LOW INCOME	☐ MENTAL HEALTH ISSUES	☐ DISCRIMINATION
☐ NO INCOME ASSISTANCE	☐ ADDICTION	☐ DON'T WANT HOUSING
☐ RENTS TOO HIGH	☐ FAMILY BREAKDOWN/CONFLICT	☐ OTHER: _____
☐ POOR HOUSING CONDITIONS	☐ CRIMINAL HISTORY	☐ NO BARRIERS TO HOUSING
☐ DOMESTIC VIOLENCE	☐ PETS	☐ DECLINE TO ANSWER
☐ HEALTH/DISABILITY ISSUES	☐ CHILDREN	

----------END OF SURVEY – PROVIDE GIFT CARD----------

A1041

THIS IS EXHIBIT “E” TO THE
AFFIDAVIT OF MEDORA UPPAL
AFFIRMED REMOTELY BEFORE ME AT
THE CITY OF HAMILTON DURING A “ZOOM” VIDEOCONFERENCE
IN ACCORDANCE WITH O.REG. 431/20,
ADMINISTERING OATH OR DECLARATION REMOTELY
THIS 17th day of July, 2023

Mohamad Bsat
_____
Mohamad Bsat
LSO NO. 75897L
Commissioner for Taking Affidavits, etc

WOMEN'S HOUSING PLANNING COLLABORATIVE

A5327

SERVICE RESTRICTION FRAMEWORK for SERVICES and SHELTERS serving WOMEN, TRANS, GENDER-DIVERSE AND NON-BINARY PEOPLE

FRAMEWORK	Agencies in this sector serving women, trans, gender-diverse and non-binary people, may, in the most serious of circumstances, find it necessary to place a service restriction or limitation on a service user's ability to access a service or remain in residence. Serious circumstances may include, but are not limited to, any behavior, possession, or threat, that creates harm to staff, community members or other service users leading to an incapacity to manage safety within a communal living setting.
PURPOSE	**The purpose of this framework is to ensure service users are informed of their right to stay engaged in the system and appeal any service restriction with which they disagree.** Service restrictions will be considered through a trauma-informed, gender and equity lens in keeping with the mission, vision and values upheld by WHPC, recognizing the systemic barriers faced by women, trans, gender-diverse or non-binary people, and experiencing intersecting oppressions including, but not limited to, race/ethnicity, substance use, mental health, disAbility, gender identity and sexual orientation. The shelter restrictions outlined should be applied by using best practice principles and good professional judgement of staff and leadership, and consider the context surrounding the incident, unique circumstances, and social location of the individual service user. Service restrictions are not to be used as a punitive measure. This service restriction framework has been recommended to promote the operations of a safe, equitable and accessible environment and was developed to help ensure the safety and well-being of all residents, service users and staff. The service restriction framework will aid in guiding communications and processes be- tween violence against women-focused agencies and those serving women experiencing homelessness, as they intersect. This document will guide communications amongst various women's sector agencies to provide a framework for consistency and best practice in how service restrictions are applied and resolved.
SCOPE	This framework applies to all members of WHPC including those that serve single women, trans, gender-diverse or non-binary people experiencing homelessness and those that provide VAW services.

SERVICE RESTRICTION FRAMEWORK for SERVICES and SHELTERS serving WOMEN, TRANS, GENDER-DIVERSE AND NON-BINARY PEOPLE

TERMS and CONDTIONS	**STANDARDS** Individuals accessing service will be made aware of the service restriction framework as reflected through each respective agency's ability to post where appropriate. All service restrictions issued by shelters must be reviewed by the manager or designate, within a reasonable time. Shelter staff or management must inform the individual of the reason for service restriction at the time of the incident, where it is safe and reasonable to do so or at next contact. Shelter staff will make all reasonable efforts to support the individual with securing an alternate place of safety. Individuals must be advised of appeal process, either at the time of occurrence, or when it is safe and reasonable to do so. **DOCUMENTATION AND COMMUNICATION** Services with the Homelessness Individuals and Families Information System (HIFIS) active at their program site must utilize HIFIS to document the Service Restriction and details as established through the process with the City of Hamilton, Housing Services Division. In cases where HIFIS is not active at the program location, the location will maintain an active service restriction list that includes name of service-user, date service restriction was applied, date service-user was informed of service restriction (if different from the date the restriction was applied), the date service restriction ends, and staff signature. Program Manager or designate will initial entries within a reasonable timeframe. Service users should be made aware of the service restriction by the shelter at the time the restriction is applied, or as soon as it is safe to do to. If an agency becomes aware of a service user's intent or potential to cause imminent risk or danger to others, they shall take reasonable efforts to forewarn the threatened individual(s) with the intent of reducing the risk of threat and danger, respecting relevant guiding privacy legislation.

SERVICE RESTRICTION FRAMEWORK for SERVICES and SHELTERS serving WOMEN, TRANS, GENDER-DIVERSE AND NON-BINARY PEOPLE

RESTRICTION GUIDELINES

Access to a particular service may be limited or denied in the following ways:

1. Postponement Period

A brief unspecified time in which the service user is asked to leave the shelter premises with a view of taking time and space to de-escalate their current behavior. In such situations, the client will be invited to return when they are able to manage within expectations of program.

2. Partial Restriction

Applies to individuals who are restricted from one or more program areas within an organization for a specific time.

Someone may be restricted from shelter bed but able to access other programming as stipulated and approved by the manager or designate.

Where a conflict of interest may occur in a specific service, a service user may not be permitted to access this service until the conflict is resolved. When this occurs and it is safe and reasonable to do so, the manager or designate will advise the individual of the parameters of the restriction and make efforts to support the individual in accessing alternate place of safety.

3. Full Restriction

A service user is denied complete access to the service for a specific length of time.

The timeframe will be determined based on each respective agency's assessment, context and in consideration of the following: pattern of behaviour, threats to safety of staff, threats to others in service, oppressive behaviours, substance use/supply or manufacturing in service, health and safety concerns, property damage or theft.

SERVICE RESTRICTION FRAMEWORK for SERVICES and SHELTERS serving WOMEN, TRANS, GENDER-DIVERSE AND NON-BINARY PEOPLE

4. System Wide Service Restriction

In the case of an individual who has acquired multiple restrictions from a number of locations, the service user or provider with consent will have the opportunity to raise the situation at the WHPC Service Coordination Case Conferencing table consider solutions to the situation.

APPEALS PROCESS

Any service user who has been restricted from service is entitled to appeal a service restriction and/or request the length of the restriction be reviewed. The service user has the right for the appeal to be heard in a timely manner with the decision of outcome clearly communicated to the service user once a timely decision has been reached. Appeals will be heard by the service manager or designate, and outcomes will immediately be shared with all applicable employees and documentation will be updated as required.

All agencies will have a written appeal process that will:

- Include how the service user accesses the appeal process,
- Provide reasonable and accountable timelines,
- Be accessible to service-users,
- And be written through an inclusive, anti-oppressive and trauma-informed lens.

THIS IS EXHIBIT “F” TO THE
AFFIDAVIT OF MEDORA UPPAL
AFFIRMED REMOTELY BEFORE ME AT
THE CITY OF HAMILTON DURING A “ZOOM” VIDEOCONFERENCE
IN ACCORDANCE WITH O.REG. 431/20,
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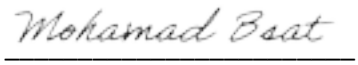

Mohamad Bsat
LSO NO. 75897L
Commissioner for Taking Affidavits, etc

A5332

[in]visible: Single Women's Experiences of Chronic Homelessness in Hamilton

Mary-Elizabeth Vaccaro

August 30, 2018

About the Project:

[in]visible is a large scale qualitative and arts-based research project investigating the experiences and housing needs of women without children in their care, who have been homeless for one year or longer in Hamilton, Ontario. The project worked with community partners in the city including non-profit organizations, advisory boards and researchers.

Recruitment criteria

Woman-identified, 18 years old or older, not currently caring for children and one or more consecutive years of homelessness in the past two years (chronically homeless).

We collected data from a total of 70 unique women.

Project design

We collected data for the [in]visible project three times over a one year period.

Sign up for the Homeless Hub weekly newsletter. Learn more (https://us1.campaign-archive.com/home/?u=61233be4a0bcc87d8977b631e&id=dbc0a7bb5b)

Sign Up

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Narrative Interviews – April – May 2017

Forty women participated in semi-structured interviews, focusing on experiences of housing and homelessness in Hamilton. These interviews were audio-recorded, transcribed and analyzed by the research team and through NVivo software.

Arts-based brainstorming sessions – October-November 2017

Thirty-four women met in groups of 8-12 to participate in arts-based brainstorming sessions.

Over two-hour meetings, women engaged in conversation about findings from the interview data and used artistic mediums (polaroid camera, markers, written word, recorded word, collaging, etc.) to depict what they imagine as ideal permanent housing.

Follow Up Interviews – December 2017 – January 2018

Six women from the original interviews had a follow-up interview, focusing on brainstorming permanent housing options for 'single' women experiencing chronic homelessness based on their own experiences and the findings from this study.

Key Findings from 40 Interviews with Women Experiencing Chronic Homelessness

The findings from this study offer insight into the ways women experience and navigate homelessness throughout their lives. Women's stories illustrate lengthy histories of unresolved homelessness, complex routes into homelessness and gendered-based strategies of remaining invisible while on the streets. This section shares some of the key findings from the forty narrative interviews, focusing on women's experiences of homelessness and housing insecurity in Hamilton.

Sign up for the Homeless Hub weekly newsletter. Learn more (https://us1.campaign-archive.com/home/?u=61233b44a0bc87d8977b631e&id=dbc0a7bb5b)

Women's unresolved and chronic homelessness

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During the interviews, women were asked about:

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1. How many years it has been since they had permanent housing
2. Any historical experiences of housing instability and chronic homelessness

Our findings showed women had experienced long periods of unresolved homelessness, had relied on temporary accommodations, shelters and their own survival techniques.

- 34% of women have been without permanent housing for four years or longer
- 15% of women describe more than 25 years of consecutive homelessness

We also learned that many women had experienced multiple periods of housing instability and homelessness throughout their lives.

- 85% of women have experienced homelessness at another point in their lives
- 48% of women report experiencing homelessness for the first time before the age of 18

Routes into homelessness for women

During the interviews, women were asked about:

- What they believe caused their first experience of homelessness
- What they believe is causing their current experience of homelessness

For women who had been homeless before the age of 18, stories about family violence, involvement with the child welfare system and young motherhood were common.

- 20% of women identified running away from group homes and foster care as one of their first experiences of homelessness

Violence was one of the leading causes of women's chronic homelessness for participants in this study, however it is important to make a distinction between intimate partner violence and the other forms of violence women are experiencing.

- 30% of women described violence outside the context of intimate relationships (family of origin, adult children, roommates, landlords etc.) as the leading cause of their current homelessness
- 25% of women described leaving an abusive relationship as their route into homelessness

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Women described being evicted, coping with the death of loved ones, experiencing floods/fires, losing custody of their children and long-term hospitalization and incarceration as some of the common routes into homelessness.

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incarceration as some of the common routes into homelessness.

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- 45% of women described more than three occasions where they have secured market rent/subsidized housing and end up experiencing eviction

Women's strategies to remain [In]visible while homeless

During the interviews, women were asked about:

1. Experiences of 'sleeping rough' (living outdoors, in tent cities and in abandoned buildings)
2. Any strategies women used to avoid sleeping rough when shelters and other resources were not available

60% of women had spent one or more nights sleeping on the streets

40% of women had always found somewhere indoors to sleep

Throughout the interviews women described the ways they avoided street homelessness when the shelters were full and they had exhausted their financial resources. Common ways women avoided sleeping outdoors include: staying with family and friends, remaining in abusive partnerships, living in their cars, motels or storage units, trading sex, care and companionship for accommodations, staying in bus stations, hospital waiting rooms and fast food restaurants.

Women's Recommendations for Permanent Housing

Women-centred

- 40% of women identified their ideal permanent housing as being women-only.

Our findings show a need to invest in the development of women-specific permanent housing programs, that can support women to live lives free from violence and exploitation.

Mother-specific supports

- 25% of women wanted to secure permanent housing for themselves and their children.

Sign up for the Homeless Hub weekly newsletter. Learn more (https://us1.campaign-archive.com/home/?u=61233be4a0bcc87d8977b631e&id=dbc0a7bb5b)

Responding to women's needs requires developing programs that focus on reuniting women with their children. Recommendations include investing in affordable permanent housing that incorporates unique supports for mothers, such as childcare, children's

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programming and advocacy with child welfare systems.

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Supportive and safe communities of housing

- 75% of women described not wanting to live independently in the community.

Our findings show a need to investigate how models of co-housing, shared accommodations and purposefully building intentional communities could support women in resolving their housing crisis.

Next Steps for the [in]visible Project

Sharing our findings widely

As this is the largest research project focusing on the needs of single women completed in Hamilton, our research team is focusing on widely sharing our findings through conferences, publications and other ways. We created a project video using women's stories and art-work to help convey our findings - please check it out! (https://vimeo.com/247279536/f377a68e50)

Using women's recommendations to develop housing for women

Two partners of our community-based research team, Good Shepherd Centres and the YWCA are in the process of developing housing for women, informed by the findings from this project.

Our research team will be sharing about these developments at the Canadian Alliance to End Homelessness Conference in Hamilton in November of 2018!

If you wish to learn more about this project, please contact Mary-Eilzabeth Vaccaro (mailto:vaccarm@mcmaster.ca).

(https://www.homelesshub.ca/researchmatters/search?tag=22985)

Sign up for the Homeless Hub weekly newsletter. Learn more (https://us1.campaign-archive.com/home/?u=61233be4a0bcc87d8977b631e&id=dbc0a7bb5b)

A1052

English

A5337

Land Acknowledgment (https://www.homelesshub.ca/land-acknowledgment)
COH's Anti-Racism Statement (https://www.homelesshub.ca/resource/canadian-observatory-homelessnesss-anti-racism-statement)
Privacy Policy (https://www.homelesshub.ca/privacy-policy)
Media Room (https://www.homelesshub.ca/about-us/media-room)
Contact Us (https://www.homelesshub.ca/about-us/contact-us)

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A1053

Court File No. CV-21-00077817-0000

ONTARIO

SUPERIOR COURT OF JUSTICE

B E T W E E N:

KRISTEN HEEGSMA et al.

Applicants

-and-

CITY OF HAMILTON

Respondent

SUPPLEMENTAL AFFIDAVIT OF MEDORA UPPAL

(Sworn June 4, 2024)

I, MEDORA UPPAL, of the City of Hamilton in the Province of Ontario, do AFFIRM AND STATE:

Introduction

1. I have personal knowledge with respect to the facts set out below, except where stated otherwise. Where the information is not based on my personal knowledge, it is based upon information provided by others which I believe to be true and credible.

2. In preparing this Supplemental Affidavit, I have reviewed three documents:

   a. the Applicants' Request to Admit pursuant to Rule 51.01 (including attachments), dated May 31, 2023;

   b. the Applicants' Request to Admit pursuant to Rule 51.01 (including attachments), dated August 2, 2023; and

   c. the City of Hamilton's Response to Request to Admit, dated August 23, 2023 (**"Respondent's Response to RTA"**).

3. In this Supplemental Affidavit, I make the following two points:

a. the data collected and reported by the City of Hamilton (**"City"**) *undercount* the demand for shelter services in Hamilton; and

b. the data collected and reported by the City *overcount* shelter bed capacity.

My experience in collecting data on Hamilton's homeless population and shelter capacity

4. Since December 2022, I have been the Chief Executive Officer of the YWCA Hamilton. From September 2011 to December 2022, I was Director of Operations of YWCA Hamilton. As Director of Operations, I conceptualized, developed, and launched Carole Anne's Place (**"CAP"**), a low-barrier drop in for unsheltered women and non-binary individuals in Hamilton that opened in 2016. From 2016 until April 2022, I was the overseeing Director of CAP's staff. From April 2022 until May 2023 , the overseeing Director of CAP reported directly to me.

5. As a senior manager at YWCA Hamilton for many years, I am very experienced in reviewing data on the demand for shelter services and shelter bed capacity to better understand the shelter system and forecast trends in demand. When I was overseeing Director of CAP, I supervised the collection of data on demand for its shelter beds from intakes, and the availability and use of its shelter beds, by staff who reported to me. I was directly responsible for providing this data to the City of Hamilton, and relied on this data in planning and decision-making regarding CAP. After becoming Chief Executive Officer of YWCA Hamilton, I continued to receive and closely monitor this data, and to use it in planning and decision-making regarding CAP, until 2024. Since 2024, the YWCA Hamilton's Vice President, Strategic Initiatives and Program Development has had primary responsibility for monitoring data from, and overseeing planning for, CAP, and reports directly to me on these issues. The YWCA Hamilton's Board of Directors places ultimate responsibility of CAP operations on me as the Chief Executive Officer.

6. From CAP's inception in 2016 until 2019, staff collected data from sign-in sheets that recorded each individual who checked-in to use our services. Staff then entered this information into an organizational database via Excel for record keeping. Moreover, CAP reported these data to the City of Hamilton. However, because CAP did not receive funding from the City, this data was not reflected in the City's official data on homelessness.

7. In 2019, the City started to provide funding to CAP. This funding allowed CAP workers to have clearer reporting data procedures, including the use of the Homeless Individuals and Families

Information System (**"HIFIS"**) to report data to the City. Unfortunately, HIFIS is imperfect and the training staff received was inadequate. In 2019, CAP staff attended a two day training session on HIFIS hosted by the City. When CAP staff asked technical questions about HIFIS, facilitators advised them that this was not the intended purpose of the training. CAP staff provided a written complaint about the training to the City's Department of Housing to advise of her concerns. No additional training was provided.

8. CAP's raw data is more robust and more accurate than HIFIS. HIFIS uses a "point of sale" model, with pre-set fields for entering data, limiting the information collected. CAP provides more than a shower, beds, food, and supplies, but HIFIS does not capture these additional services. Moreover, CAP could not enter case management data into HIFIS, limiting the amount of information available to the City. As a consequence, CAP continued to collect its own data in parallel with inputting data into HIFIS. Moreover, CAP provided its own data to the City on a monthly basis in financial reports which it provides as a condition for City funding. Although the City does not regard CAP as a shelter, it nevertheless uses CAP's data to calculate overall shelter bed capacity in Hamilton on the Housing and Homelessness Dashboard which it posts online.

9. A Master Guestlist was used by YWCA Hamilton to capture all guests at CAP after we switched to HIFIS, from December 2019 until May 2022. In reviewing the Master Guestlist, it is evident that there was an increasing demand for shelter beds at CAP during this time period. For example, in August 2021, up to 598 unique women had stayed at CAP since it opened in 2016. In May 2022, that figure increased to 786 women. 62 of 101 women who stayed at CAP in May 2022 were also on the Master Guestlist in August 2021 – indicating they remained homeless throughout this period. Sadly, three women on the list from August 2021 had died prior to May 2022. Overall, the Master Guestlist reveals that demand for shelter beds at CAP increased during this time period. Moreover, we turned away women most nights during this time period. Since CAP is an overflow shelter – i.e., it accommodates women who cannot access emergency shelter beds – these women were left without shelter.

10. During the COVID-19 pandemic, I worked alongside the Women's Housing Planning Collaborative to gather more data about the growing homelessness problem in Hamilton. Over this period, members of the collaborative worked together and identified 50 women who consistently attempted to access shelter services but were chronically unhoused throughout the year, because

they could not be effectively supported in shelter. For those 50 women, there was no housing or supports available to end their homelessness or to shelter them for extended periods within the existing landscape. Moreover, based on my experience, in my opinion the number of women needing services from CAP and Willow's Place drop-ins who were unhoused was actually much higher than 50.

11. I presented this data to Mr. Edward John, then Director of Housing. I also presented data related to these findings to the Emergency and Community Services Committee of Hamilton City Council on: (a) February 21, 2019, with Amy Deschamps; and (b) November 7, 2019, with Denise Christopherson. The goal of these presentations was for the City to better understand how demand for the shelter and drop-in system exceeded supply, and that more funding was required for women experiencing homelessness.

City's data undercounts the demand for shelter services

12. In my opinion, the data collected and reported by the City *undercount* the demand for shelter services in Hamilton, for *four* reasons. As an illustrative example, I discuss data collection at CAP. However, based on my longstanding experience as a manager in the Hamilton shelter system, I believe these facts to be true of other shelters in Hamilton.

13. *First*, shelters can only report those homeless individuals who come to shelters and identify themselves as homeless. If a person does not come into the shelter or CAP they are not counted. Some homeless individuals do not come to shelters for a variety of reasons, and therefore are not counted. Homeless individuals may have experienced mistreatment in shelters or fears of what may happen to them or their belongings. Sometimes these fears are based on real experiences; in other cases, these fears may reflect underlying mental health issues. Homeless individuals may be unable to follow rules and manage in environments that require communal living and minimal conflict with minimal to no tolerance for violence or aggression. Finally, some homeless individuals may stop coming to shelter, because they have been turned away previously and have concluded it is futile to attempt to access shelter again. I have observed that some of these women sleep outside CAP, for example, on our front window ledges, our building's grates, the sidewalks across the street, and our fire escapes, because they perceive it is safer to be closer to CAP than outside. Moreover, our staff attempt to check on these women, to the extent that our capacity permits.

14. *Second*, shelters can only report data from homeless individuals who have given shelters permission to do so. For example, at CAP, where an individual does not give us permission to share their data, CAP does not include them in the reports sent to the City on shelter demand. As a consequence, those individuals are not reflected in the City's data on the number of homeless persons in Hamilton.

15. *Third*, the data reported by the City only comes from City funded shelters. Since violence against women (**"VAW"**) shelters are *not* funded by the City, the City's data does not include data on shelter demand from those facilities. Since only women can stay in VAW shelters, the City's data on shelter demand therefore systematically undercounts demand for shelters by women, which is higher than the City's data suggests.

City's data overcounts shelter bed capacity

16. The data collected and reported by the City of Hamilton *overcount* shelter bed capacity, for *three* reasons.

17. *First*, not every shelter bed that is reported as "available" is actually available for use on a given night. The reason is that some beds are in rooms with multiple beds, and in some cases, not every bed in a room can be used. It is sometimes unsafe for a complex needs client to share a room with other individuals. A family may use some but not all the beds in a room, rendering the other beds unavailable for other individuals who are not members of the family.

18. *Second*, shelter beds may be physically unavailable on a given night due to maintenance. These maintenance issues include damaged beds (which a shelter may not be able to afford to repair or replace because of a lack of funding) and bed bugs (which requires treatment).

19. *Third*, inadequate staffing on a given night may limit the ability of a shelter to make all its beds available, because of the need for an adequate staff to shelter client ratio. At CAP, inadequate staffing has resulted from high staff turnover rates and limited funding. In addition, inadequate staffing might mean there are not enough staff to turn over a bed vacated by a client in the middle of the night for a new client that same evening.

20. The Respondent's Response to RTA states:

> It should also be noted that the "Shelter Beds Available" data does not exhaustively record the number of shelter beds available within the City of Hamilton. The "Shelter Beds

> Available" data tracks shelter beds and rooms available in the City-funded emergency shelter system. For example, the City provides partial funding for Violence Against Women's (VAW) shelters for women escaping violence, which are managed through the Ministry of Children's and Community Social Services (MCCSS); however the beds available through those shelters are not included in the number of beds in the emergency women's sector. As well, any shelter beds available through charities or non-City funded sources are not counted in the "Shelter Beds Available" data.

21. This statement is highly misleading. If the City wishes to assert that its own data on shelter beds undercount shelter bed *capacity* because it omits VAW shelter beds, it must accept that its own data also undercounts *demand* for shelter beds because it omits demand for those VAW shelter beds. If the City wishes to count VAW beds toward the supply of shelter beds, it would be inconsistent and create a very inaccurate picture to not count demand for those VAW beds, as the City appears to have done.

Sworn remotely by Medora Uppal in the Province of Ontario, before me on June 4, 2024 in accordance with O. Reg. 431/20, Administering Oath or Declaration Remotely.

A. Choudhry

Commissioner for Taking Affidavits

Sujit Choudhry

"Medora Uppal"

Medora Uppal

ONTARIO
SUPERIOR COURT OF JUSTICE

B E T W E E N:

KRISTEN HEEGSMA, DARRIN MARCHAND, GORD SMYTH, MARIO MUSCATO, SHAWN ARNOLD, BRADLEY CALDWELL, CHRISTINE DELOREY, GLEN GNATUK, TAYLOR GOGO-HORNER, CASSANDRA JORDAN, JULIA LAUZON, AMMY LEWIS, ASHLEY MACDONALD, COREY MONAHAN, MISTY MARSHALL, SHERRI OGDEN, JAHMAL PIERRE, LINSLEY GREAVES and PATRICK WARD,

Applicants,

- and -

CITY OF HAMILTON,

Respondent,

This is the Cross-examination of MEDORA UPPAL, on her affidavits sworn July 17, 2023 and June 4, 2024, conducted via Zoom videoconference hosted by the offices of Nimigan Mihailovich Reporting, One James Street South, 7th Floor, Hamilton, Ontario, on August 20, 2024 at 10:00 a.m., with all participants attending remotely.

APPEARANCES:

SUJIT CHOUDRY, ESQ. — For the Applicants
MS. SHARON CROWE
CURTIS SELL, ESQ.
HCLC

MS. NONYE OKENWA
CLCYR

JORDAN DIACUR, ESQ. — For the Respondent
MS. VIVIAN CALDAS
Gowling

TABLE OF CONTENTS

A5344

Page No.

UPPAL, MEDORA: Affirmed

CROSS EXAMINATION BY MR. DIACUR..... 1
RE-EXAMINATION BY MR. CHOUDRY..... 55

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NIMIGAN MIHAILOVICH REPORTING INC.

---Upon commencing at 10:00 a.m.

MEDORA UPPAL: AFFIRMED

CROSS EXAMINATION BY MR. DIACUR:

1. Q. Ma'am, would you state your full name for the record please.

A. Medora Uppal.

2. Q. Would you spell your last name please.

A. U-P-P-A-L.

3. Q. Thank you. I'm going to have some questions for you about the two affidavits that you've provided in this matter; the first, July 17, 2023, and the second, June 4, 2024. I'm going to be able to put those up on the screen and show you references when I ask you questions about particular parts of those documents, but I wanted to ask you before we began whether you have a copy of those documents handy, either a hard copy or electronically?

A. I have hard copies in front of me.

4. Q. Do you have any other notes or anything else with you?

A. No.

5. Q. Where are you signing in from today?

A. 75 MacNab Street South, the YWCA

NIMIGAN MIHAILOVICH REPORTING INC.

Hamilton building and I'm in my office.

6. Q. Okay. And nobody else is present with you?

A. No one else is here, no.

7. Q. Thank you. So, ma'am, what do you understand your role is in this litigation?

A. I understand I'm a witness.

8. Q. Do you understand your role is providing fact evidence or opinion evidence?

A. I understand I'm providing fact evidence.

9. Q. To the extent that there is any opinion in your affidavits, we can disregard that?

A. What's presented in my affidavit, from my point of view, is facts.

10. Q. I'm going to put up on the screen your first affidavit, as I said, that was the July 17, 2023 affidavit. You do say in the first paragraph that you have personal knowledge with respect to the facts set out below, but there are several references in this affidavit, I'll take you to one of them, paragraph 13, the last sentence you say, "I adopt this report," and we'll get to it, what that report is, but you say, "I adopt this report as part of my opinion in this matter." When

A1060

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you say opinion there, what do you mean?

A. So I mean that that is part of my perspective, the information I'm sharing, so I'm using the information from the research findings that I was part of helping to develop as part of the rationale for the information I'm providing.

11. Q. To be clear, though, you've not been qualified in the past by any court in Ontario as an expert witness?

A. Correct.

12. Q. And you've not signed or provided an acknowledgement of expert's duty, sometimes called a Form 53 in this matter, correct?

A. Correct.

13. Q. So I would like to turn to paragraph 9 of this first affidavit, the July 17, 2023 affidavit, it's under the heading, "Women's Shelter System in Hamilton."

A. Okay.

14. Q. You say in this paragraph, "There were frequently no shelter beds for women who needed them." You say, "Despite best attempts to provide accommodation, there were frequently no shelter beds for women who needed them." Are you referring to the situation before Carol Anne's

A5345

Place existed at this point in your affidavit?

A. I'm referring to both when Carol Anne's Place existed and after Carol Anne's Place existence.

15. Q. So before and after?

A. Yes.

16. Q. Okay. And you say frequently, so sometimes there were sufficient shelter beds available for women in Hamilton, all women who are seeking such shelter, even before Carol Anne's Place opened, is that right?

A. Yes, there would be times when that would have occurred. Yes.

17. Q. If we go through to paragraph 14 of your affidavit, you state that, "The increase in demand for shelter for women from 2019 onwards is clear. From December 2018 to March 2019, Carol Anne's Place supported 260 unique women."

A. Yes.

18. Q. So that's a four-month period; December 2018 to March 2019?

A. Yes.

19. Q. And then you state, "We reopened December 2019, and up to March 2022, Carol Anne's Place supported 660 unique women." If I'm counting

correctly, that's a 28-month period, is that right?

A. Yes, that's a longer period of time.

20. Q. So to support your assertion that an increase in demand for shelter for women from 2019 onwards occurred, you state that in the four months from December 2018 to March 2019, Carol Anne's Place supported 260 unique individuals, and then you state that in the 28 months from December 2019 to March 2022, Carol Anne's Place supported 660 unique individuals. Do I have that correct?

A. Correct.

21. Q. So if 260 unique individuals were seeking assistance in a four-month span and 660 received assistance in a 28-month span, doesn't that indicate that there was a decrease in demand over time?

A. No, because there's more homeless women who were seeking our services than were previously. So instead of 260 women, we had 660 women seeking out services from us who were supported during that period.

22. Q. I understand that, but we are talking about a span that's seven times longer in the second instance where there's 660 unique women served but only two and a half times as many women

received assistance. That's correct, right?

A. That's correct. That's correct that during the shorter period we saw less women, and when we were open longer, we did see more women seeking service. But overall, we saw an increase in the number of women who were seeking service from Carol Anne's Place, recognizing that we saw more women who were homeless, that's what we saw; more women who were homeless than we had seen before. We could've seen 260, we could've seen 300 throughout that whole period if there was no increase in homelessness. There was an increase in homelessness, so we saw 660 women. That number today is higher.

23. Q. The principal goal in supporting women who are using an emergency shelter is to get them into permanent housing, is that correct?

A. Yes.

24. Q. And that does happen?

A. Yes.

25. Q. It happens regularly, would you say?

A. I couldn't say what -- it depends what "regular" means to you. It certainly happens less now than it did previously.

26. Q. If we move to paragraph 15 in your

A1061

affidavit, you reference a number of turn aways. You say, "In the 28 months from December 2019 to March 2022, 636 turn aways occurred." Those aren't 636 unique individuals, correct?

A. No.

27. Q. Is there a reason that you used "unique individuals" when counting who Carol Anne's Place assisted but now you're stating a cumulative total of all instances of turn away?

A. So when we document the individual women who come in to Carol Anne's Place when we do turn aways, we aren't necessarily documenting the unique individual. So we know how many times we turn people away, but we don't have a number of how many people are contained within that 636.

28. Q. So why isn't that something that's tracked? It seems like it would be important.

A. It's our staffing capacity, we don't have the resources to do that, and we don't always -- and the other qualifier here is that we don't necessarily document the name or seek all the information if we don't have a bed. We don't then proceed to ask all the questions that we would typically ask.

29. Q. So there is an uncertain number of

A5346

unique individuals who were turned away over this period?

A. Yes. I don't have documentation of who the unique individuals were who were turned away.

30. Q. And so you're not aware of whether any or all of them sought shelter elsewhere before or after coming to Carol Anne's Place, correct?

A. No, I would know if some of them had sought shelter. If we -- sorry, let me be clear. We know the names of the women who are unsheltered in the community, certainly not every woman, and we can identify and we do have communication with the other shelters around where those women are and if they have gone to those places. So there's information available, I can certainly characterize who are unsheltered women in the community, we have information about those. But, no, those 636 specifically in the affidavit, I couldn't name those individuals for you or say where those individuals have gone.

31. Q. So you have the ability to track certain people when they identify themselves, but since it's not something that Carol Anne's Place tracks when there is a turn away, you're not aware

and could not, in fact, be aware whether any or all of them had sought shelter elsewhere before or after coming to Carol Anne's Place, is that right?

A. I don't think that's accurate.

32. Q. I'm confused. You're saying that it's not something that you track, who these individuals who were turned away are, but you are saying that you are able to find out whether or not these people, who you do not know the names of or do not keep records on, can be tracked in some way about where else they have gone?

A. Let me explain -- let me give some clearer information. So we understand -- we have a number of women we know to be unsheltered in the community, we have their names, we have a list of those individuals. We communicate with the other women's shelters and drop-in programs, we are able to -- we understand who some of -- where some of those women are, where some of those women are going. When we're doing turn aways, we know that some of those women are in that turn away number. So, you know, how many times we turned her away and how many -- those women are represented in that 636, I couldn't explain to you, but do I know who some of those women are? Do I know where they have

been, where they have gone, whether they are sheltered now or housed now or unsheltered, some of that information would be available. So we would know that -- some of the women we do know and we track and we can identify are contained within that 636. How many times they are represented, I couldn't tell you.

33. Q. All right. Paragraph 20 of your affidavit, I'll scroll down to it, this is the Point In Time count that's attached as Exhibit D to your affidavit. The report at Exhibit E, which I will flash forward to here, is dated April 2022, prepared by the City of Hamilton, but it's results dating back to 2021, is that right?

A. Correct.

34. Q. At that time, if we scroll through to page 5 of the report -- no, that's page 6. So there's two different numbers, there's page 5 of 29 at the top and at the bottom it's numbered page 4.

A. Okay.

35. Q. Just for the record, I'm talking about page 5 of 29 at the top, top right. There's a reference here, it says, "Snapshot of homelessness in Hamilton on November 19th, 2021," is that the end date of Point In Time count that is

A1062

referenced in this report?

A. I don't know, it might be. I have to review the report.

36. Q. Okay.

A. I didn't create this report.

37. Q. I understand. But you say that you adopt its findings. So the snapshot of homelessness in Hamilton on November 19, 2021, the first bullet point is, "Shelters were at 93 percent capacity during the period November 15-19, 2021." To your knowledge, is that a correct statement?

A. That's the information I'm reading in front of me. That was what was reported by the City.

38. Q. So you would agree that, at that time, there was capacity in the City funded shelter system?

A. That's possible, yes.

39. Q. Well, if it's 93 percent---

A. On that day, yes.

40. Q. In that period---

A. Yes.

41. Q. ---if it's 93 percent full, then it's seven percent empty, is that fair?

A. Sure, I could agree with that. Yes.

A5347

42. Q. If we go to page 7 of this report and, again, this is page 7 of 29 in the top right-hand corner, there's a figure, Figure 2, it says, "Monthly shelter bed usage and max capacity by month." Can you see that?

A. Yes.

43. Q. And you can see that the orange line there is shelter bed capacity and the black line is shelter bed usage. Is that accurate?

A. Correct. Yes.

44. Q. And if we look at those two lines as they proceed over time, we can see that in or about March of 2020, shelter bed capacity exceeded shelter bed usage and that remains true until the end of period of the report in November of 2021, is that accurate?

A. Yes.

45. Q. I'm going to go back to your affidavit in just a moment cause there's no simple way to click back to it. I'm going to go to the Table of Contents and click down. After paragraph 20 in your affidavit, in fact, after paragraph 21, beginning in paragraph 22, there's a number of paragraphs that fall under the heading, "Violence Against Women," can you see that?

A. Yes.

46. Q. Over these several paragraphs beginning with paragraph 22 of your affidavit, you discuss a number of different criminal acts that you've been aware of occurring outside of Carol Anne's Place and you reference assaults, sexual assaults, the use of air mace, breaking and entering, carrying of weapons and a death threat. Is that accurate?

A. Correct.

47. Q. Are there any other crimes that you're aware of having occurred outside of Carol Anne's Place? And I'll scroll down now.

A. Yes, I just had one reported this morning.

48. Q. What was that?

A. The security guard's car was lit on fire and I have photographs of it, and also another car of a staff person was damaged.

49. Q. Is that a suspected arson or an accident?

A. Arson. Suspected arson.

50. Q. That's why I qualified. Lawyers have to say alleged or suspected, I understand that. So that's the most recent, is that right?

A. Yes, that's this morning. That happened overnight, yes.

51. Q. Understood. It might've been yesterday, it might've been today. Is there anything else to add to that list in terms of criminal acts that you've become aware of occurring outside of Carol Anne's Place?

A. No, there's more than that. Yes.

52. Q. What would you add to that list?

A. So I'm aware of drug trafficking, I'm aware of -- I've been told reports of human trafficking, there was a -- these are outside of Carol Anne's Place, these are not---

53. Q. I'm clear on that. That's the question---

A. Yes.

54. Q. And you're clear in your affidavit on that as well. I'll acknowledge it's outside.

A. Yes. A man was stabbed and died right on the street in front of the building. He was assisted by -- our staff tried to provide first-aid CPR to him. He was stabbed in the heart and died. There have been other incidents of violence around. I met with the police chief last week and I've talked to the police different

A1063

periods of time, confirming that there are incidents of criminal activity around the building. We have -- I'm trying to think. There's so many incidents that go on out of harassment and violence around and we're reporting fairly regularly and contacting the police. So right now, off the top of my head, those are two things that are coming to mind, but there are more incidents than that.

55. Q. Okay. And you did mention the police. In circumstances where a crime is known to have occurred outside of Carol Anne's Place or witnessed, is it Carol Anne's Place staff's practice to contact the police and report it?

A. Yes, it would be.

56. Q. And the police have responded to those calls?

A. For the most part, yes.

57. Q. Are there instances where the police didn't?

A. I wouldn't say they didn't at all. There were early in Carol Anne's Place -- early in the pandemic, I'm sorry, when we were calling and they were not attending to the scene while the incidents were occurring or we were waiting for a response back. Those issues had been addressed by

A5348

the police and I would say they're overall very responsive to us now.

58. Q. In paragraph 30 you mention that the Hamilton Police developed what's called a Problem Oriented Policing Project or POPP for the area. Is that still true?

A. That's true. I don't know if they call it a POPP now what they're doing, but they have more support that they provide here and are more actively involved.

59. Q. Understood. So the name may have changed, but the policing -- or increased policing in the area hasn't changed?

A. Yes.

60. Q. If I scroll down to paragraph 33 of this affidavit, you state, "There is not a uniform shelter restriction policy for women's shelters in Hamilton."

A. Yes.

61. Q. I understand the City of Hamilton does have a policy regarding shelter restrictions, are you drawing a distinction between that and ones specifically for women's shelters?

A. Correct. So there's the shelter restrictions that were developed for the men's

shelter system and then---

62. Q. I understand.

A. Yes.

63. Q. So it's not a one-size-fits-all policy, is what you're saying?

A. It doesn't apply at all to the women's shelters. So the women's shelters developed a restriction protocol framework, I think we call it framework in there, and -- yes, so we developed that and then the City was certainly involved in discussions around that, but it's not a City shelter restriction framework, it is our own. And more recently, the City has released a shelter restriction protocol more recently, but we haven't discussed that at the Women's Housing Planning Collaborative.

64. Q. Understood. You'd agree that service restrictions are sometimes necessary to maintain the safety of staff and others inside a shelter, correct?

A. Correct.

65. Q. Staff are entitled to a safe work environment?

A. Correct.

66. Q. I'd like to look at paragraph 40 of

your first affidavit for a moment. I'll put that up on the screen next. This comes after a subheading, "The System - Design and Intent."

You start here discussing the design and intent of the shelter system, but to be clear, and this is the discussion we had at the outset, you're giving your opinion here about those two subjects; the design and the intent of the system?

A. I've been fundamentally involved in the design of some of our women's shelters in Hamilton. I oversaw Good Shepherd Women's Services and the design of both Martha House and Mary's Place in its new site in iteration when we moved in 2010 or 2009, and I had developed the -- Carol Anne's Place from its concept to its inception, and also the transitional living housing program, which is part of the homeless system here at YWCA, I have also developed the program and the design of that, and then, as well, Phoenix Place, which is our second stage VAW shelter in -- which we -- YWCA operates and runs. I also informed the design and development.

67. Q. And these statements in these paragraphs are based on that?

A. So -- yes, these statements and the

A1064

paragraphs are based on my knowledge of the women's shelter system from what I informed and designed as well as from my collaborations in discussions with other women's shelters through the Women's Housing Planning Collaborative.

68. Q. Understood. If we scroll down to paragraph 44 of your affidavit, you say, "There are women and gender diverse people in Hamilton who have limited or no access to shelter or overnight beds." My first question is, who are we talking about here? Any specific individuals?

A. Yes, there are specific individuals who would fit into this.

69. Q. And you're speaking about them generally?

A. Generally, yes.

70. Q. What's the basis for stating limited or no access? Is it limited or is it nonexistent?

A. There is some fluidity to this. So for some women, they'll go through periods where they cannot access any women's shelter or drop-in service. There are times where -- that restrictions will be limited to a particular period of time or a particular shelter or a number of particular shelters. So, for example, there might

A5349

be a woman who accesses Carol Anne's Place and that is, in fact, the only shelter or drop-in that she can access overnight because everybody else is service restricted or likewise. There could be service restriction on her at Carol Anne's Place and then Willow's Place or another program is the only place she can attend.

71. Q. So this is partially due to service restrictions, the fluidity between limited access or nonexistent access?

A. So the limited access, those would be service restriction related, and then the other side of that is when all the beds are full and this -- so when all the beds are full and all the spaces taken, there can be because of capacity as well. So capacity can be a limitation and then the other side of it is service restrictions could also be a limitation.

72. Q. Okay. If we go to paragraph 45 of your affidavit, this is where you refer to the Invisible Project---

A. Yes.

73. Q. ---and attach a copy of that at Exhibit F. You state, "I adopt the Invisible Project as part of my opinion in this case." If we

go through to Exhibit F, click down to it, it states that it's a qualitative and art's based research project, what does art's based mean in this context?

A. There was a video that they had done as part of this project and so the researcher used our component to provide and present the information.

74. Q. It's art based as opposed to a study based and a scientific method?

A. I'm not a researcher. There's different methods of research that I'm aware of in the work I do with researchers, so this is one type of research that has validity within a research sector.

75. Q. And it states on the first page of the Invisible Project report, "We collected data from a total of 70 unique women," it's there in italics, do you see that?

A. Yes.

76. Q. Were all of those 70 women seeking assistance from Carol Anne's Place?

A. No.

77. Q. Do you know, was there -- were there records kept of whose those 70 women were?

A. My understanding is that there's a record of those.

78. Q. Do you know what survey method was used?

A. The researcher did interviews.

79. Q. Do you know how the survey group was selected?

A. It was based on -- I believe it was based on who presented themselves. I'm sorry, I don't want to speculate because I don't have that information in front of me.

80. Q. It's just not clear to you how that was done?

A. I'm aware that there were interviews and people voluntarily came forward if they were staying in the Good Shepherd or YWCA, and so they were invited to come forward, offered an opportunity, and so I know that's how the interviews were conducted, but I don't have more information about the process.

81. Q. Understood. If I scroll down to page 4 of this document, there's a number of Women's Recommendations For Permanent Housing, do you see that heading there?

A. Yes.

A1065

82. Q. The first subheading is, "Women's Centre," it says, "Forty percent of women identified their ideal permanent housing as being women only." Is that a realistic goal in your experience?

A. It's not realistic in that there are very few women's housing only -- permanent women's housing only locations in Hamilton. We built one of them, but there aren't that many and there are transitional housing that are women only.

83. Q. When you say you built one of them, what are you referencing?

A. YWCA, Putman family YWCA on Ottawa Street.

84. Q. Understood. How many spaces does that have?

A. Fifty apartments.

85. Q. When did that open?

A. 2021 or 2022. I should know this date offhand, but admittedly---

86. Q. That's fine.

A. Okay.

87. Q. If I scroll down to page 5 of this document, the Invisible Project still, there's a subheading, "Supportive and Safe Communities of

Housing," can you see that there?

A5350

A. Yes.

88. Q. It states, "75 percent of women described not wanting to live independently in the community." Is that a reason that you have seen individuals cite in declining an offer of housing?

A. No, I can't say that is.

89. Q. But certainly this report indicates that as many as 75 percent of the respondents said that they did not want to live independently in the community?

A. That's what it says, yes.

90. Q. I'm going to return back to your first affidavit now. I'm going to have to go through the process of clicking through it from the index again. It's paragraph 47 that I'd like to look at now, which I'll scroll to. It's on the screen now. Do I understand that there are individuals who will refuse to enter any shelter no matter when or whether one is available to them?

A. Yes.

91. Q. That's correct?

A. Yes.

92. Q. At paragraph 49 you indicate that, "For some women, women's shelters and/or drop-ins

feel too invasive, unsafe and they feel put them at risk," is that correct?

A. That's correct.

93. Q. Is CAP invasive or unsafe? I should say Carol Anne's Place.

A. It depends on your perspective and your experience and the realities -- your social context. So for some women, it can feel unsafe and it can feel too invasive. There's lots of people in Carol Anne's Place. We have up to -- right now we have up to 70 women and gender diverse people a night. That's a lot of people. The safety -- people are presenting with very different issue. Sometimes there are incidents of violence that occur.

94. Q. There are incidents of violence that occur even within Carol Anne's Place?

A. Yes.

95. Q. So at paragraph 58, I'm going to skip down to that for a moment, you reference women actively trying to use space around the YWCA building to create temporary homes or beds. You also say that women have told staff that they can create more secure and comfortable spaces in tents. Is that something that, in your experience, is

actually possible?

A. I believe that the women believe that that's possible when they're saying it. They're reporting it. I don't have the experience of living in tents. I couldn't speak to what that would be like and I trust that when they represent their interests and what's safe and secure for them, I trust and believe in what they say.

96. Q. I understand you believe that these women believe it, but in your experience, is a tent -- staying outside in a tent safer than staying in an indoor space like Carol Anne's Place?

A. I think, again, that the experience -- their experience of safety says that that does feel safer at times, and I would still invite them in and talk to them about how could we create more safety but recognize that -- sometimes we can't create the conditions that would allow women to feel safe.

97. Q. Sometimes you can't create the conditions that would help them feel safe?

A. Yes.

98. Q. Certainly there are fewer crimes that occur within Carol Anne's Place than just outside it?

A1066

A. Absolutely. There's containment, yes, within Carol Anne's Place.

99. Q. I just want to scroll up briefly to paragraph 54 in your affidavit. You mention that Violence Against Women's shelters funding is managed through the province and homelessness shelter funding was downloaded to the municipalities, do you know when that occurred, when that downloading occurred?

A. I couldn't say off the top of my head.

100. Q. Was it recent or was it a long time ago?

A. My understanding it was some time ago.

101. Q. Okay.

A. Certainly in my time, the responsibility for municipalities -- for homeless and shelters has been on the municipalities while I've been in management in the sector, so it's been a number of years.

102. Q. And that's since 2011 if I understand it right?

A. No.

103. Q. When did you start a management role

in the shelter?

A5351

A. It's in my CV, I think, so.

104. Q. I can go to that.

A. Yes, I would refer to that. Also because it's hard to remember some days these days, so 2004.

105. Q. I see. The date that I had in my notes was when you began as Director of Operations by YWCA in 2011. So 2004 was when you first entered a management role and that was at Good Shepherd?

A. Yes.

106. Q. Okay. And at that time, there had been a downloading of the costs of managing homelessness shelters to municipalities?

A. Correct.

107. Q. Okay. I'd like to now turn to your supplementary affidavit again. This was the June 4th, 2024 affidavit that you've provided us. I'm going to put that on the screen as well. Can you see that okay?

A. Yes.

108. Q. In paragraph 2 you say that you reviewed three documents, including two requests to admit and a response to a request to admit, did you review any other documents beyond those three when

preparing this affidavit?

A. When preparing the affidavit? I may have reviewed a number of documents in preparation, but these are the three that were referenced, yes, and included.

109. Q. Okay. Do you recall what other documents you reviewed in preparing this?

A. I have a lot of documents and research from both the City and also our own documentation, so no, I can't recall which ones I've reviewed.

110. Q. They're certainly not referenced by research source or any factual assumptions provided, is that correct?

A. Yes.

111. Q. If we go to paragraph 4 of this supplemental affidavit, this is under the subheading, "My Experience In Collecting Data on Hamilton's Homeless Population and Shelter Capacity," there are a number of statements about the YWCA Hamilton, Carol Anne's Place, and my first question is, what is the nature of the relationship between YWCA Hamilton and Carol Anne's Place?

A. YWCA Hamilton was responsible for starting and -- under my leadership starting and

implementing and operating Carol Anne's Place. We run, we operate Carol Anne's Place at YWCA.

112. Q. What's the nature of the relationship between YWCA Hamilton and the City of Hamilton?

A. The City of Hamilton provides funding to YWCA to operate some of our services.

113. Q. That includes Carol Anne's Place?

A. That currently includes Carol Anne's Place.

114. Q. Just in terms of the name, who was Carol Anne?

A. So Carol Anne was the founder in Hamilton for Out Of The Cold and it was Out Of The Cold who asked us to start a program like Carol Anne's Place, so I decided to name it after Carol Anne.

115. Q. So that was a decision you made in order to honour her?

A. Yes. She's still alive, but yes.

116. Q. Understood. What staffing does Carol Anne's Place have currently?

A. Currently our staffing is increased. We have a supervisor, we have a manager, we have a frontline staff on duty, at least two on-site, we have harm reduction workers working in the space

A1067

now and we also have staff from St. Joseph Womankind, who provide detox -- not detox, sorry, withdrawal management support, and then we also have other practitioners who come in, other clinicians or social navigators, social workers who come in to assist.

117. Q. I understand the City began funding Carol Anne's Place in 2019, is that right?

A. Yes.

118. Q. I've scrolled down to paragraph 8 of your supplemental affidavit, you mentioned that the City does not regard Carol Anne's Place as a shelter.

A. Yes.

119. Q. In what way is that true?

A. So it's considered a drop-in service with bed capacity. It doesn't qualify as a -- the qualification in shelter is rather complex and maybe arbitrary for the City, but it provides beds, overnight beds and then it also is a low barrier shelter. I would qualify that the staffing I described for you is what we have today on the staffing based on current funding, it is not the staffing we had in 2019.

120. Q. Understood. There's been changes in

A5352

funding levels over time?

A. Yes.

121. Q. There was a period of time when Carol Anne's Place was not operating, is that correct?

A. It started operating in 2016 and up till 2019-2020, it was always run from March to December, and so it was -- there were periods where we wouldn't have a Carol Anne's Place operating in the City.

122. Q. The funding levels increased to the point where it could operate year-round?

A. That's right.

123. Q. It does offer shelter beds?

A. It offers overnight beds, yes.

124. Q. I would think that including Carol Anne's Place bed count as part of the overall City's shelter capacity is a reasonable choice, is that right?

A. Yes.

125. Q. And it shows that the City does include it among its other shelters?

A. Yes. For bed capacity, yes.

126. Q. If we go to paragraph 9 of your supplemental affidavit, you say that, "62 of 101 women who stayed at Carol Anne's Place in May 2022

were also on the Master Guestlist in August 2021 indicating that they remained homeless throughout this period." Any or all of those 62 individuals may have obtained housing at least once during that period of ten months, isn't that right?

A. They may -- yes, they may have.

127. Q. That's not something you're aware of?

A. Yes.

128. Q. So you're making a generalization about this group of people, about those 62 individuals?

A. I'm saying those 62 individuals were homeless in May 2022 and they were homeless in August 2021.

129. Q. Yes, but you also draw an inference from that that they remained homeless throughout the intervening period, and I'm saying that you don't know that, you're generalizing---

A. I see what you're saying. What I'm saying is that they -- whether they had housing or not, they became homeless again. So remained homeless, I would say that for most part of that list. That's my knowledge, is that those individuals remained homeless during that period, but I can't say for certain that none of them had

housing and lost that housing.

130. Q. Based on what you know, all of them may have obtained housing during that period and then lost---

A. No.

131. Q. ---and you wouldn't know that.

A. I would know that. That, I would know.

132. Q. You would know that?

A. Yes.

133. Q. On what basis?

A. On the basis of the staff's reports of who -- I know who the individuals are on that list and could track where they had been and how they've been through the period of time between that time if they've been coming in to Carol Anne's Place. So from August 2021 to May 2022 we could see through their case management notes whether they have obtained housing or not.

134. Q. You do have the ability to track whether or not these 62 individuals had obtained housing in the interim?

A. We could examine those 62 and we could look to see if they had obtained housing.

135. Q. But have you done that or is this a

A1068

generalization and an inference from the fact that they were on the list in May 2022 and in August 2021?

A. Yes. So this is -- you're correct, I didn't look specifically to see had they had -- is there any reference or indication that they had obtained any kind of housing? No, I didn't do that.

136. Q. If we go back just momentarily to paragraph 8 of the supplementary affidavit, you mentioned some of the additional services that Carol Anne's Place offers beyond a bed.

A. Yes.

137. Q. Many women obtain services from Carol Anne's Place other than shelter, correct?

A. Yes.

138. Q. And all of those individuals, are they counted by Carol Anne's Place as having accessed services?

A. Yes.

139. Q. Does Carol Anne's Place keep track of the women it assists who obtain housing?

A. Could you clarify that question, sorry.

140. Q. Of course. In terms of records that

A5353

Carol Anne's Place would keep, does it keep track of the women that it assists who obtain housing?

A. You're asking -- yes, so once -- if we know them to obtain housing, that would be noted and that information is also available in HIFIS.

141. Q. Of the 101 women that you noted who stayed at CAP, Carol Anne's Place, between May 2022 and -- or between August of 2021 and May of 2022, do you know how many of them obtained housing?

A. Offhand, no, I don't know of any of them obtaining housing.

142. Q. But it's not something that you've looked at?

A. I could go back and look at that information. I have that information, but I haven't done that.

143. Q. You indicate as well that turn aways occurred most nights between August of 2021 and May of 2022. So, again, there were nights when no turn aways occurred, correct?

A. Yes.

144. Q. And so you would agree that there were times when the shelter capacity of Carol Anne's Place was sufficient?

A. Sufficient to respond to who came to

the door, yes, but not necessarily representative of who was experiencing homelessness in our community.

145. Q. Of the people who sought shelter, you were able to provide shelter to all of them on some nights?

A. Yes.

146. Q. If we go to paragraph 10 of your supplementary affidavit, you had mentioned previously the Women's Housing Planning Collaborative?

A. Yes.

147. Q. And you do give some information about it in your initial affidavit. That is still operating?

A. Yes.

148. Q. Who created that collaborative?

A. It was a group of women's shelters who created the Collaborative. I was involved in that creation.

149. Q. And you mention here 50 women who consistently attempted to access shelter services but were chronically unhoused throughout the year, is that a list that's maintained by the Collaborative?

A. So this is -- I would like to clarify. This was a list that was used, it was referenced in my first affidavit, from the triage group, and the triage group represented people who -- agencies that participate in the Women's Housing Planning Collaborative, and that list -- so we had that list and worked -- used that list early in the pandemic of the 50 women who were consistently -- and chronically unhoused, so that list is -- it was a list that we were using at that point in time where we were drawing it out from all the women who access our services.

150. Q. Understood. So in this paragraph, paragraph 10, you say that that group of 50 women were chronically unhoused throughout the year because they could not be effectively supported in shelters, what does effectively supported mean in this sentence?

A. That we didn't have the adequate supports of whether -- it would mostly be staffing supports, to be able to maintain them -- those individuals in a shelter setting, so we couldn't provide whatever level of intensive supports, privacy requirements, it could be a number of things, each one would be different. It also could

A1069

be because their presentation of mental health issues, it could be because of drug use. We had no ability to provide any kind of safety because we were under resourced as a whole system.

151. Q. In terms of effectively supported, does that also means that there were difficulties in obtaining permanent housing for these women?

A. Yes.

152. Q. And would it be the same reasons that you believe that to be a difficulty for these particular 50 women?

A. It would be same or similar, yes, reasons.

153. Q. In terms of ability to pay, is that an additional issue in terms of obtaining permanent housing for women like the 50 on that list?

A. Not necessarily, particularly at that time, because it wasn't a question of getting the housing allowances or the RGIs or those pieces weren't -- or their income sorted out with ODSP or OW, those weren't the issues that we were confronted with that were challenging, it was the other aspects of their own individual needs and presentations that created the challenges and our limitation in terms of our resources that we had

A5354

available.

154. Q. You used the phrase RGI, is that rent geared to income?

A. Correct.

155. Q. There are rent subsidies available via the City of Hamilton, is that right?

A. Yes.

156. Q. And, of course, there are provincial programs like ODSP and Ontario Works that persons who qualify can access?

A. Yes.

157. Q. In fact, ODSP has a shelter portion that can be accessed if shelter is obtained?

A. Yes.

158. Q. And so I would suggest that there are housing supports available in the City of Hamilton, would you agree with that?

A. Generally there are housing supports for this population. Those supports, no, were not available.

159. Q. If we go to paragraph 12 of your supplemental affidavit, I'll put that on the screen now, it's under the subheading "City's Data Undercounts The Demand For Shelter Services," you say that data collection at Carol Anne's Place is

different than at other shelters in the City of Hamilton, you'd agree that Carol Anne's Place data may, in fact, not be representative of other shelters in Hamilton then?

A. So the data that we -- so the collection of data being different was that we were not entered into the HIFIS system and our data prior to 2019 wasn't being captured by the City.

160. Q. All right. But you would agree then that that since Carol Anne's Place is different, it may not be representative of other shelters in the City?

A. Do you mean the data may not be representative? I'm sorry, I don't understand the question.

161. Q. There are a couple of ways that we've discussed that Carol Anne's Place is different, but yes, let's limit it to the data collection. Since the data collected at Carol Anne's Place is collected differently than at other shelters in the City of Hamilton, the data collected at Carol Anne's Place may not be representative of the other shelters in the City of Hamilton, is that right?

A. Yes, there might be data not representative of the other shelters. They were

collecting -- so what we would be collecting and journaling would be similar data, but we're just collecting the information or entering the information differently because we weren't using HIFIS.

162. Q. Paragraph 13 of your supplementary affidavit there are a number of statements, including "Shelters can only report those homeless individuals who come to shelters and identify themselves as homeless." You would agree that if a person does not seek shelter, then they cannot reasonably be counted as seeking shelter, right?

A. Correct, they can't be counted as seeking shelter if they weren't seeking shelter.

163. Q. You list a number of reasons why homeless individuals might not come to shelters. You list past mistreatment, fear of what will happen to belongings, fears that may not be real due to mental illness, an inability to follow rules, perceived futility, have each of these reasons been communicated to you by any identifiable individuals?

A. Yes, so these reasons have been communicated to me by staff, it's been communicated to me through the interactions that staff have had

A1070

directly with clients. That would be where that information would come from.

164. Q. So it hasn't been communicated to you by any identifiable individuals using the shelter, it's by staff members, is that right?

A. It's the notes and documentation from staff that would inform me that this is the reason why, yes. And also, I'd like to clarify not just my staff, but the staff from other women shelters as well.

165. Q. Right. Those would be people that you communicate with via the Collaborative?

A. Via the Collaborative, yes, or the triage.

166. Q. You indicate in this paragraph that some or all of those reasons; past mistreatment, et cetera, may apply to some or all of the individuals that you've seen staying outside Carol Anne's Place, that's an assumption you're making, correct? You haven't gone out and spoken to each of them and asked them why they're not making use of Carol Anne's Place?

A. No, I haven't done that.

167. Q. You don't know if the women that you've seen outside of Carol Anne's Place have ever

A5355

sought assistance from other shelters, correct?

A. Yes, I know some of them have.

168. Q. Some of them have done that?

A. Yes.

169. Q. Okay.

A. The women outside aren't totally unknown to me. The relationship is I don't have a direct client relationship in my capacity as CEO or in my capacity as Director of Operations. I would come in every day as Director of Operations pre-pandemic, see the women outside, I would -- my interactions were limited to conversations, somebody may ask me for shelter, somebody may say, you know, something critical or may be seeking other kinds of help, but those were limited interactions that I would see and come across and then I would also talk to the staff daily. During the pandemic I was 24/7 on-call, available to staff. I talk directly to staff, I talk directly to the management who were frontline overseeing staff. So my interactions -- there was lots of interactions, but at that capacity as opposed to direct client service delivery. That's not within my role as Director of Operations or CEO.

170. Q. Thank you. If we go to paragraph 14

of your supplementary affidavit, you reference that shelters can only report data from homeless individuals who have given shelters permission, how often would you say individuals assisted by Carol Anne's Place refused to provide any data?

A. It occurs regularly, but not most individuals.

171. Q. You say that Carol Anne's Place does not include those individuals in the report sent to the City on shelter demands, why would a refusal not still be logged?

A. We have to enter the name of the person, so that's part of it. We wouldn't provide a name of an individual who said they didn't want us to provide any name.

172. Q. Understand. I understand that.

A. Yes.

173. Q. In terms of what's being provided to the City of Hamilton, is a refusal still logged as a refusal even without a name?

A. My understanding is that -- so just to be clear, for most of this time that we have not used HIFIS. It was only after 2019 was data being reported to the City at all. We don't have -- so in terms of the information that's shared, it was

not -- we would send the number of turn aways and we would send the number of beds used and women staying to the City and we would collect that data.

174. Q. I appreciate that.

A. Okay.

175. Q. So if we go to paragraph 13 of your supplementary affidavit, you reference VAW shelters, Violence Against Women shelters, and the fact that they are not funded by the City of Hamilton, but you'd agree with me that there are other organizations in the City of Hamilton; charities, churches, mosques, temples, Gurdwaras that may offer shelter in various capacities, is that right?

A. I'm only aware of shelters -- VAW shelters -- charitable VAW shelters that offer beds. I'm sorry, I'm not aware of anyone else offering beds for women. You mentioned Gurdwaras, you mentioned other mosques, I'm not aware of them providing beds.

176. Q. To be clear, I'm not solely talking about Violence Against Women assistance, I'm talking about shelter space in general for women.

A. No, I'm not aware of any. If there are, I'm not aware of them.

A1071

177. Q. You're aware of the Society of St. Vincent de Paul opening a facility called Mary's Ark?

A. No, actually, I'm not.

178. Q. Mary's Ark specifically for homeless women, you're not aware of that?

A. No, that's not information I've had and nor has it been discussed at the Women's Housing Planning Collaborative. I've never heard of it.

179. Q. You'd agree that alleviation of poverty is one of the goals of many charities?

A. Of charities? There are charities, yes, that would be -- alleviation of poverty would be a goal.

180. Q. Would you agree that only counting City funded shelter beds may be under counting the total actual shelter capacity of the City?

A. So there are beds that would not -- you're saying they're not counted by the City? Yes.

181. Q. And that only counting City funded shelter beds would be undercounting the total capacity of the City?

A. If you mean the City broadly, you

A5356

mean the City as in just what's contained within the geography of the City, that there are additional shelter beds that are not City funded? That's correct.

182. Q. So only counting City funded shelter beds would be undercounting the total capacity?

A. It would be under counting -- it would be not representative of the total shelter, all the shelters -- all the shelter beds across the City, whether they're -- however they are funded, yes.

183. Q. Are you aware of how many hospital beds there are in the City of Hamilton for opiate treatment?

A. I don't know that number.

184. Q. Are you aware of how many hospital beds are available in the City of Hamilton for mental health treatment?

A. I don't know that number.

185. Q. Are you aware of there being any of those two classes of possible beds available?

A. Yes.

186. Q. There are such beds in the City of Hamilton?

A. Yes, the beds are not the same as the

shelter beds, may not, you know, keep people overnight. But, yes, there are beds.

187. Q. Would you agree that tracking data on the City funded shelter system helps to best deploy the City's resources?

A. I would assume that that would be valuable. I would understand that's valuable information. Data -- tracking data helps you design and decide on how you resource the system.

188. Q. Would you agree that the City cannot force shelter providers that it's not funding to provide data?

A. I agree, they can't be forced.

189. Q. If we go to paragraph 17 of your supplemental affidavit, you say, "Not every shelter bed that is reported as available is actually available," or able to be used, I suppose, is another way of paraphrasing that. Would you agree?

A. Yes.

190. Q. And you reference things like bedbugs or damage due to complex needs of individuals or family use preventing the use of some of those beds?

A. Yes.

191. Q. Is that something that CAP does

experience, loss of beds for those reasons?

A. Not specifically for those reasons, but yes, there might be beds that would be unavailable. Yes.

192. Q. Are you aware of that ever happening in any other shelters on any particular day?

A. Yes, I'm aware that there have been days when beds are not available or nights.

193. Q. How does that information come to you?

A. So it would get reported. So, for example, staff is looking for a bed for somebody and they can't find the beds because -- so this would happen during the pandemic. For example, I would get a call, we'd have, you know, an individual who needed somewhere to go, there were no beds available, such and such shelter couldn't open up the bed because they were in the process of changing it over or they had a situation, they didn't have the staff to manage to bring in, we'd have to wait until something was done. So that was an occurrence that would get reported to me.

194. Q. That's because of the fact that the shelters communicate with one another?

A. That's right.

A1072

195. Q. I just want to be clear, in paragraph 19 you mention inadequate staffing on a given night, again, that's information that would come to you because of the communication that occurs between shelters?

A. Yes.

196. Q. But your purview doesn't include monitoring or managing staffing levels at any other shelters, correct?

A. Correct.

197. Q. And you don't have any evidence regarding the capacity or the usage of beds at any VAW shelter in Hamilton, right?

A. I have information that was shared -- so what I would have is what was shared at the Women's Housing Planning Collaborative, I would have information from media reports. In terms of monitoring their numbers, no, I don't have any information.

198. Q. In paragraph 21 of your supplemental affidavit you say that the demand for VAW beds is not tracked by the City, given that VAW beds are also not tracked by the City, you'd agree that there's nothing misleading or inconsistent about the City's data, it doesn't include either one?

A5357

A. I think that the City's data doesn't represent the demand -- the total demand of -- for women shelter beds, and I think that by the representation of what is available, doesn't express the whole picture, and by representing who -- the number of people who seek out or receive service from City shelter beds doesn't tell the whole picture. So I do think that within that scope, it is misleading. I don't think it's intended to be misleading. I don't want to paint that. But it is misleading and the picture is bigger than what is shared by the City.

199. Q. I could see saying that the City's data is misleading or inconsistent if the City was including VAW beds as available capacity but not including their usage. But the City isn't doing that, right?

A. I'm not aware of the City doing that. I'm aware the City doesn't take in the whole picture of what the demand for service is.

200. Q. Right. But I mean they're also not referencing the supply, and that's reasonable, wouldn't you say?

A. But they're also not referencing then the turn aways and, you know, the families who are

staying or the individual women who have had to sleep in an office or on a chair or in a boardroom.

201. Q. The City just doesn't have access to VAW data at all and the City has openly acknowledged that in its response to request to admit that you've reviewed and referenced in your affidavit, right?

A. So the City doesn't -- what access they have, I don't know. What they report, what's visible, what's visibly shared is that the -- only the City-funded services.

202. Q. To be clear, the City has said in the response to request to admit that you reference in your affidavit, that they don't have access to VAW data at all. You don't have any reason to disbelieve or challenge that evidence?

A. At the Women's Housing Planning Collaborative we presented VAW data, so I know that's being provided to the City. But does the City have regular, consistent access, that's between the City and the VAW shelters and the province. I don't think it's unfair to say that there's limitations or challenges to the sharing of data, but the data has been presented through the Women's Housing Planning collaborative since its

inception.

203. Q. Final question: at the end of your supplementary affidavit there's just your name in quotation marks, can you just confirm for me that you agreed that this document would bear an electronic signature and that you approved it?

A. Yes, I can confirm that.

204. MR. DIACUR: Counsel, just a momentary indulgence but I believe I'm finished.

DISCUSSION OFF THE RECORD

BRIEF RECESS

BY MR. DIACUR:

205. Q. Are you a proponent of the Housing First philosophy?

A. Meaning am I -- do I promote the Housing First philosophy?

206. Q. Do you believe it? Do you think that it is scientifically sound and it should be applied?

A. So I believe that there's validity in Housing First supports with -- Housing First with the right supports in place. I don't believe Housing First is always implemented as it's fully intended and as it was studied in the original study by---

A1073

MR. CHOUDRY: Mr. Diacur, are you asking Ms. Uppal for an opinion?

207. MR. DIACUR: No. I'm asking her whether she considers Housing First to be a scientifically sound method of addressing the unhoused individuals that she personally works with.

MR. CHOUDRY: It sounds to me like a bit of an opinion.

208. MR. DIACUR: If that's a refusal, that's fine. Those are all my questions, Counsel. Thank you.

DISCUSSION OFF THE RECORD

BRIEF RECESS 11:14 - 11:20

RE-EXAMINATION BY MR. CHOUDRY:

209. Q. I have two questions, Ms. Uppal. The first is Mr. Diacur asked you about criminal incidents outside Carol Anne's Place in addition to what you described in your affidavit, but he didn't ask you to specify the timeframe and nor did you. So the examples you gave, what kind of period of time were you describing?

A. Within the last year, the examples I provided.

210. Q. Was that a comprehensive list of

A5358

examples?

A. No, not at all.

211. Q. Are you able to estimate how many -- Mr. Diacur asked you about crimes and you gave certain types of crimes as examples.

A. Yes.

212. Q. Are you able to estimate, in your experience, how many crimes against persons or property occur outside CAP a week or a month?

A. To estimate -- I can go back to the affidavit where I specifically report the number of incidents that the police have had reported on an increasing -- I have to find it.

213. Q. Sure, you're welcome to refer to your affidavit in any answer, so if you want to take a moment to get to it, please do.

A. Okay. So it was in the first affidavit from July 2023 at paragraph 30. I speak about the number of calls we would make to police for Carol Anne's Place, and so those accounts would represent from December 6, 2021 and it talks about the number of nine individuals arrested, six charges laid in eight provincial offences in that period, to go and look at what's happened since that time, I actually have been looking at some of

that data but I couldn't estimate for you how much. We call the police weekly, every few days at least, and so there's a number of incidents that we continue to report.

214. Q. Another topic that Mr. Diacur asked you about was the VAW shelter system.

A. Yes.

215. Q. I'm just wondering, have you ever worked in the VAW shelter system in any capacity?

A. Yes. So the first part of my career when I was with Good Shepherd was working with the VAW system starting with Martha House. I was a manager overseeing VAW programs, and the VAW shelter, which was Martha House. And then when I came to YWCA and we acquired Phoenix Place, which is a VAW second stage funded service through the same funding portfolio from the province, as well as other services for Violence Against Women supports. So we've continued to operate and run residential and nonresidential VAW services.

216. Q. Those are all my questions. Thank you, Ms. Uppal.

---Whereupon the cross-examination was concluded at 11:25 a.m.

I hereby certify the foregoing to be the evidence of **MEDOR UPPAL**, given under oath before me on the **20th** day of **August**, 2024, recorded verbatim and later transcribed by me.

CERTIFIED CORRECT:

Helen Matsos

Helen Matsos, CVR

Certified Verbatim Reporter

Commissioner of Oaths (Expires July 18, 2025)

This document must bear the original signature and certification of the Reporter in Attendance at the examination of the witness in the above captioned matter. Absence of this certification and signature is indication this document has been reproduced without the permission of Nimigan Mihailovich Reporting Inc., and as such, is not an original document.

A1074

Court File No. CV-21-00077187-0000

ONTARIO SUPERIOR COURT OF JUSTICE

BETWEEN:

KRISTEN HEEGSMA, DARRIN MARCHAND, GORD SMYTH, MARIO MUSCATO, SHAWN ARNOLD, BRADLEY CALDWELL, CHRISTINE DELOREY, GLENN GNATUK, TAYLOR GOGO- HORNER, CASSANDRA JORDAN, JULIA LAUZON, AMMY LEWIS, ASHLEY MACDONALD, COREY MONAHAN, MISTY MARSHALL, SHERRI OGDEN, JAHMAL PIERRE, LINSLEY GREAVES and PATRICK WARD

Applicants

-and-

CITY OF HAMILTON

Respondent

AFFIDAVIT OF JILL WIWCHARUK

SWORN JUNE 7, 2024

I, Doctor Jill Wiwcharuk, of the City of Victoria in the Province of British Columbia,

AFFIRM AND STATE:

1. I have personal knowledge with respect to the facts and reports set out below, except where stated otherwise. Where the information is not based on my personal knowledge, it is based upon information provided by others which I believe to be credible and true.

2. I am a physician formally with the Shelter Health Network (SHN) and the Hamilton Social Medicine Response Team (HAMSMaRT). These organizations provide medical care to individuals affected by homelessness or housing precarity.

3. I provided a report to the Hamilton Community Legal Clinic dated May 31, 2022 with respect to Cory Monahan. Attached hereto and marked as **Exhibit "A"** is a copy of this medical letter.

4. I provided a report to the Hamilton Community Legal Clinic dated June 1, 2022 with respect to Cassandra Jordan. Attached hereto and marked as **Exhibit "B"** is a copy of this medical letter.

5. I provided a report to the Hamilton Community Legal Clinic dated June 2, 2022 with respect to Sherri Ogden. Attached hereto and marked as **Exhibit "C"** is a copy of this medical letter.

6. I provided a report to the Hamilton Community Legal Clinic dated June 3, 2022 with respect to Patrick Ward. Attached hereto and marked as **Exhibit "D"** is a copy of this medical letter.

7. I provided a report to the Hamilton Community Legal Clinic dated June 8, 2022 with respect to Jahmal (Jammy) Pierre. Attached hereto and marked as **Exhibit "E"** is a copy of this medical letter.

8. I provided a report to the Hamilton Community Legal Clinic dated June 9, 2022 with respect to Mario Muscato. Attached hereto and marked as **Exhibit "F"** is a copy of this medical letter.

9. I provided a report to the Hamilton Community Legal Clinic dated June 9, 2022 with respect to Misty Marshall. Attached hereto and marked as **Exhibit "G"** is a copy of this medical letter.

10. I provided a report to the Hamilton Community Legal Clinic dated June 10, 2022 with respect to Shawn Arnold. Attached hereto and marked as **Exhibit "H"** is a copy of this medical letter.

Affirmed remotely by Dr. Jill Wiwarchuk stated as being located in the City of Victoria in the Province of British Columbia, before me at the City of Richmond Hill, Province of Ontario, in accordance with O. Reg 431/20, Administering Oath or Declaration Remotely.

Dr. Jill Wiwcharuk

Commissioner for Taking Affidavits
Sharon Crowe LSO 47108R

SCHEDULE

A5363

Shelter Health Network

82 Stinson St
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Shelterhealthnetwork.ca

May 31, 2022

Hamilton Community Legal Clinic

100 Main St. E. Suite 203

Hamilton ON L8N 3W4

ATTN: Sharon Crowe and Stephanie Cox

This is Exhibit "A" referred to in the affidavit of J.U. Wiwchariuk sworn before me, this 7 day of June 2024.

Sharon Crowe
A COMMISSIONER, ETC.

RE: Cory Monahan, dob: April 26, 1976

I am a physician with the Shelter Health Network in Hamilton, Ontario. The Shelter Health Network provides healthcare to people who are homeless or precariously housed. Mr Monahan has accessed medical care through the Shelter Health Network since April, 2020. Throughout this time, notes indicate that this gentleman has been homeless and has commonly been sleeping rough (ie: not accessing shelters and instead sleeping outdoors). One note dated March 9, 2022 outlines his distress at sleeping outside in the cold and wishing for help accessing a shelter bed. He had been trying to access a men's shelter bed and had been unable to do so. He notes he "is frustrated he can't get into a shelter" and that he "just wants to feel warm again." At that time, the health care practitioner who saw him advocated for agency staff to use the HIFIS system to check on whether there were service restrictions in place. She was able to help secure a bed for him at Mission Services Men's Centre on that occasion.

~~As is common in the homeless population who often only access healthcare episodically~~, We do not have in depth medical records available for this gentleman. I do know that this gentleman suffers from opioid use disorder, stimulant use disorder and I am convinced that he has undiagnosed mental health issues. He has had near fatal opioid overdoses which required multiple doses of naloxone (opioid antidote) and emergency care. Mr Monahan has mostly made contact with the SHN looking for help with acute skin infections. On July 28, 2020 he saw us with infected bites on his body. Note was made that he was sleeping outside and had no access to a tent. ~~It is likely that if Mr Monahan had had access to a tent, he would have had fewer bug bites resulting in infection.~~

A1079

I have spoken to Mr Monahan about his homeless status and he has shared the mental distress this causes him. He has broken down in tears on occasion when he speaks to me about his desperate desire to be housed. I believe that his homeless state causes him deep, ongoing stress that negatively impacts his mental health. This increased state of anxiety is often cited as a reason why people use illicit substances, to cope with stressors that feel insurmountable.

I hope this is helpful. Please let me know how I can be of further assistance.

Dr Jill Wiwcharuk, MD, CCFP (EM)

Shelter Health Network

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Shelterhealthnetwork.ca

This is Exhibit "B" referred to in the affidavit of Jill Winchanko sworn before me, this 1 day of June 20 22
Sharon Crowe
A COMMISSIONER, ETC.

Hamilton Community Legal Clinic

100 Main St. E. Suite 203

Hamilton ON L8N 3W4

June 1, 2022

ATTN: Sharon Crowe and Stephanie Cox

RE: Cassandra Jordan, dob: April 29, 1983

I am a physician with the Shelter Health Network in Hamilton, Ontario. The Shelter Health Network provides healthcare to people who are homeless or precariously housed. Ms Jordan has accessed medical care sporadically through the Shelter Health Network since October, 2020.

~~As is common in the homeless population who often~~ only access healthcare ~~episodically~~, We do not have in depth medical records available for this woman. I do know that she suffers from opioid use disorder, stimulant use disorder, chronic pain and a recent acetabular fracture and hip dislocation requiring surgery. I am also certain she has significant undiagnosed mental health issues.

On November 24, 2021, I provided medical care to Ms Jordan in her tent at JC Beemer Park. She had sustained a significant burn to the back of her leg two days prior. This was a partial thickness burn that encompassed ¼ of her back upper thigh and was causing her significant pain. If she had presented to hospital, she would likely have been admitted to a specialized burn unit.

While I was assessing her and providing care, there was a large police presence who were engaged in clearing this encampment. Ms Jordan was very distressed in that she had no appropriate options available to her with regards to where she could go. She had a large tent

with significant possessions and was totally overwhelmed as to how to keep her possessions safe.

Follow-up for high quality wound care was paramount to treating this burn. I tried my best to organize follow up for her but it was essentially impossible because she had no idea where she was going to be the following day. She did end up accessing the Barrett Centre (a crisis shelter that is only for short stays up to 5 days usually) and was seen the following day by a nurse practitioner from the SHN. Unfortunately, she left the Barrett Centre after a few days and did not receive any other care for her burn that I am aware of. I saw her two months later in January and her burn had healed by that time.

Given the severity of her injury, if Ms Jordan had not been evicted from her encampment, I would have made it a priority to see her daily for wound care. As it played out, being evicted from the encampment while in the midst of a significant medical issue like that made it impossible for me to follow up with her on an ongoing basis. Her priorities in this case were far more focused on keeping her tent and her possessions and finding a new place to stay than on her medical care. ~~This is a common hierarchy of priorities among people who are homeless.~~

More recently, I saw Ms Jordan during her stay at the Hamilton General Hospital after she sustained an acetabular fracture and hip dislocation secondary to an altercation with police on May 6, 2022. She required surgery at that time. I was involved in providing addiction related care for her during her inpatient stay. She had significant pain from this injury and is likely to develop chronic pain in this hip in the future.

I hope this is helpful. Please be in touch if I can be of further assistance.

Dr Jill Wiwcharuk, MD, CCFP (EM)

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Hamilton Community Legal Clinic

100 Main St. E. Suite 203

Hamilton ON L8N 3W4

This is Exhibit "C" referred to in the affidavit of Jill Winschanik sworn before me, this 7 day of June 20 24

Sharon Crowe
COMMISSIONER, ETC.

June 2, 2022

ATTN: Sharon Crowe and Stephanie Cox

RE: Sherri Ogden, dob: July 31, 1993

I am a physician with the Shelter Health Network in Hamilton, Ontario. The Shelter Health Network provides healthcare to people who are homeless or precariously housed. Ms Ogden has accessed medical care through the Shelter Health Network since 2010 when she was 17 years old. Initially she was seen infrequently but she has been seen regularly since September 2020. I am certain she has been homeless since 2020 ~~and I suspect she has been in and out of homelessness her entire adult life.~~

Ms Ogden has a family physician outside of SHN whom she sees sporadically. She has only ever seen SHN practitioners for issues related to contraception, poor sleep or aches/pains and various rashes. I am certain that she has very significant undiagnosed mental health illness. ~~Many people who are homeless are unable to access specialized medical care as they have so many competing priorities in their lives. Medical records do not always capture all the conditions that a homeless individual struggles with because they access care so sporadically and often do not have the time or inclination to address some of the underlying issues.~~

For the majority of the last two years, Ms Ogden has been sleeping rough. At one point she was sleeping in a tent in her mother's back yard. Other times she sleeps outside of the Wesley Day Centre. On November 11, 2021 she came to see me and stated that she wanted to get inside from the cold and asked for help getting into a shelter. I asked Wesley staff to help her with this process. To my knowledge she did not end up securing a shelter bed at that time.

Ms Ogden would often see me with complaints of poor sleep and being tired. Although she would sometimes have a tent, many other times she was sleeping entirely unsheltered. This can result in a lot of anxiety and stress and a feeling of constantly having to be on the look-out. Women in particular

~~describe feeling unsafe sleeping unsheltered outside~~) I would often see her sleeping in the Wesley Day Centre during the day, simply exhausted from having slept so poorly outside the night before.

Hospital records indicate that Ms Ogden has accessed the emergency department on 10 occasions since the fall of 2020. I notice that all of these visits were for functional pain. Functional pain diagnoses are things like headaches and abdominal pain that can often be related to stress and anxiety but have no underlying pathology and is not associated with any abnormal labwork or imaging. This would be in keeping with the extraordinarily stressful situation that Ms Ogden has been in as she continues to remain homeless, often unsheltered and at times unable to access a shelter bed when she feels she needs one.

I hope this is helpful. Please let me know if I can be of further assistance.

Dr Jill Wiwcharuk, MD, CCFP (EM)

INTENTIONALLY OMITTED - APPLICANT REMOVED

INTENTIONALLY OMITTED - APPLICANT REMOVED

Shelter Health Network

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This is Exhibit "F" referred to in the affidavit of J.M. Wiwcharuk
sworn before me, this 7
day of June 20 24
Sharon Crowe
A COMMISSIONER, ETC.

June 8, 2022

ATTN: Sharon Crowe and Stephanie Cox

RE: Jahmal (Jammy) Pierre, dob: Dec 20, 1989

I am a physician with the Shelter Health Network in Hamilton, Ontario. The Shelter Health Network provides healthcare to people who are homeless or precariously housed.

Ms Pierre is a trans woman who suffers from stimulant use disorder and opiate use disorder. She has rarely sought help through the Shelter Health Network so the medical history I can provide is very limited. She has only been seen on three occasions and these were all related to opiate overdoses in 2020. On one occasion in August she had an unintentional opiate overdose and was hospitalized in the Intensive Care Unit for a period of time. She was encouraged to follow up with doctors at the YWCA after that incident and that is when she saw my SHN colleagues. Ms Pierre described this overdose as entirely unintentional. She had used a contaminated supply of methamphetamine and did not know that there was street fentanyl in the supply that she had received. Ms Pierre was lucky to have survived as I have had had many opiate-naive patients in the exact same situation who have died in this scenario.

In November of 2020, I was doing outreach work and saw Ms Pierre slumped over on the sidewalk. I approached her and quickly recognized that she had suffered an opiate overdose. It required many doses of the opiate anecdote naloxone to get her to start breathing spontaneously on her own. Once again, she was very lucky to survive. I saw her later that day in the emergency department where she had been brought by EMS. Unfortunately, she was not at a point where she was ready to engage with treatment for her substance use disorders. Given this, she continues to be at an extremely high risk of overdose in the future.

I hope this is helpful. If there is any way I can be of further assistance, please let me know.

Sincerely,

Dr Jill Wiwcharuk, MD, CCFP (EM)

Shelter Health Network

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This is Exhibit "F" referred to in the affidavit of Jill Winchanuk
sworn before me, this 1
day of June 20 24
Sharon Crowe
A COMMISSIONER, ETC.

Hamilton Community Legal Clinic

100 Main St. E. Suite 203

Hamilton ON L8N 3W4

June 9 2022

ATTN: Sharon Crowe and Stephanie Cox

RE: Mario Muscato, dob: Oct 31,1973

I am a physician with the Shelter Health Network in Hamilton, Ontario. I also practice addiction medicine at The Hamilton Clinic. I regularly provide healthcare to people who are homeless or precariously housed. Mr Muscato has been a patient of mine since early 2019 and I see him both at SHN clinics and at The Hamilton Clinic. I often see him several times a week for medical care. Mr Muscato has been homeless the entire time I have cared for him. He is often unable to access shelter beds due to service restrictions and shelters being at capacity. For this reason, he often ends up sleeping rough. Despite Mr Muscato's very significant disabilities, he has never been prioritized for housing in an effective way.

Mr Muscato has very significant disabilities. He suffers from opioid use disorder, stimulant use disorder, HIV, post-traumatic stress disorder, major depressive disorder, acquired brain injury, left partial forearm amputation, extensive burn injuries to neck and face resulting in chronic pain, severe neuropathy to both upper extremities, right forearm amputation, tendon and nerve grafts to left forearm resulting in severely compromised use of this arm.

Mr Muscato suffered a near fatal electrocution in 2018 which resulted in the partial amputation of his left forearm. He also had severe burn injuries to his right forearm and there was extensive grafting that needed to be done to try to salvage any use of this hand/arm. Unfortunately, the grafting was only partially successful. So Mr Muscato now has extremely limited use of his right forearm. He is unable to fully extend the arm, and his fingers are

permanently fixed in a claw-like grip. He has no sensation to any of these fingers which puts him at a constant risk of further injury. For example, he has seen me for burns to these fingers from the top of an electic stove that he was cleaning and he didn't even know that the stove was hot. In the winter, he has suffered frostbite injuries to this hand due to an inability to feel the cold.

When he suffered this near fatal electrocution, he also ended up with a bleed in his brain. This eventually improved with time, but I believe he has been left with a significant acquired brain injury. People with acquired brain injuries struggle with things like memory, mood lability (ie: are often quick to anger and have difficulties with their emotions), chronic headaches, etc. They will have a harder time managing psychiatric diagnoses such as anxiety and depression and have a high propensity for addictions.

Mr Muscato would be eligible for a right arm prosthesis but the process to obtain one requires multiple appointments and fittings. His precarious housing situation, rarely having reliable access to a phone, his acquired brain injury and the chaotic lifestyle that ensues due to his unstable addictions have made it impossible for him to follow up as is necessary to obtain a prosthesis.

Mr Muscato's mental health has suffered. As I mentioned, he has posttraumatic stress disorder both from adverse events in childhood (physical and sexual abuse) as well as from the electrocution injury in 2018. In order to use drugs intravenously, he relies on other people to inject him due to his disability. He has spoken to me on numerous occasions of feeling so depressed that he would like to die by overdose and to do that he feels he would need to trick someone into injecting too much fentanyl.

Another significant health issue of Mr Muscato's is that he has untreated HIV. In order to benefit from medications for HIV, an individual has to be able to take medications consistently. If this is not possible, it is highly likely that the virus will become treatment-resistant and therefore harder to treat. Because Mr Muscato's lifestyle is so chaotic, he has never been able to access medications consistently. He is a target on the street due to his disability and often has his belongings stolen. So When he does have medications on him, more often than not, they are lost or stolen within a few days. From a practical standpoint, it would be near impossible for him to even open a standard pharmacy bottle of pills on his own. Given his untreated HIV, he is at risk of developing AIDS down the road if he does not find enough stability to start accessing medications regularly.

Mr Muscato sees me regularly in most part for addictions related care. He wants to access opioid replacement therapy and stop using street drugs. To get to a therapeutic dose of opioid replacement therapy (ie: methadone), he needs to access a pharmacy every day to receive his dose. This consistency has been his biggest struggle. His housing instability is the main factor behind this inability to access a pharmacy daily. Because he bounces between shelters, encampments and couch surfing, he can rarely count on being able to access medications from

one geographic location every day. For example, someone that is housed knows that they will wake up in the same place every day and can simply build a routine of waking up and walking to a nearby pharmacy for their daily dose of medication. Mr Muscato does not have this luxury.

On April 11, 2019, note is made in Mr Muscato's chart that "this patient needs housing above all else" and this is reiterated in his medical chart over the subsequent years. This is specifically because his most critical medical issues are simply not being effectively treated while housing is so unstable. There were times when he would receive two weeks of opioid agonist therapy consistently but then he would be service restricted from a shelter or moved from an encampment and he would lose that stability and have to restart again down the road.

Mr Muscato has spoken to me on numerous occasions about difficulties that he encounters in the shelter system. He has cited racism as one of the issues that he faces. He feels that he is commonly discriminated against due to his Indigenous status. He also has difficulty in congregate settings because his physical needs are so different than others'. For example, he needs much more time to eat a meal due to his compromised ability to manipulate utensils. He also often needs much longer in bathrooms or other hygiene facilities due to his disability. He has people getting angry at him when he cannot complete tasks in the same time that it takes an able-bodied individual to do so.

I hope this has been helpful. Please be in touch if there is any further way I can be of assistance.

Sincerely,

Dr Jill Wiwcharuk, MD, CCFP (EM)

Shelter Health Network

82 Stinson St
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This is Exhibit "G" referred to in the affidavit of Lal-Winchank sworn before me, this 7 day of June 20 24

Sharon Crowe
A COMMISSIONER, ETC.

Hamilton Community Legal Clinic

100 Main St. E. Suite 203

Hamilton ON L8N 3W4

June 9, 2022

ATTN: Sharon Crowe and Stephanie Cox

RE: Mysty Marshall, dob: Dec 18, 1991

I am a physician with the Shelter Health Network in Hamilton, Ontario. The Shelter Health Network provides healthcare to people who are homeless or precariously housed. I first met Ms Marshall when she was living in a tent on Ferguson Avenue in the summer of 2020. Since that time she has remained homeless. Prior to that, she was couch surfing or staying in budget motels (which is also a form of homelessness). I am unsure how long she was in that position.

To my knowledge, Ms Marshall has a past medical history of opiate use disorder, stimulant use disorder, major depressive disorder with suicidal ideation and asthma. She has a history of abuse in childhood and has been in abusive relationships throughout her adult years.

I saw Ms Marshall initially for asthma exacerbations when she was homeless and living in a tent on Ferguson Avenue. The heat and humidity were very oppressive and this often exacerbates asthma in people who are unable to access cooler indoor air. I saw her on October 1st and was able to reassess her the following week. I noted that her asthma had worsened and she needed some emergency treatment at that time. I was glad that she was in the same area because knowing that she was at risk of deteriorating medically, I was able to reassess her and provide the emergency treatment when it was needed.

In September, 2021, I again saw Ms Marshall at a drop-in centre for individuals experiencing homelessness. She was extremely disheveled, had dirty clothes and extensive matting of her

hair with a severe case of head lice that was causing underlying cellulitis (skin infection) to her scalp and ears. She also had an extensive body rash that was likely caused by scabies. ~~It was clear she had had no access to shower or laundry facilities for a long period of time~~. I suspected that she was profoundly depressed as well.

Despite having an addiction to opioids, she has not been ready to engage with treatment. Nor does she readily engage with anyone regarding her mental health. It is noted that she does not accept help from people readily. ~~This is not at all uncommon in the Indigenous population who face systemic racism in many colonial institutions,~~ often preferring ~~to avoid these institutions altogether.~~

~~In instances like this, what is needed above all else is regular contact with someone to slowly build trust over time~~. Once Ms Marshall was evicted from the encampment on Ferguson Avenue, I did not see her for a year and when I did finally see her again, she had drastically decompensated physically and mentally. When I knew where she was living, I was able to follow up with her from a medical perspective and treat the issues that were surfacing. ~~It is~~ my ~~opinion that if she had remained in one place, she would not have decompensated to the extent that she did. I would also have had a chance to build more of a relationship with her and help build the trust that many people require to start engaging in addictions and mental health treatment.~~

I hope this is helpful. Please be in touch if I can be of further assistance.

Sincerely,

Dr Jill Wiwcharuk, MD, CCFP (EM)

Shelter Health Network

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This is Exhibit ....H..... *referred to in the affidavit of* ....JM Wiwchar.... *sworn before me, this* ....7.... *day of* ....June.... 20.22....
Sharon Crowe
A COMMISSIONER, ETC.

Hamilton Community Legal Clinic

100 Main St. E. Suite 203

Hamilton ON L8N 3W4

June 10, 2022

ATTN: Sharon Crowe and Stephanie Cox

RE: Shawn Arnold, dob: July 23, 1969

I am a physician with the Shelter Health Network in Hamilton, Ontario. The Shelter Health Network provides healthcare to people who are homeless or precariously housed. I am also a physician with The Hamilton Clinic which is an addiction medicine clinic. Mr Arnold has been a regular patient of mine both through the SHN and The Hamilton Clinic since 2020 although I sporadically provided care to him since 2018.. His past medical history is significant for opiate use disorder, stimulant use disorder, attention deficit hyperactive disorder, hepatitis C (recently treated) and chronic left shoulder pain.

I saw Mr Arnold regularly during 2021. He was living in a tent at JC Beemer Park in the winter of 2020/21. Prior to that time, he only came to see me sporadically but would always talk about his desire to treat his opioid use disorder and get on opioid agonist therapy (ie: methadone). However, he was unable to follow up regularly enough to do so. Getting to a therapeutic dose of methadone requires attending a pharmacy daily for doses and not missing appointments. From at least the summer of 2020 (and possibly earlier), Mr Arnold was homeless and regularly sleeping outside. He found the crowded conditions in shelters too hard to manage and he would end up sleeping outside or couch surf somewhere.

Once he was settled at JC Beemer Park, Mr Arnold was able to see me regularly and attend a pharmacy daily. He was able to stay on a methadone maintenance program for well over a year and used much less illicit street drugs than he had ever used previously. Because of his

consistency, I was also able to treat his hepatitis C. He followed through on the entire two month program of anti-virals and is now cured from hepatitis C. This is something that can only be achieved when people are able to take their medications daily. Otherwise, treatment resistant strains of hepatitis can develop.

~~If Mr Arnold had been forced to move from place to place the entire winter, it is clear to me that he would not have reached the level of stability he did with regards to treatment of his addiction and his hepatitis C. He was able to engage with housing workers who ultimately knew where to find him and were able to follow up with him because he was in one place. This led to him becoming housed later in 2021.~~

I hope this is helpful. Please let me know if I can be of further assistance.

Sincerely,

Dr Jill Wiwcharuk, MD, CCFP (EM)

Heegsma et al
Applicants

-and-

CITY of HAMILTON
Respondents

Court File No. CV-21-00077187-0000

Ontario
Superior Court of Justice

PROCEEDING COMMENCED AT HAMILTON

Affidavit of Dr. Jill Wiwcharuk

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Court File No. CV-21-77187

ONTARIO
SUPERIOR COURT OF JUSTICE

BETWEEN:

KRISTEN HEEGSMA, DARRIN MARCHAND, GORD SMYTH, MARIO MUSCATO, SHAWN ARNOLD, BRADLEY CALDWELL, CHRISTINE DELOREY, GLEN GNATUK, TAYLOR GOGO-HORNER, CASSANDRA JORDAN, JULIA LAUZON, AMMY LEWIS, ASHLEY MACDONALD, COREY MONAHAN, MISTY MARSHALL, SHERRI OGDEN, JAHMAL PIERRE, LINSLEY GREAVES and PATRICK WARD

Applicants

- and -

CITY OF HAMILTON

Respondent

CROSS-EXAMINATION OF DR. JILL WIWCHARUK,
on behalf of the Applicants,
on her affidavit dated June 7, 2024,
held via Zoom Videoconference hosted by
the offices of Nimigan Mihailovich Reporting Inc.,
Hamilton, Ontario, on Friday, August 16, 2024,
at 11:17 a.m. EDT

APPEARANCES:

Sujit Choudhry Sharon Crowe Curtis Sell Michelle Sutherland Nnonyechi Okenwa	for the Applicants
Bevin Shores Jordan Diacur Vivian Caldas	for the Respondent

ALSO PRESENT:

Jojo Johnson	Articling Student

INDEX

	PAGE
AFFIRMED: DR. JILL WIWCHARUK	3
CROSS-EXAMINATION BY MR. DIACUR	3

LIST OF UNDERTAKINGS, REFUSALS, & UNDER ADVISEMENTS

Undertakings (U/T) found at pages:
NONE

Refusals (REF) found at pages:
NONE

Under Advisements (U/A) found at pages:
21

Zoom Videoconference

--- Upon commencing on Friday, August 16, 2024, at 11:17 a.m. EDT

AFFIRMED: DR. JILL WIWCHARUK

CROSS-EXAMINATION BY MR. DIACUR:

1 **Q.** Good morning, Dr. Wiwcharuk. My name is Jordan Diacur. I'm a lawyer acting for the City of Hamilton. So my questions are going to be posed to you from that perspective.

I understand that there is an affidavit in your name with a date of June 7th -- I can pull it up -- June 7, 2024. Do you have a hard copy of that document?

A. I do in front of me, yes.

2 **Q.** Okay. And I can see that you're in a room that looks like it's got some other documents in it. Is that the only document that you have in front of you?

A. Correct.

3 **Q.** Okay. Are you at home?

A. I am, in my office at home.

4 **Q.** And are you alone in the room?

A. I am indeed.

5 **Q.** So just to be clear, if there are any interruptions or if anyone enters the

room, I'd like you to tell me. We can always take a break if something happens, or if you need one, let me know. But for purposes of this examination, you are to be alone and have just a copy of your affidavit with you, not to refer to any other documents.

A. That sounds fine. No problem.

6 **Q.** Thank you.

So I'm also going to share my screen so that there's a copy of the affidavit that I'm referencing up on the screen. You can reference either that or the hard copy that you have in front of you, just as long as you have a copy that you are able to reference.

So my first question for you has to do with the form of the affidavit. I note that at the beginning it does say "Sworn June 7, 2024." However, if I scroll through it to the end, it indicates that it was, in fact, affirmed remotely by you and that you stated that you were located in the city of Victoria.

Is that accurate that this affidavit was affirmed and it was done remotely with you in the city of Victoria in British Columbia?

A5380
A1096

A. Yes.

7 **Q.** Okay. And I note that this part of the affidavit, called the jurat, doesn't indicate a date that it was commissioned. Do you recall the date that you signed this affidavit?

A. I would have to look at my notes. So no, I don't recall that date off the top of my head. I assume it's the date that was noted, June 7, 2024, but that would just be an assumption. I'd have to look at my calendar.

MS. CROWE: Sorry, if I could interject for one second and just direct your attention to the first page where it indicates sworn June 7, 2024 --

MR. DIACUR: Yes, I understand that it references that it's sworn June 7, 2024, on the first page. I posed that question to the witness, but she's also indicated that she didn't swear it -- in fact, she affirmed it -- and there's no date in the jurat. So I'm trying to establish the date that it was actually signed. If the witness doesn't recall, I'll accept that answer.

MR. CHOUDHRY: We'll provide an undertaking to give it.

MS. CROWE: We will provide you

with an undertaking to provide that information.

MR. DIACUR: To provide what information?

MS. CROWE: The date that it was affirmed.

MR. DIACUR: The witness doesn't recall. That was the question. I don't know how you can answer on behalf of the witness.

MR. CHOUDHRY: Counsel, we can provide you with an undertaking to get you the information as counsel. I think we've settled it. So why don't you move on.

MR. DIACUR: I don't believe that we've settled anything. The witness stated that she doesn't recall when she swore the affidavit, or I should say affirmed the affidavit. I'm accepting that answer.

8 **Q.** Now, if I scroll through this affidavit, you indicate that you have personal knowledge with respect to the facts and reports set out below, except where stated otherwise. You state:

"Where the information is not based on my personal knowledge, it is based upon information provided by

others which I believe to be credible and true." (As read.)

A5381

You then state:

"I am a physician formally with the Shelter Health Network, SHN, and the Hamilton Social Medicine Response Team, HAMSMaRT." (As read.)

The word "formally," does that mean that you are still with the Shelter Health Network, SHN, and the Hamilton Social Medicine Response Team, HAMSMaRT, as of the date of this affidavit?

A. As of the date that I -- that I wrote the letters is when I was -- I was part of Shelter Health Network and Hamilton Social -- the HAMSMaRT.

9 **Q.** Okay. It's perhaps the word "formally" that's causing the issue. Do you mean formerly, F-O-R-M-E-R-L-Y?

A. No. No, no. No. I believe it is meant to be formally. I am a physician with the -- yeah, I don't believe it's formerly. It's meant to be formally. Yeah.

10 **Q.** As of today's date, are you still a physician with the Shelter Health Network,

SHN, and the Hamilton Social Medicine Response Team, HAMSMaRT?

A. No.

11 **Q.** So as of today's date, you are formerly a physician --

A. Yeah, as of today's date, indeed. Yeah.

12 **Q.** And as of the date that you swore this affidavit, whatever date that was, you were formally with them?

A. So I -- yes, absolutely, because I swore that when I swore it.

13 **Q.** And I understand --

A. I think I -- I think I'm mixed up between swearing and affirming. I'm not -- I'm not clear on what those terms are and what -- what the dates --

14 **Q.** When this affidavit was signed by you, was it explained to you that you had the opportunity to take an oath in order to, as you've done today, tell the truth?

A. Well, that's exactly what I did when I swore it. That's what I do -- yeah.

15 **Q.** Was it explained to you that there's a difference between swearing to tell the

A1097

truth on a holy book that binds your conscience or to take an oath affirming that you will tell the truth without doing so on a holy book that binds your conscience?

A. I do not recall.

16 **Q.** Do I understand that you are no longer practising medicine in Hamilton?

A. Correct.

17 **Q.** When did you cease practising medicine in Hamilton?

A. June 30, 2022.

18 **Q.** Did you resign from the College of Physicians and Surgeons of Ontario as of that date?

A. Yes.

19 **Q.** And have you considered -- or continued, I should say, practising medicine in the province of British Columbia?

A. Yes.

20 **Q.** And you currently reside in the city of Victoria, British Columbia?

A. Yes.

21 **Q.** And scrolling down beyond paragraph 2 of your affidavit, you then begin to reference a series of what you call reports to the

Hamilton Community Legal Clinic. They're on various dates and they're attached as exhibits to your affidavit; is that accurate?

A. Yes.

22 **Q.** And beyond stating that you provided reports to the Hamilton Community Legal Clinic on certain dates with respect to certain individuals, which are also referred to as medical letters, there are no other statements in your affidavit?

A. Yes, correct.

23 **Q.** There's no statement in your affidavit that you adopt any of the statements in the exhibits to your affidavit as true. Your affidavit is limited to providing copies of these reports, or what you call medical letters; is that accurate?

A. Can you say that one more time? I'm -- this seems -- like, you're getting --

24 **Q.** There is no statement in your affidavit, as we've just seen, that you adopt any of the statements in any of the exhibits to your affidavit as true. Your affidavit is limited to providing copies of what you refer to as reports

or medical letters; that's accurate?

A5382

A. No, that's not accurate because Number 1 says that the information --

"I have personal knowledge with respect to these facts... Where the information is not based upon my personal knowledge, it's based upon information provided by others which I believe to be credible and true." (As read.)

I'm not in the habit of writing letters that I do not believe are true.

25 **Q.** I understand that.

But you do not state in your affidavit that you adopt any of the statements in the exhibits to your affidavit as true. Your affidavit is limited to providing copies of the reports, or what you call medical letters; is that accurate?

A. Yes.

26 **Q.** In this matter, you've not provided any current or up-to-date curriculum vitae, or CV; is that accurate?

A. Yes. I believe that can be found in a -- my CV is in evidence in the

injunction motion, that I believe you have a copy of.

27 **Q.** The injunction motion occurred in 2021. You've not provided any current or up-to-date curriculum vitae, or CV, in this matter; is that accurate?

A. Yes.

28 **Q.** You've not signed any form entitled "Form 53, Acknowledgement of Expert's Duty" in this matter; is that accurate?

A. Yes.

29 **Q.** And in this affidavit, you do not describe any factual assumptions on which any of your opinions are based; is that accurate?

A. Do not describe any factual assumptions -- I don't think I understand what that means.

30 **Q.** Well, as we've just scrolled through, there are no statements in this affidavit which state "I am assuming to be true for purposes of my opinion X, Y or Z facts." Is that accurate?

A. Yes.

31 **Q.** And in this affidavit, you do not describe any research conducted by you that led you to form any opinions; is that accurate?

A1098

A. Yes.

32 **Q.** And in this affidavit, you do not describe or list any documents, if any, relied upon in forming any opinions; is that accurate?

A. No. I -- I refer to medical records for every one of these patients, legal medical record documents.

33 **Q.** So the documents that are referenced in the reports, or what you call medical letters, attached as exhibits to this affidavit are the extent of the documents that you relied upon in forming any opinions that are expressed?

A. No. That's not accurate. I wrote these letters based on medical records that -- for each of these patients.

34 **Q.** Yes. So the medical letters referenced in the reports, or what you call medical letters, attached as exhibits to this affidavit are the extent of the documents on which you relied in forming any opinions that are expressed?

A. No. These medical reports are not medical records. The medical reports are based on medical records that are not part of the

affidavit. They're -- they're in an electronic medical record that is part of the patient's health record.

35 **Q.** Yes, Doctor. I'd ask that you listen to my question.

The medical records or notes referenced in the reports, or medical letters, that are attached as exhibits to your affidavit are the extent of the documents that you reviewed or relied upon in forming any opinions that are expressed; is that accurate?

A. No, because in Number 1, I said when information is not based on my personal knowledge, it's based upon other information. So, for example, if I said that I -- at times, I would ask a -- well, there's -- there's examples of that in the letters.

36 **Q.** Examples of what in the letters?

A. Where something was based -- like, I -- for example, I would ask a shelter worker to find a bed for one of my patients. I would ask someone at a drop-in centre to find a bed for one of my patients, and then I would -- I would note to my knowledge, that was not available

or, if it was available, that it became available. But it's not solely medical-record information that I was giving there.

A5383

37 **Q.** No, I understand.

We're solely talking about documents; you understand? I'm saying the --

A. Okay. Documents. Okay.

38 **Q.** The medical records or notes that are referenced in the reports, or what you call medical letters, that are exhibits to your affidavit form the extent of the documents on which you relied in forming any opinions that are communicated; is that accurate?

REF MS. CROWE: Asked and answered.

THE WITNESS: Yes.

MR. DIACUR: That has not been answered. She --

MR. CHOUDHRY: Counsel, she just said, "Yes."

THE WITNESS: Yep. Let's move on.

MR. CHOUDHRY: She just said, "Yes."

MR. DIACUR: So after an objection was raised to the question being asked and answered, the answer was given? I want to --

THE WITNESS: No. Actually, it --

MR. DIACUR: -- be clear for the record.

THE WITNESS: Actually, it happened at the same time. I said "Yes" at the same time.

MR. DIACUR: No. That's not going to be clear on the record. I'm not going to accept an answer that's given after an objection by counsel. I want to --

MS. CROWE: No, no, no --

MR. DIACUR: -- ask this question and get an answer to it. Are you --

MR. CHOUDHRY: Mr. Diacur --

MR. DIACUR: -- objecting to the question?

MR. CHOUDHRY: Mr. Diacur, please watch your tone. Why don't you restate your question calmly and then --

MR. DIACUR: I am perfectly calm.

I am responding to an objection from counsel. Is the question objected to or not?

MS. CROWE: It is because our position is that, prior to the objection, the question had been asked and answered. She's explained what she has done, what kind of

A1099

consultations she undertook --

MR. DIACUR: Yes. That's not a response to the answer to the question. Talking about oral conversations she had with others is not an answer to a question about documentation, and I want, on the record, an answer to the question.

39 **Q.** Dr. Wiwcharuk, other than any medical records or notes that are referenced in the reports, or what you call medical letters, that are attached as exhibits to your affidavit, were there any documents that you relied upon in forming any opinions expressed?

A. Was there any documents that I relied upon. That's a different question than you first asked -- no, there wasn't any other documents I relied upon.

40 **Q.** Thank you.

A. Yes, no.

41 **Q.** Dr. Wiwcharuk, do you consider yourself to be independent in this case?

A. Yes. I'm a treating physician of these patients.

42 **Q.** You consider yourself to be independent in this case?

A. Yes.

43 **Q.** And by that, I mean you do not favour one side or the other?

A. I am the treating physician of these patients in front of me, and I'm here to provide objective evidence of that. That is what I'm here for.

44 **Q.** You prepared the medical letters or reports referenced in your affidavit at the request of the lawyers for the applicants; is that correct?

A. Yes.

45 **Q.** In fact, you addressed the letters to the lawyers for the applicants?

A. Indeed.

46 **Q.** The letters were prepared at or after the time that this litigation began?

A. Yes.

47 **Q.** You've not included any of the applicant lawyers' requests or instructions to you in your affidavit or in the attached medical letters; is that accurate?

A. Yes.

48 **Q.** Is there -- I'm sorry, you're saying that you have not done that?

A. Sorry, can you repeat that question one more time?

A5384

49 **Q.** Yes. You have not included the applicants' lawyers' requests or instructions to you in the affidavit or in the attached medical letters; is that accurate?

A. I don't have any instructions from the lawyers regarding these applicants. I was simply asked to provide a letter for them.

50 **Q.** Is there any additional correspondence -- emails, letters, notes of calls -- between you and the applicants' lawyers with reference to this matter?

A. With reference to each individual patient?

51 **Q.** With reference to this litigation, this matter.

A. I can't recall of any off the top of my head right now, no. But there -- I mean, probably if I go back in my emails.

52 **Q.** Did you prepare the medical letters on your own, or did the applicants' lawyers assist you with that?

A. I 100 percent prepared these letters on my own. There was -- there was no one

helping me with that, at all.

53 **Q.** Well, tell me about how you were contacted and asked to provide the letters.

A. Okay. I'm trying to bring this back. This is 2021 that I wrote these letters. So there's a bit of a time gap here. I --

54 **Q.** Well, just to be clear, they're dated in 2022; correct?

A. Sorry, 2022. That's right. Sorry, my bad. My mistake.

So I guess I can't recall exactly. I know that I would receive an email stating that this -- that someone has been -- well, actually, no, I -- I can't recall exactly. I would have to check my emails. I was requested to provide a letter, a medical letter, and I did so. And there -- that's all I can speak to.

MR. DIACUR: Counsel, I'd request an undertaking that copies of any emails that Dr. Wiwcharuk is able to locate with respect to the instructions or requests that she provide these medical letters attached to her affidavit be disclosed.

A1100

MR. CHOUDHRY: We're happy to do

so, subject to litigation privilege.
MR. DIACUR: Is there an assertion that litigation privilege attaches --
MR. CHOUDHRY: We'll look at the -- sorry, go ahead. Just to be clear, I just want to make sure --
MR. DIACUR: Is there an assertion of litigation privilege with respect to instructions or requests being made to a participant expert? Is that --
MR. CHOUDHRY: No.
MR. DIACUR: -- the case?
MR. CHOUDHRY: No, I said subject to it. So we'll review the correspondence and determine whether to make any assertions of privilege in relation to them.
MR. DIACUR: And so you're taking that under advisement?
U/A MR. CHOUDHRY: We're taking it under advisement. We'll get back to you.
MR. DIACUR: Thank you.

55 **Q.** Dr. Wiwcharuk, did you review the notice of application in this litigation before preparing the reports or medical letters?

A. No.

56 **Q.** Did you speak with any of the applicants before preparing medical letters or reports with respect to them?

A. Well, they're my patients. I spoke to them regularly. I would see them.

57 **Q.** So at the time you were preparing the reports or medical letters attached to the affidavits, did you speak again with the applicants?

A. Well, I would ask for their consent because I would never -- I would never provide something to someone, a third party, without consent from a patient.

58 **Q.** So I don't believe that's referenced in the reports or medical letters. So you obtained the consent of each of the applicants that are referenced in these reports or medical letters before preparing them?

A. That is a standard procedure for any -- for any physician who is providing medical -- medical information to a third party. That is -- it would be entirely unethical to do otherwise.

59 **Q.** Did you provide drafts to the applicants before finalizing the letters?

A. Absolutely not. That is not -- no.

A5385

60 **Q.** What information did you provide to the applicants when seeking their consent?

A. I would ask them if they were okay with me providing their medical history to the legal clinic as requested by the lawyers. That is what I would ask them.

61 **Q.** Was consent obtained in writing?

A. No. Verbal consent would have been obtained and documented in their medical record, as is common practice amongst physicians.

62 **Q.** Did you review the applicants' own affidavits in this matter before preparing your reports or your medical letters?

A. No.

63 **Q.** You're aware that some of the affidavits were prepared before the dates of your medical letters?

A. I'm not aware of that.

64 **Q.** Are you aware of the other portions of the record in this case, other experts on behalf of the applicants or on behalf of the

City of Hamilton, and did you review that material before preparing your affidavit?

A. Not before -- no. So there's two questions you just asked there. I'm not sure which one you want me to answer, but --

65 **Q.** Are you aware of any other parts of the record in this case?

A. I am aware of other people's names that are mentioned as witnesses, yes.

66 **Q.** Did you review any affidavits by any other person before preparing your own affidavit?

A. No.

67 **Q.** Did you review the evidence of Dr. Koivu given by affidavit on behalf of the City of Hamilton?

A. Just a week or two ago.

68 **Q.** You did not prepare any reply affidavit responding to the evidence of Dr. Koivu; is that accurate?

A. Correct.

69 **Q.** You did not prepare any reply affidavit responding to the evidence of any other witness on behalf of the City of Hamilton; is that accurate?

A1101

A. Yes.

70 Q. I'd like to know, while you were employed or working on behalf of the Shelter Health Network or HAMSMaRT, how you provided services to patients. Can you explain that?

A. Yeah. I was a -- I worked in a clinic in the basement of the Salvation Army, and so every Monday, I would be there providing care throughout the entire day for people that would come and see me for health care, not just residents of the Salvation Army.

I also worked a full day a week at a drop-in centre for people experiencing homelessness, at the Wesley Day Centre, and I would also do outreach work. So I worked -- I would go directly to encampments, directly to people living outside, providing health care and so would often be -- you know, would come in my car with medical supplies. In my car, I'm able to provide direct care there.

I am also -- being an addiction medicine specialist trained with a diploma from the International Society of Addiction Medicine, I also provided addiction care in my role as outreach and -- outreach -- as an outreach doctor.

71 Q. And was that the sole -- the sole -- I'll ask it this way. In terms of your medical practice, was that the only services that you were providing to patients, or did you have a broader medical practice than this?

A. Yes. I'm also an emergency doctor.

72 Q. So you have hospital privileges and served in emergency departments in hospitals?

A. Yes. And at that time, I was also working as an inpatient addiction medicine specialist.

73 Q. And at what hospitals did you provide emergency services?

A. Brantford General Hospital.

74 Q. Any others?

A. Not at that time, no.

You did -- oh, no. Go ahead.

75 Q. I did what?

A. I -- no, that's fine. I was just -- I was curious if you had asked about the affidavit from Dr. Koivu as I was -- as I was describing my medical practice, which is, in particular, working with people who are homeless

in encampments, in shelters.

A5386

It -- I was thinking of the fact that with that experience of 13 years -- at this time, I guess 11 years in 2022 -- working directly with people in their own environments, whether that be shelter or encampments, I certainly have -- you know, I was able to see very clearly what was happening with these patients as opposed to just working in a hospital setting.

76 Q. Were there any other parts to your practice at these times?

A. No, that was them. Oh, sorry, I had a -- I had a -- no, that's wrong. I had an addiction practice as well, a very specific addiction practice at The Hamilton Clinic, and so --

77 Q. At which Hamilton clinic?

A. It was called "The Hamilton Clinic."

78 Q. Okay, at The Hamilton Clinic?

A. You got it. Capital "T."

79 Q. Understood.

Anything else you can recall about your practice?

A. I enjoyed it.

80 Q. You'd agree that in treating a patient, just as a general statement, it's important to obtain an accurate medical history; is that right?

A. Yes.

81 Q. And it's important that a medical history be comprehensive?

A. So that, I do not always agree with, no. And the reason for that -- or, well, no.

82 Q. Comprehensive in the sense that it doesn't leave out anything significant?

A. So when -- when you are dealing with people who have a lot of competing priorities and who are homeless and are often in a state of crisis, it is not an appropriate time to -- there are some times when you cannot get an extremely comprehensive health history.

83 Q. You'd agree that an accurate medical history is important in giving a medical opinion?

A. Oh, yes.

84 Q. And you'd agree that having an inaccurate or an incomplete medical history may affect the reliability of a medical opinion or a

A1102

medical assessment?

A. No, I would not agree with that.

85 **Q.** On what basis?

A. Because when you provide patient-centred care, you -- you do what is best for the patients given -- given the circumstances that are there and given the difficulties that they're facing. So you -- over time, you may get an entire medical -- you slowly develop the medical history over time.

Classically, you might have the idea of a patient coming in and you have a 40-minute intake and you discuss all your past medical history with all previous reports, and that is a very privileged way of being able to access health care, and it's not the reality for the majority of people that are -- have significant mental health and addictions histories.

So in my extensive practice working with people in these scenarios, I have found that I can absolutely get an accurate medical history over the time that I spend with them, and it might not all be in one specific time and it might be

put together over time, but a medical opinion that is -- that is given from that is absolutely just as -- just as accurate as it would be if I had spent more time -- you know, if they were able to give me more time at the beginning of a session.

86 **Q.** I understand that you can develop a more accurate picture of a patient over time. But you would agree that an inaccurate or incomplete medical history would affect the reliability of a medical opinion or assessment?

A. No, I would not agree with that.

87 **Q.** On what basis?

A. Because there are all sorts of medical opinions that can be given. If I were to give a medical opinion of a certain part of something on someone, then yes, I might need an entire medical history. But if I were to give a very specific medical opinion on something, I would not do so unless I had an accurate history on which to do that.

88 **Q.** So I --

A. So I actually --

89 **Q.** So, again, I appreciate that an accurate history can be obtained. But if you

had an inaccurate history, it would affect the reliability of a medical opinion or assessment; isn't that accurate?

A5387

A. That is not accurate because there are different medical opinions. There are -- there are different medical opinions that someone can give for different things. So if you were to ask me a medical opinion on a certain specific -- a specific area for I do not have an accurate medical history, then yes, I would not be able to -- I would not be able to provide that.

But other -- you know, you -- I can absolutely give accurate medical opinions based on -- and I would never -- I would never pretend to give a medical opinion that wasn't accurate with -- with -- I wouldn't -- if I didn't have -- if I didn't have information on which to base my medical opinion, I would never presume to give a medical opinion.

90 **Q.** A medical opinion or assessment would be less reliable if the medical history that you had was inaccurate or incomplete; is that true?

A. That would depend on what the medical opinion -- what medical opinion is being

asked, is being requested.

91 **Q.** You'd agree that some patients may not be able to give you an accurate or a comprehensive medical history for themselves; is that true?

A. Yes. I have -- I have referenced that in my letters.

92 **Q.** And patients may not be able to comprehensively report their own experiences; is that true?

A. Yes, that's true. And physicians get medical histories from more places than just the -- than just the patient. We're often accessing -- well, all the time, we're accessing hospital records, former psychiatric records, other doctors' records. So the patient's history is just one place where we get medical history.

93 **Q.** So in taking a medical history from a patient, obtaining it from these various sources, do you take any steps to account for the possibility that there may be inaccuracies?

A. We do that all the time. That's what we do as doctors.

94 **Q.** What steps do you take?

A1103

A. We cross-reference. We check things out in emergency records. We check things out in addictions records. We call other providers to -- to get collaboration. We -- we -- that's how we -- that's how we build a medical record, and that is what I do with my patients as well, of course.

95 Q. So if I understand, there are times when you would render a medical opinion without gathering a complete medical history?

A. No, absolutely not. And I find that quite offensive.

96 Q. Well, if I understood your answer previously, it's that you may render an opinion on a small part of a person's treatment without having a full understanding of their medical history. Did I misunderstand?

A. Yes, you did.

97 Q. All right. So you would not render a medical opinion without gathering a complete medical history on a patient?

A. Do you want me to say something after that? You're telling -- sorry --

98 Q. Is that correct, the proposition I've just put to you?

A. Sorry, can you say that one more time?

99 Q. You would not render a medical opinion with respect to a patient without gathering a complete medical history on that patient; is that accurate?

A. No, but I'm happy to rephrase that to make it accurate. I would not render a medical opinion on someone unless I had appropriate past medical history and a medical to do so.

100 Q. So you would render a medical opinion with respect to a patient without having a complete medical history on that patient in some circumstances; is that true?

A. No. I told you that a medical opinion on a certain aspect, you -- there are -- for -- I would not -- I would not render a medical opinion on someone without having all the medical history I needed to provide that medical opinion. Absolutely not. I would never do that.

101 Q. And that would involve reviewing all of the necessary medical records?

A. All of the necessary medical records, correct.

102 Q. And it would involve taking time to carefully examine the patient?

A5388

A. Of course.

103 Q. And you would agree that your opinion would not be valid if you did not review the appropriate medical records and if you did not carefully examine the patient?

A. No. I believe that my medical opinion would be valid based on my practice for the last 13 years, which is always -- I would never -- again, as -- as a physician with integrity, one does not provide medical opinions unless they would be accurate.

104 Q. I'm not sure that was an answer to my question.

A. Yeah.

105 Q. You would agree that your opinion would not be valid if you did not review the appropriate medical records and did not carefully examine the patient you were --

A. Yeah. No, I -- I suppose, yeah. Yeah, I agree that it would not be valid if I -- yeah. Yeah, no. That's --

106 Q. I'd like to turn now to the --

A. Sorry, can I just ask -- I

have 30 minutes booked for this time and I have medical care that I need to -- I have things going on. Are we at 30 minutes here, or where -- what's going on here? Can I just double-check on the time?

107 Q. I'm going to be posing questions to you. If you have to leave, then we can address it via counsel.

A. I --

MS. CROWE: Sorry. Sorry, Dr. Wiwcharuk. One moment.

Mr. Diacur, do you have an estimate for how much longer you have in your examination?

MR. DIACUR: Well, it would be difficult for me to estimate. I have some questions about each of the reports and medical letters attached to the affidavit. I would estimate about another half an hour, maybe 45 minutes.

THE WITNESS: That is a lot longer.

MS. CROWE: Can we go off record for a moment?

MR. CHOUDHRY: Can we go off record for a moment?

MR. DIACUR: Yes, that's fine.

A1104

--- (Off-the-record discussion.)

MR. DIACUR:

108 **Q.** I'd like to turn briefly to Exhibit A to your affidavit. It's a report or letter relating to Corey Monahan.

A. Yes. I have it here.

109 **Q.** It's dated May 31, 2022.

A. Mm-hmm.

110 **Q.** Now, you state that this letter is based on your review of Mr. Monahan's medical records; is that accurate?

A. Yes.

111 **Q.** And you reference notes; one note dated March 9, 2022, for example?

A. I do reference that.

112 **Q.** And that's not a note that you prepared?

A. Yeah, that was a note that I made in his medical -- well, actually, I can't be absolutely certain that it was me that wrote that note in his medical record. But it was in his Shelter Health Network EMR, yes.

113 **Q.** And you also reference a health-care practitioner who saw him at a different time. Do you see that?

A. Yes. I -- where does it say different time, though?

114 **Q.** It says "At that time" --

A. Yeah, at that time --

115 **Q.** -- "the health-care practitioner who saw him" --

A. Yeah.

116 **Q.** That was not you?

A. I -- I cannot confirm or deny that. I have -- I don't know. I'm just speaking to the note in his medical record.

117 **Q.** And you do not attach the medical note that you referred to dated March 9, 2022?

A. No.

118 **Q.** Have you ever personally observed Mr. Monahan outside of a clinic circumstance?

A. Oh, yes.

119 **Q.** Is that part of your visits to encampments? Is that when that would have occurred?

A. Well, not necessarily. Just in everyday -- like, at a soup kitchen. I would see him walking around town. People that are

homeless are very visible. They're around all the time because they have no place to stay inside, often. So I --

A5389

120 **Q.** There were times that you observed him outside of the clinic just walking around?

A. And in a clinic and in an encampment, possibly, and at a soup kitchen, possibly.

121 **Q.** Did you ever personally assess Corey Monahan?

A. Many times, yes.

122 **Q.** Was that part of treating Mr. Monahan?

A. Yes.

123 **Q.** Do you recall how many times you saw Mr. Monahan for treatment?

A. No.

124 **Q.** Do you recall when you started treating Mr. Monahan yourself?

A. Not off the top of my head, no.

125 **Q.** Do you keep medical notes when you were treating Mr. Monahan?

A. Of course I do.

126 **Q.** And you have not produced any medical records evidencing your treatment of Mr. Monahan?

A. They are all sitting in his record. I don't have any in my affidavit here. My notes are based on those, on the EMR. My notes are based on his medical records, as noted.

127 **Q.** Do you recall when you spoke with Mr. Monahan about his homeless status?

A. It comes up at every single appointment with someone. It's -- so every time I would have seen him, it would have been a discussion.

128 **Q.** Did you discuss Mr. Monahan's homeless status with him after you were asked to prepare the medical letter at Exhibit A to your affidavit?

A. I have no idea.

129 **Q.** It's possible?

A. I -- I can't remember. I do not recall.

130 **Q.** I'd like to turn to Exhibit B to your affidavit, which has to do with Cassandra Jordan. This letter is dated June 1, 2022.

Do you have a copy of that?

A1105

A. I do.

131 **Q.** You state in the second paragraph:

"I do know that she suffers from opioid use disorder, stimulant use disorder, chronic pain and a recent acetabular fracture and hip dislocation requiring surgery. I am convinced she has significant undiagnosed mental health issues." (As read.)

A. Yes. No, "I am also certain she has" is what it reads, but yes.

132 **Q.** Did you personally assess Ms. Jordan to establish these diagnoses?

A. Well, I have -- as noted here, they're undiagnosed.

133 **Q.** Did you ever personally assess Ms. Jordan at all?

A. Yes.

134 **Q.** Was that part of treating Ms. Jordan?

A. Yes.

135 **Q.** Do you recall how many times you saw Ms. Jordan for treatment?

A. I do not recall.

136 **Q.** And, again, you have not produced any medical records evidencing your treatment of Ms. Jordan?

A. No. The letter that I've written is based on her medical records.

137 **Q.** In terms of undiagnosed mental issues, or mental health issues, do you ever make referrals to mental health practitioners so that such diagnoses could be considered?

A. Yes, regularly when -- when that's something that is in the patient's best interest. Yes. Many times --

138 **Q.** Did you do that with --

A. Many times, family doctors or addictions doctors like myself can also make those diagnoses when there's --

139 **Q.** Did you do that with respect to Ms. Jordan?

A. Did I do what?

140 **Q.** Make a referral to a mental health practitioner so that a diagnosis could be pursued.

A. One -- just give me one second. I have to read the thing.

No, and the reason is because she was -- she was receiving care from another doctor regarding -- this particular patient had another doctor that was involved in their care and she was seeing him at his clinic, and I was only involved for the wound care that was -- that I talk about in this -- in this report.

A5390

141 **Q.** So that is the burn that you reference?

A. Yes.

142 **Q.** You indicate that if she had presented to hospital, she would likely have been admitted to a specialized burn unit. Did she decline such care?

A. Yes. I reference that in my letter, yeah. She was --

143 **Q.** And that burn --

A. She --

144 **Q.** Sorry, please continue.

A. She was living in a tent and there was a huge police presence all around her, and she was afraid of having all her possessions taken if she were to leave. So she -- again, her health care -- health care goes way down on a list of priorities when someone is afraid that

everything they own in the world is going to be taken away.

So that's why she felt she was absolutely unable to go to the hospital, and that's why she asked that I come back and that I take care of her wound as best I can, which I did until she was no longer at that park and I could no longer find her.

145 **Q.** And that burn healed without being admitted to hospital or a specialized burn unit; is that accurate?

A. In this case, yes, it did. She will have had a much larger scar and may be left with chronic pain from that scar. So it may not have been the most optimal healing process, and it likely would have been much better had she received specialized wound care.

146 **Q.** Did you treat her for chronic pain?

A. No, I did not treat her for chronic pain at that time. No. Again, as noted, she did have another doctor that was involved in her care as well.

147 **Q.** And when you say that she may have suffered from chronic pain, that's an

A1106

assumption you're making?

A. That is an assumption, yeah.

148 Q. Did you treat Ms. Jordan in an encampment or in a clinic setting?

A. In an encampment.

149 Q. Were you present and saw the police presence that you just referenced, or is that something reported to you by Ms. Jordan?

A. I was present.

150 Q. Have you listed in this letter all the instances where you provided medical care to Ms. Jordan?

A. I can't recall. Yeah. Again, a lot of times people come to us for episodic care only because there's an acute infection or there's an acute -- you know, there's something and they're unable to get to their regular provider. So we do often provide -- we can, in some circumstances, be providing acute ad hoc care. Most people are really only seeing us. But this -- in particular, this patient also had an addictions and -- an addictions doctor that was also providing some family care, some family medicine care, at another clinic.

151 Q. You do also reference on the

second page an altercation with police on May 6, 2022, in the second-last paragraph. Now, is it the case that you did not observe the alleged altercation with police?

A. No, but I was -- I was privy to hospital records that spoke to that.

152 Q. And it was also something reported to you by Ms. Jordan?

A. Yes.

153 Q. You provided Ms. Jordan with addiction-related care; is that true?

A. Yes, because I was an inpatient addiction medicine doctor and she had an inpatient stay in hospital. So I saw her in that capacity as well, while she was in hospital, yeah.

154 Q. What addiction-related care did you provide?

A. Opioid agonist therapy.

155 Q. The expected progression of an opioid-addicted patient who is not getting such treatment is to worsen; is that true?

A. Not always, no.

156 Q. That's not the expected progression?

A. No. No, it's not -- that's --

no, that's not the expected progression.

157 Q. The best practice for treating a patient with opioid addiction is to get a baseline; is that true?

A. I don't even know what getting a baseline would mean.

158 Q. How do you assess if somebody is getting better or not?

A. By looking at their social situation, their work situation, their relationship situation, their housing situation, how much -- like, how much -- how much -- how many substances they're using, how they're interacting with people. You look at it all and, most importantly, you talk and listen to the patient.

159 Q. So in terms of my question about getting a baseline, that would be a baseline for their current usage of opiates. So is it best practice for treating a patient with opioid addiction to get a baseline for their opiate usage?

A. Oh, yeah. Okay. Mm-hmm, yes.

160 Q. Is it an accepted premise in addiction medicine that the goal is for the patient to stop using the opiates that they are

addicted to?

A. Not necessarily, no. That does not have to be -- that does not have to -- that's certainly not everyone's goal. That's where harm reduction and an understanding of harm reduction comes in.

161 Q. The four pillars of addiction medicine are prevention, treatment, harm reduction and enforcement; is that true?

A. I've never heard of enforcement in those pillars. I'm not aware of -- I'm not aware of -- of where that -- that specific -- those specific four pillars -- like, I -- I'm -- certainly, the first three ring true to me. Enforcement, I am not at all sure about.

162 Q. Is it true that changes in the brain of an addicted person affect their executive function?

A. Sorry, can I -- are we -- I'm here to provide evidence for these affidavits, as a treating physician of these affidavits -- of these patients of mine. Is this -- is this relevant to that?

163 Q. Yes.

A. Okay. Can you ask the

A5391
A1107

question again?

164 **Q.** Is it true that changes in the brain of an addicted person will affect their executive function?

A. Yes.

165 **Q.** Is it true that patients rely on health-care providers to provide them with the information they need in order to make an informed decision about something like opioid agonist therapy?

A. That is a part of the picture. Many of the decisions that are -- I mean, we take our direction from patients on what their goals are, and that is how -- that is what patient-centred care is and that is what harm reduction is, which is by far the more -- the more successful way of treating people with opiate use disorder.

166 **Q.** So opioid agonist therapy is still something that you use in your practice?

A. Every single day, yes.

167 **Q.** What form of opioid agonist therapy do you recommend or use?

A. Well, those are two questions. But I use methadone. I use Kadian, which is

long-acting, sustained-release oral morphine. I also use buprenorphine, both sublingual tablets and extended-release injection, and I use hydromorphone.

There's -- I mean, there's many different medications that are used for opioid agonist -- again, I am -- I'm not entirely sure where -- how this is relating to the affidavits in front of me.

168 **Q.** What is --

A. I thought I was here as a treating medical physician of these -- of these patients.

169 **Q.** What is the reason why one form of opioid agonist therapy might be used as opposed to another?

A. There's all sorts of different reasons. It depends on patients' goals above and -- above and beyond anything else.

170 **Q.** What form of opioid agonist therapy was Ms. Jordan put on?

A. So she was not treated by me. I was not her -- I was not her addictions doctor, and I make -- I make no reference to being her -- in hospital, when she was in the hospital, she was

on opioid agonist therapy, and I can't recall what that was.

A5392

But as an outpatient, prior to being in hospital, she was being treated for her opiate use disorder by another doctor, and I was just providing wound care for her. In the -- however, again, in the hospital, I don't know what her opiate -- I cannot recall what her opiate agonist therapy was.

171 **Q.** Do you recall what practitioner was providing her with those services?

A. In -- as an outpatient? Yes.

172 **Q.** Who was that?

A. Dr. Dennis Divalentino.

I remember also, because she was so distressed in that tent with the police all around her, she had no way of getting to the pharmacy to get her medications for her addiction because she was so -- so worked up and distressed.

And I went to the pharmacy around the corner to get her medications for her while she stayed in her tent trying to protect her belongings from this huge presence at the park. So I specifically remember going to the pharmacy,

picking those medications up and bringing them back to her that day.

173 **Q.** So she was on a form of opioid agonist therapy that required her to go to a pharmacy every day?

A. Yes.

174 **Q.** There are forms of opioid agonist therapy that do not require that; is that true?

A. Yes.

175 **Q.** Was there any consideration given to putting her on a form of opioid agonist therapy that would --

A. I was not her addiction medicine doctor.

MR. CHOUDHRY: Mr. Diacur, I understand -- I mean, I think -- just if I could clarify, I think she provided addiction-related treatment on an inpatient basis but not on an outpatient basis, and she's indicated that another doctor did.

A lot of the questions you're asking are about outpatient addiction treatment care that this witness is not -- doesn't have information about. So I'm not sure what the value

A1108

is of asking her questions about treatments she didn't provide.

MR. DIACUR: Comments noted, Counsel.

She references opioid agonist therapy in the document that she's attached and I'm examining her on her statements.

MR. CHOUDHRY: Yeah, but I think she also has clarified, Counsel, with respect, that she provided therapy on an inpatient basis, and you're asking lots -- and she's also indicated and given you the name of the physician who provided her addiction therapy on an outpatient basis, and she said she didn't provide that; she only provided wound care.

And on one occasion, I believe, she's provided evidence that she went to a pharmacy to get that medication. So I'm not quite sure what else she can tell you other than to say she doesn't know. And she shouldn't be giving evidence about care she didn't provide and doesn't know about, unless she --

MR. DIACUR: I certainly agree with you on that, Counsel.

MR. CHOUDHRY: Yes, and --

MR. DIACUR: I'll take that answer as -- I'll take that as noted.

MR. CHOUDHRY: Yeah. Thanks, Mr. Diacur.

I just don't know what the value is of asking her about care that she wasn't responsible for providing.

MR. DIACUR: No, I agree.

176 **Q.** So let's move on to --

A. I just want to -- Counsel, do you know the difference between inpatient and outpatient? Do you know what those terms mean?

177 **Q.** Yes, I understand --

A. Okay. I just wanted to be sure. I wondered if that was the --

178 **Q.** No. I appreciate the comment of counsel stating that you shouldn't be giving evidence about something that you didn't do.

A. Yes. I agree as well.

179 **Q.** So in Exhibit C to your affidavit, this is a letter dated June 2, 2022, regarding a Sherri Ogden.

It appears from this letter that you treated Ms. Ogden at least once; is that true?

A. I treated her many times, yes.

Many times.

A5393

180 **Q.** And is it the case that you did not obtain a complete medical history or examine Ms. Ogden with respect to medical -- or with respect to mental health complaints? Is that accurate?

A. That is untrue. Entirely untrue.

181 **Q.** Well, if I'm reading this letter correctly, you state:

"She has only ever seen SHN practitioners for issues related to contraception, poor sleep or aches or pain and various rashes." (As read.)

A. Yep.

182 **Q.** That's true?

A. Yes. And when you -- when you see someone -- when someone walks in to say, "This is my concern," I look at that patient's concern and I also look at the whole person, every time they come to see me.

So they -- they are here because they have a rash. I am there. I see the rash and I look at the whole person, and I see their

past -- I see the mental health issues that they're struggling with, and I see all the social determinants of health that are causing poor health outcomes. I see that stuff as well.

So that is part -- they're coming to us with one thing, because that is their concern, and as a doctor with the years of experience I have, I am looking at the whole person and I am seeing the background stuff. So yes, every time she came to see me, I would also see the fact that she had significant undiagnosed mental health issues.

183 **Q.** Yes. You refer to undiagnosed mental health illness.

You're qualified to diagnose mental health illnesses?

A. Yes.

184 **Q.** And you did not diagnose Ms. Ogden with any mental health illness?

A. That I can -- so I can't -- I have not looked in my -- in those medical records recently, and I can't recall if I have -- if -- I can't recall.

185 **Q.** Did you ever see Ms. Ogden subsequent to writing this letter?

A1109

A. I'm -- I don't recall.

186 **Q.** You refer to any mental health illness she may have as undiagnosed. Can we not infer from that that you did not diagnose her with anything?

A. No, I would say we can't, because it doesn't say that I have -- that I have actually not diagnosed certain mental illnesses as well. So I may very well have diagnosed certain illnesses, but there may have been other ones that were undiagnosed.

187 **Q.** You've not provided any medical records or reports with any diagnosis with respect to any mental health issue suffered by Sherri Ogden; is that true?

A. In this letter? No, I have not, yes.

188 **Q.** And, in fact, in your affidavit, you've not provided any medical records or reports of your diagnosis of any mental health issue by any person?

A. Correct. There's no -- there's no -- yeah, no medical records that are attached, just the letters.

189 **Q.** There is no treatment plan

attached to this medical letter or any treatment plan for Ms. Ogden, period?

A. No. As noted, I'm not her -- I was not her family doctor. She has a family doctor outside of Shelter Health Network, who she also sees sporadically, who would have -- who would presumably have more medical records.

190 **Q.** Did you provide any medical care to Ms. Ogden with respect to the issues of contraception, poor sleep or aches or pains and various rashes?

A. Yes.

191 **Q.** Did anyone else at the Shelter Health Network do so?

A. I am -- I don't know. I think likely -- I think it's highly likely, but I can't be certain without looking at the medical record.

192 **Q.** Do you know where you saw Ms. Ogden, in a clinic or in an encampment?

A. I definitely saw her at the Wesley Drop-in Centre, the Wesley Day Centre, and I can't recall if I've seen her in other places.

193 **Q.** You refer to some hospital records in this letter. Did you see Ms. Ogden when she accessed an emergency department?

A. No, but the reference to that goes back to how I say we find our medical records on people. You go into hospital records and look to help build a bigger picture and understanding of the issues at hand. It's part of being a comprehensive and good doctor.

194 **Q.** You reference Ms. Ogden suffering from functional pain. Is that something that you diagnosed Ms. Ogden with?

A. Let me look.

No. I do indicate that these are hospital records. All the hospital records were noted to be visits for functional pain, which is commonly seen in people that have mental health issues.

195 **Q.** Is that something that you treated Ms. Ogden for?

A. Yes, and I referenced that we would see her for aches and pains -- poor sleep or aches and pains and various rashes, so yes.

196 **Q.** Is functional pain something that is a symptom of withdrawal from opiates?

A. No. Not necessarily, no.

197 **Q.** Is --

A. Pain can be. Pain can be, but

not functional pain, necessarily.

198 **Q.** Not necessarily. So sometimes it is?

A. No. No, it's not. It actually -- it would be a different diagnosis of pain.

199 **Q.** I'd like to turn to Exhibit D to your affidavit. This is a letter dated June 3, 2022, with reference to a Patrick Ward.

Do you have that?

A. Yes.

200 **Q.** How did you see Mr. Ward for medical treatment?

A. I don't understand the question.

201 **Q.** Did you see him in a clinic setting or in an encampment?

A. Mostly in a clinic setting, and sometimes I would see -- I believe I may have -- actually, I can't be absolutely certain if I saw him in an encampment. I'd have to access my medical records.

202 **Q.** And you've not attached any medical records to this letter; is that accurate?

A. That is accurate.

A5394
A1110

203 **Q.** In paragraph 2 there's a list of different portions of a past medical history. Is that something that you treated Mr. Ward for?

A. Every single one of those issues? Is that what you're asking?

204 **Q.** Yes, the list.

A. I think it's unlikely that I treated him for every single one of these issues. No. A past medical history is not about what one doctor has treated someone for. It's their -- over their health history.

205 **Q.** So it's possible that many other physicians have provided treatment for Mr. Ward with respect to all of these things?

A. No. That's unlikely because he is someone that doesn't access health care regularly. But he -- he will -- and hepatitis C, for example, sometimes people never receive treatment for that.

206 **Q.** But this is a past medical history.

A. Right.

207 **Q.** So, clearly, he has received some form of treatment for all of these things; isn't that accurate?

A. That is absolutely not accurate. You do not -- you have your hand up. Sorry.

No. People can have medical issues that do not get treated and that never get treated because their mental health might be too poor, because their housing -- because all sorts of -- all sorts of reasons why they might never receive care for their -- for their health issues.

Having a diagnosis of something absolutely does not mean that you are -- that you have at some point in your life received care for that. You have received a diagnosis. You have not necessarily received care.

208 **Q.** I see. So you're drawing a distinction between seeing a doctor and the doctor doing anything to assist?

A. No, that's not what I'm doing. You assist a patient in many ways, not just by handing them a pill and not just by treating their whatever it is. Every time you see a patient, when you have -- when you have a patient-centred encounter with that patient, you have been assisting that patient.

209 **Q.** So does diagnosis include

treatment?

A5395

A. No.

210 **Q.** So you're drawing a distinction between diagnosis and treatment.

You're saying that Mr. Ward has a past medical history of diagnosis with this list of things -- alcohol use disorder, stimulant use disorder, peptic ulcer disease, pancreatitis, hepatitis C, major depressive disorder, osteoarthritis causing chronic pain, as well as previous fractures in spine, pelvis and wrist causing chronic pain, and substance-induced psychosis -- is that accurate?

A. You just read a big, long list. What did you start with? What was the question?

211 **Q.** Mr. Ward has been diagnosed with all of these things --

A. Yes, he has. He's been diagnosed with all of -- and I've actually treated him for many of them, but not all of them.

212 **Q.** You've provided treatment to him for some of these things?

A. For many of them is what I just said.

213 **Q.** And you are unable to tell me whether any other medical practitioner treated him for any of the others or for some that you --

A. Oh, he had -- for his peptic ulcer disease, he was in the -- he was -- had an inpatient stay in hospital receiving blood transfusions because he was -- he nearly died during a perforated peptic ulcer disease. So he -- he received hospital care for that, yes.

214 **Q.** For the aspects of this list that you've not provided treatment, you're not able to tell us whether anyone else has provided treatment?

A. I just told you that he received treatment in hospital by other providers as well.

215 **Q.** You mentioned in the third paragraph that Mr. Ward has been sleeping rough. What does that mean?

A. Sleeping outside unsheltered.

216 **Q.** Does that include --

A. Or in a tent. It could -- it's sleeping when you're outside.

217 **Q.** Does that include being housed in a shelter system?

A1111

A. No. Sleeping rough is sleeping outside.

218 Q. Potentially in a tent, potentially completely unsheltered?

A. Correct.

219 Q. And you're not aware of the full chronology of when Mr. Ward has been sheltered indoors versus not?

A. I would have to access my notes, and even then I'm not sure it would give an exact chronological picture.

220 Q. In the fourth paragraph, you mention that Mr. Ward was unable to tolerate the close quarters of homeless shelters and all of the stress that these can incur on individuals. That's what he reported to you?

A. Yes.

221 Q. Is that something that you've seen firsthand?

A. Commonly, yes.

222 Q. No, I mean in Mr. Ward.

A. Yes.

223 Q. How did that come to pass?

A. He -- given his -- he just shuts off. He gets -- he has to leave. He has a

hard time with all the close quarters. Like many people who have very significant mental health issues, it makes his stress level go really high. He would feel extremely uncomfortable and he wouldn't be able to tolerate. It was -- it was very clear.

224 Q. Again, this is something he's reporting to you?

A. Well, and I saw it.

225 Q. Where did you see it?

A. I would -- I would also see him in -- I mean, when I saw him even inside a crowded soup kitchen, if he wasn't sleeping, which he often was, but if he would -- you know, if he was up, he would often not being able to tolerate being in large crowds for a long time.

226 Q. When would you have seen him in a soup kitchen?

A. At the Wesley Day Centre, where I provided care for him.

227 Q. Anywhere else?

A. I can't recall. It's possible. I can't recall.

228 Q. I'd like to move to Exhibit E. This is a letter dated June 8, 2022, with respect

to a Jahmal Jammy Pierre.

A5396

Do you see that?

A. Yep.

229 Q. Now, from the letter, it appears that you may have treated Ms. Pierre once when doing outreach work. It's not clear. Do you recall how many times you saw Ms. Pierre?

A. Let me see here.

I saw her on three occasions. Well, me or another person saw her on three occasions for --

230 Q. That's the area that I'm unclear on. It says that she's only been seen on three occasions. Do you recall seeing her on more than one occasion?

A. I -- I don't recall, no. I can't be absolutely certain that I saw her other than that very significant overdose in the street that I talk about here.

231 Q. So it's possible that parts of this letter are based on the reports of others?

A. Well, that's what -- an electronic medical record is made up of -- of reports of all the health-care providers -- I mean of all the doctors that are part of that specific

-- you know, in this case, Shelter Health Network. So it's her Shelter Health Network record that I would have accessed.

232 Q. And those records are not identified or included with this letter?

A. Correct.

233 Q. You indicate here that records indicate that the overdose was unintentional, the significant overdose that you just referenced?

A. Let me see.

Well, I see that she told me they were entirely unintentional, that she described it as entirely unintentional, as most overdoses are.

234 Q. Now, did she describe that to you, or was that somebody else that reported that description within a reference for it --

A. Oh, she was --

235 Q. -- on the medical note?

A. She described that directly to me, and I would have then put it in her medical record.

236 Q. I just want to be clear. What the letter states is:

"She was encouraged to follow up with doctors at the YWCA after that

A1112

incident, and that is when she saw my SHN colleagues. Ms. Pierre described this overdose as entirely unintentional." (As read.)

A. Yeah. She -- she described that to me. I responded to her overdose with multiple doses of naloxone in the street. We called EMS. She went straight to the hospital. As noted, I am also an inpatient addiction specialist, and I subsequently saw her in the hospital several hours later, hoping to engage --

237 Q. I see. I understand now. I think that there's confusion over the timeline.

A. Okay.

238 Q. So at the second paragraph of this letter, you state:

"On one occasion in August she had an unintentional opiate overdose and was hospitalized in the intensive care unit for a period of time." (As read.)

A. Yep.

239 Q. In the third paragraph, you reference a different time, November of 2020, and you say, "I was doing outreach work and saw

Ms. Pierre slumped over," and you recognized that she'd suffered an opiate overdose.

A. Oh, yes.

240 Q. Then you're talking about the occasion in August, and you say that she saw your SHN colleagues and that Ms. Pierre described the overdose in August as entirely unintentional.

A. She may have told me -- she may have told me that -- well, I know she told me that her opioid overdoses were unintentional. One of the things is that she wasn't an opiate user. She didn't -- she didn't have opioid use disorder.

So she was entirely opiate-naive and she used a contaminated supply of a stimulant, and that is why she had such a severe overdose, because she had no tolerance to opiates. So that is -- so she would tell me each time, "Oh, my God, I can't believe I overdosed," and when I say "unintentional," she unintentionally used opiates. She did not want to use opiates.

She had -- she -- she had a stimulant use disorder and used a contaminated supply. So I referenced that many of my patients have died in this scenario when they have no opiate tolerance and use a contaminated supply of

a stimulant, yeah.

A5397

So each time I saw her, she would say, "I --" you know, that it was entirely unintentional. She didn't -- what I mean by that, it was unintentional that she used opiates at all. She thought she was accessing either crack or crystal meth.

241 Q. And then she became diagnosed with opiate use disorder subsequent to that time? It's indicated there --

A. She absolutely very well may have. So those -- those overdoses, oftentimes someone with stimulant use disorder might go on to develop opiate use disorder. That would not be uncommon. But with those, the specific overdoses that I am referencing here, she has -- they were when she was opiate-naive and only using stimulants.

So she -- she did -- subsequently, after these, she developed opiate use disorder because that is something that -- as noted, that is something that you often, you know -- it can lead -- one can lead to another. So she initially was a stimulant -- had stimulant use disorder only, had these unintentional overdoses, and then

started using opiates and did develop an opiate use disorder.

242 Q. You indicate in the second paragraph:

"She was not at a point where she was ready to engage with treatment for her substance use disorders." (As read.)

Is that based on your assessment of her or based on a review of notes?

A. I'm not sure. Probably both.

243 Q. There's no indication in this letter of any options being presented to her for treatment for her substance use disorders; is that true?

A. The fact that she was in the emergency department and went to the ER and was seen by multiple doctors and was even seen by me in the ER as the inpatient addiction doctor, it is absolutely presumed that she was -- and, in fact, I remember very clearly begging her to get on opiate agonist therapy, would help -- which would help protect her from future overdoses.

244 Q. That's not referenced anywhere in this letter?

A1113

A. And I -- I reference that I saw her in the ER, I believe. Yeah. I went specifically to the ER to see her and try to engage with her further to -- to start some treatment, which would help protect her from future overdoses, namely Suboxone, buprenorphine.

245 Q. And it was determined she was not ready for that?

A. She determined that, indeed. She determined that.

246 Q. I'd like to turn to Exhibit F to your affidavit now, a letter dated June 9, 2022, with reference to a Mario Muscato.

Do you have a copy of that?

A. I do, and I'm looking at -- yeah. Yeah. Okay. Let's keep going.

247 Q. You state in the letter that he can't get regular treatment but also that he sees you -- or saw you regularly, several times a week, in fact, on the second page of this letter.

A. Yep.

248 Q. That's accurate?

A. Yes. So by "regular treatment," I mean getting to a pharmacy every day to get a dose of opioid agonist therapy. He was

not able to manage that. His -- he was sleeping in a different place every night and not able to get there.

249 Q. Right. And I think we established earlier that there are other forms of opioid agonist therapy. You referenced buprenorphine; right?

A. Yes, and that is appropriate for some people and it's inappropriate for others.

250 Q. It doesn't need to be administered daily?

A. That is an -- that's an injection that is monthly that -- at the time, it was a very new -- it was newly covered in Ontario at that time, but unfortunately it was not in keeping with Mr. Muscato's goals. It would not have been an appropriate medication for him.

251 Q. Well, you mention in this letter that there were times that Mr. Muscato would receive two weeks of opioid agonist therapy. Is that true?

A. If I wrote it in the letter, it's true. I -- it's a rather lengthy one, if you want to remind me where that is.

252 Q. So we can go to that. It's in

the first full paragraph on page 3. So it's on the screen now:

A5398

"There were times when he would receive two weeks of opioid agonist therapy consistently but then he would be service-restricted from a shelter or moved to an encampment and he would lose that stability and have to restart again down the road." (As read.)

That's accurate?

A. Yes. Over and over, yes.

253 Q. Now, if I understand how buprenorphine works, there's a week of Suboxone first, which is administered daily at a pharmacy, and then there is the injection you referenced, which lasts for a month, and that's the buprenorphine; is that accurate?

A. That is only one way that it can be -- and I -- there are intricacies to addiction medicine that specialists -- I mean, I could talk to you about five different ways of starting buprenorphine, and I'm not interested in explaining that to you here because I have patients that are waiting to get it from me at my

clinic right now, but yes.

254 Q. Is what I just put to you accurate?

A. No. It is only one way that buprenorphine is started. Buprenorphine is started many different ways.

255 Q. Mr. Muscato showed the ability to, for a period of two weeks at a time, attend daily and receive opioid agonist therapy. He could have attended for one week to receive Suboxone; isn't that true?

A. If he wanted Suboxone, that would have been true. As I've noted when you asked me about all the different types of opioid agonist therapy, I said different ones are appropriate for different people, and it is -- the number-one thing is patient preference.

And when someone does not have buy-in to a certain type of opioid agonist therapy, it is by far -- what kind of paternalistic approach would I be if I said, "This is what you need, because I know better than you what you need."

Of course I would offer every single type of opioid agonist therapy to every

A1114

patient I had in hopes that they would take one to somehow have higher chances of remaining alive down the road. But they do not -- when they are -- they will decline certain types of medications that are not in keeping with their goals, and he declined Suboxone.

256 **Q.** You're saying that you did offer it to him and he declined it?

A. Many times. And there -- and yes, he was also -- we even tried Suboxone at different times. We tried several different types -- I think we've -- I think we tried all three different types of opioid agonist therapy with him, including methadone, buprenorphine, and Kadian, all three lines.

257 **Q.** Is there a reason that wasn't referenced in this medical letter?

A. Because I'm -- there's -- this is a lengthy letter and there's no reason for me to -- I mean, I'm not -- I don't know what you -- for some reason, you would think you would need to know that I -- I, you know, try to get my patients to access opioid agonist therapy every single time I see them in an effort to help them stay alive.

That is actually something that one

would assume an addiction doctor is doing every day that they see the patient. That's -- I wouldn't -- I wouldn't presume that would have to be written down in a letter. I provided -- I saw him multiple times a week at times when he was able to get in to see me. I was his addiction medicine doctor and I provided him with all sorts of different avenues for care.

258 **Q.** You'd agree that it is the case that doctors have more information about what treatments are available or appropriate than patients?

A. I don't. People -- people with opioid agonist therapy are on -- are always taking to each other on the street. They're always discussing different -- what people are doing here, what people are doing there.

Only when a new therapy becomes available would a -- would a doctor necessarily have more information than a patient. I mean, you know, certainly there are certain patients that are more informed than other patients, but patients come to us very well-informed about what's available.

259 **Q.** Would you consider

Suboxone and buprenorphine more appropriate for a patient who has difficulty attending a pharmacy daily?

A. I would -- not necessarily. Again, I told you it's about patient goals. And I could sit here and describe the pharmacology of buprenorphine. Buprenorphine -- which I -- which I'm not very interested in doing right now.

But buprenorphine blocks opioid receptors. Some people, in a harm reduction approach, they still want to be able to access a high, a euphoria when they use. When you use -- when someone is on buprenorphine, it will be harder for them to have any sense of euphoria.

Again, people access this euphoria because they are -- they are having a lot of -- often self-treating mental health issues and other stresses in their life. So when people are on buprenorphine, it is much harder for them to actually have any sense of euphoria and to get high. So many people don't want buprenorphine at all.

260 **Q.** Did you ever provide treatment to a Linsley Greaves?

A. I -- I believe I did, yes. I

don't have an affidavit here in front of me.

261 **Q.** No, I understand that.

We've heard his evidence, and he said that he saw you for a complaint of frostbite. Do you have any recollection of that?

A. Yes. I do remember him having frostbite. Clearly, actually. Yeah.

262 **Q.** I'm going to show you, briefly, his affidavit because he makes some reference to you. I'm just going to click through to that.

So what I have on the screen is the Affidavit of Linsley Greaves sworn June 2, 2022, and at paragraph 32 he states:

"I only learned of this application today after meeting with Dr. Wiwcharuk at the Wesley Day Centre for treatment of my frostbite." (As read.)

A. Yes. Mm-hmm.

263 **Q.** Is it true that you were the one who informed him of this litigation?

A. Sorry, do I -- I don't have an affidavit in front of me for -- am I here to provide -- I'm just trying to -- am I missing

A5399
A1115

something? Am I supposed to have an affidavit about my information for Linsley Greaves?

MR. CHOUDHRY: Dr. Wiwcharuk?

THE WITNESS: Yeah?

MR. CHOUDHRY: There's an affidavit on the screen.

THE WITNESS: Yeah.

MR. CHOUDHRY: That's from Mr. Greaves.

THE WITNESS: Yep.

MR. CHOUDHRY: And there's a statement there --

THE WITNESS: Oh, yeah.

MR. CHOUDHRY: -- at paragraph 32, and I think you should -- I think Mr. Diacur is asking you a question based on Mr. Greaves' evidence, which he's put on the screen for you to review.

THE WITNESS: Okay. Yeah, mm-hmm. So yeah, I believe that's accurate. Yeah.

MR. DIACUR:

264 **Q.** Can you tell me what you told Mr. Greaves about this litigation?

A. I can't recall. I -- I'm -- I can't recall with certainty. I suspect that --

based on what I'm seeing here, I do absolutely remember him, his frostbite. I remember his toes were essentially autoamputating; they were starting to fall off.

I had -- I had seen that he had -- he had sustained significant harm from being unsheltered, from losing his tent, from losing his source of warmth, and we were in the middle of some -- of, you know, this litigation that was coming up, and I asked him if he wanted to -- if this -- he -- he was distraught at this and very angry at the fact that it had happened.

And I asked him if he would like to -- if he'd like me to connect him with someone who -- with one of the lawyers who was doing some work, and after that I made a connection. And that would have been the extent of my -- my part in letting him know about that.

265 **Q.** And he references, at paragraph 31 just before that, getting frostbite on his left foot and toes last winter.

A. Yeah.

266 **Q.** You saw him in June of 2022; is that accurate?

A. Yep, and that's about how long

it takes for toes to autoamputate. It's a long process.

A5400

267 **Q.** So frostbite doesn't always result in amputation?

A. No, not always. Not always, but many times it does. It's very common. I have many patients who are missing the ends of multiple digits, and it can take up to six months or even longer for them to slowly, again, autoamputate, kind of fall off. They become black and they eventually fall off.

268 **Q.** In particular, it's unlikely that frostbite will result in amputation if it's treated properly?

A. That is inaccurate.

269 **Q.** In what way?

A. In that frostbite, once you have -- so frostbite is difficult -- is just about impossible to treat. Once you have established frostbite and you have lost those capillaries, it is a waiting game. You can't get back circulation to tissue that was -- that has been lost to frostbite. So the only way to ensure that one does not lose digits from frostbite is to ensure that frostbite does not happen.

270 **Q.** When Linsley Greaves presented to you with this frostbite that he says was months old, did you refer him for any treatment? What did you do?

A. I -- I don't have an affidavit in front of me and I haven't referenced his medical records. So I don't know. This is a question out of the blue. This is over, you know --

271 **Q.** You recall meeting with him and you recall his frostbite. Do you recall what treatment you recommended or referred him for?

MR. CHOUDHRY: Mr. Diacur?

MR. DIACUR: Yes?

MR. CHOUDHRY: Out of fairness, could you maybe scroll through the affidavit to the top so she can at least read the rest of this affidavit before she answers questions about it?

MR. DIACUR: Well, I'm not asking her about the affidavit in front of her.

MR. CHOUDHRY: I think --

MR. DIACUR: She remembers meeting with him. I'm asking if she remembers what treatment was recommended.

MR. CHOUDHRY: So, Mr. Diacur,

A1116

you're putting to her an affidavit from another witness. I think it's fair when anyone does that in this proceeding to any other witness that they be provided with that affidavit in full and they be able to review it.

MR. DIACUR: I disagree. I think that --

MR. CHOUDHRY: Well, I disagree with --

MR. DIACUR: -- she understands what I'm asking her. I'm asking her about a meeting that she recalls. I'm only asking her if she recalls what treatment she recommended at that time. That's it.

THE WITNESS: I don't recall.

MR. DIACUR:

272 **Q.** Thank you.

So just a brief indulgence. I believe I may be finished. I just want make sure that I haven't inadvertently skipped a question. Just a moment.

A. So I will have a brief indulgence after that, if you don't mind.

MR. DIACUR: Yes. I confirm those are all of my questions for this witness.

Thank you, Dr. Wiwcharuk, for attending and answering.

THE WITNESS: I am appalled that you took this long when you had me here for half an hour.

MR. CHOUDHRY: Dr. Wiwcharuk, please --

THE WITNESS: Okay.

MR. CHOUDHRY: Okay, please. We're all doing our best here.

So, Dr. Wiwcharuk, now what happens is there's something called redirect, and we realize that you have patients and I can see the impatience in your face and I'm very, very sorry about this.

THE WITNESS: Okay. All right.

MR. CHOUDHRY: We have a couple of different options, and I'm trying to do this collaboratively with our friends from the City. Option one is that we take a short break so that Ms. Crowe and I can collect ourselves and assess what the scope of the redirect would be, and Ms. Crowe would lead those questions. She would try to be as efficient as possible. I expect she would be 10 to 15 minutes.

MS. CROWE: Yes, no more.

A5401

MR. CHOUDHRY: No more than 10 to 15 minutes.

Option 2 is to do what we call -- is to not dismiss you but to what's called adjourn this cross-examination and then to schedule, at a time that works for everyone, the redirection by Ms. Crowe, which again would be no more than 10 or 15 minutes. But if we were to do that, I have to put on the record that you are still under oath.

THE WITNESS: Yep.

MR. CHOUDHRY: You cannot speak with me or anyone from this legal team. You cannot be in touch with us.

THE WITNESS: Yep.

MR. CHOUDHRY: You cannot speak with anyone else about this evidence or this testimony. You are still under oath. You have to be -- unfortunately, you have to be in -- you're in that room for the purpose --

THE WITNESS: Yep. That's no problem. That is no problem at all.

MR. CHOUDHRY: I just want to clarify that it's very natural to want to speak with partners or loved ones about these

experiences, and you can't.

THE WITNESS: No.

MR. CHOUDHRY: Okay?

THE WITNESS: Yep.

MR. CHOUDHRY: So given that we're way past time, I think we'd like to present you with these two options: Push it on a bit further, with giving us a bit of a break -- so 10 minutes of a break and then 10 to 15 minutes more, possibly, so 20, 25 -- or we adjourn under those very strict conditions and we work with you simply -- we communicate with you simply for the purposes of scheduling, and the communications will be with all counsel copied on these emails.

THE WITNESS: That is -- yeah.

MR. CHOUDHRY: So what would you prefer of those two options?

THE WITNESS: Thank you very much for giving me the option. I have to take number two. I'm so sorry because I know it's just harder for everyone involved. I'm really sorry, but I do -- I am -- I have a commitment to my patients who are all waiting for me right now.

MR. CHOUDHRY: So just to be clear, and, Mr. Diacur, just -- so what we will do is we

A1117

will adjourn this cross-examination but not dismiss.

We will -- you and I or someone from our team and someone from your team, Mr. Diacur, will work -- will communicate jointly to Dr. Wiwcharuk to propose some alternative times. She's on the west coast, I'm gathering. So there's a three-hour time difference that we should be alert to.

And we will be in touch with you as soon as possible, Dr. Wiwcharuk.

Mr. Diacur, is that acceptable?

MR. DIACUR: That's fine.

MR. CHOUDHRY: Okay, good. Thank you.

THE WITNESS: I can be very flexible because in, like, three hours I am on vacation for two weeks. I can -- anytime you tell me, I can be available.

MR. CHOUDHRY: Okay. We will be -- we really are grateful for your time, and we will jointly be in touch with you; okay? And so please -- don't call us; we'll call you. Okay?

THE WITNESS: Okay. Thank you.

MR. CHOUDHRY: Okay. Thank you.

MS. CROWE: Thank you.

--- Whereupon the proceedings adjourned at 12:53 p.m. sine die

A5402

* * * * * * * *

This is to hereby certify that the foregoing is a true and accurate transcript of DR. JILL WIWCHARUK to the best of my skill and ability.

_____

Kristy Fulton

Court Reporter

A1118

COURT FILE NO. CV-21-77187

ONTARIO

SUPERIOR COURT OF JUSTICE

BETWEEN:

KRISTEN HEEGSMA, DARRIN MARCHAND, GORD SMYTH, MARIO MUSCATO, SHAWN ARNOLD, BRADLEY CALDWELL CHRISTINE DELOREY, GLEN GNATUK, TAYLOR GOGO-HORNER, CASSANDRA JORDAN, JULIA LAUZON, AMMY LEWIS, ASHLEY MACDONALD, COREY MONAHAN, MISTY MARSHALL, SHERRI OGDEN, JAHMAL PIERRE, LINSLEY GREAVES and PATRICK WARD

Applicants

-AND-

CITY OF HAMILTON

Respondent

The Continued Cross-Examination of Dr. Jill Wiwcharuk, on Affidavits dated October 3rd, 2021, and June 7, 2024, taken upon affirmation in the above action this, 6th of September, 2024, conducted via videoconference hosted by the offices of Nimigan Mihailovich Reporting Inc.

APPEARANCES:

For the Applicants:

For the Hamilton Community Legal Clinic:

SHARON CROWE

For the Community Legal Clinic of York Region:

MICHELLE SUTHERLAND

NONYE OKENWA

BENJAMIN HOGNESTAD

For the City of Hamilton:

JORDAN DIACUR

JOJO JOHNSON

Gowling WLG (Canada) LLP

I N D E X

PAGE

WITNESS: DR. JILL WIWCHARUK

Re-Examination by MS. CROWE 29

EXHIBITS

GUIDE TO UNDERTAKINGS, ADVISEMENTS, and REFUSALS:

This should be regarded as a guide and does not necessarily constitute a complete list:

UNDERTAKINGS:

(None noted).

UNDER ADVISEMENTS:

(None noted).

REFUSALS:

(None noted).

--- Commencing at 1:23 p.m.

DR. JILL WIWCHARUK,

THE WITNESS HEREINBEFORE NAMED,

Having been duly sworn by me to testify to the truth,

testified on their oath as follows, to wit:

RE-EXAMINATION BY MS. CROWE:

70 Q. This is a follow-up to the examination that took place a couple of weeks ago with Mr. Diacur. And so you indicated that you were practising with Shelter Health Network and HAMSMaRT at the time of completing your affidavit.

Are there other doctors with either of those organizations?

A. Yes.

71 Q. Do you know how many?

A. I don't know exactly how many there were with Shelter Health Network. It was at least 18. At least 18. And with HAMSMaRT, there were, I believe, three.

72 Q. Okay. And were there any other types of medical practitioners with either organization?

A. Oh, yes, many. Certainly with Shelter Health Network, there were numerous nurses, and nurse practitioners, and social workers.

And with HAMSMaRT, there were peer workers

A5404

and a midwife. Yeah.

73 Q. Okay. What about non-medical practitioners working with either organization?

MR. DIACUR: No. I object to that. That's not a new issue whatsoever. There's nothing asked of her about nonmedical practitioners and there is no ambiguity in her answers about these questions.

That's not proper re-examination, counsel.

BY MS. CROWE:

74 Q. Okay. That's fine. We will move on.

Mr. Diacur asked you about what information sources for patient records you consult and you indicated that you often access hospital records, former psychiatric records, other doctors' records.

Was this is an exhaustive list of where you might get information about a patient's history or are there other sources of information?

A. There are other sources. I would also talk to a pharmacist. I would look at pharmacy records, especially regarding opioid agonist therapy because it would help me know what they have been taking and how often they're getting their medication if they are missing doses, et cetera.

And sometimes it would also just be calling another doctor and speaking over the phone without getting

official records, but calling. And as we are all part of the circle of care, and discussing the patient, and working together to provide best care.

75 Q. Sorry, what do you mean by "circle of care"?

A. Circle of care is when there are multiple different providers involved in providing care for someone. Yeah. So that would be a circle of care.

And I would also, with patient's consent, I would also speak to, for example, shelter workers about issues, and housing workers, and even ministry workers.

If there's any involvement with the Ministry, often people are obviously on social assistance, and ministry workers can be an area of support. So with patient consent, I would speak to many different people.

76 Q. Okay. And Mr. Diacur also asked about steps that you take to account for the possibility that there might be inaccuracies in a patient history; and you responded that you cross-reference:

"We checked things in emergency records. We checked things in addiction records. We call other providers to get collaboration."

What are the other providers you are referring to?

A. The other. Well, for example, sometimes I will be the addiction doctor for someone and they have a family doctor elsewhere. There was one patient in particular we had discussed about that.

So, yeah, their family doctor would be a very important source of collaboration.

77 Q. Okay.

A. Yes. Sometimes -- I'm trying to think of other. You are asking about other healthcare providers in particular?

78 Q. You just indicated you call other providers --

A. Yeah.

79 Q. -- in collaboration?

A. A pharmacist also would be another source because they see a patient every single day for their OAT, when they are on opioid agonist therapy. So sometimes I would want to know, hey, are they getting their dose every day. And also how are they when they come in. Are they reliable? Do they look like they are in a reliable and mentally health space when they are there because certainly pharmacists are big collaborators with us as well.

80 Q. Okay. And then you mentioned "accessing addiction records". Where are those records that you

A1120

would have access to?

A. So accessing addiction records. Do you remember the context in which I said that just so that I know exactly what?

81 Q. Yes. It was a question about potential inaccuracies and having a fulsome having a sense of a patient's medical history.

A. Yeah.

82 Q. And you were explaining what things you might check or cross-reference.

A. Yes. So hospital records are really important because it can even tell us the reasons that people are visiting the emergency department.

It could be very clear that they are being seen for addiction-related issues or addiction-related sequela. So I can see, for example, that they were seen for multiple abscesses, for example, for many years back; and then I could say, Is it possible that you been injecting for this long because I see that you've been seen for a lot of abscesses, and then it might help clarify a timeline.

Do you know what I mean?

So hospital records would be a really good source of that.

And also whenever someone is on social

A5405

assistance, you can -- and their meds are getting paid for them, that's just about every single addiction patient that I would see, there is a provincial record of their medications that I can access. So I can see how long they've been receiving methadone, or Suboxone, or whatever it may be.

83 Q. Thank you.

Mr. Diacur also asked you about what steps must be taken before you can give a valid medical opinion and put it to you that your opinion would not be valid if you didn't review the appropriate medical records and didn't carefully examine the patient.

There was some back-and-forth where you answered both yes and a no and so I would like to clarify.

In your past practice with Shelter Health Network and HAMSMaRT what steps did you take to ensure that you formed a valid medical opinion for a particular patient?

A. Well, it's communication with a patient. It's having an appropriate interaction with the patient so that they feel non-judged so that they can actually open up to me and tell me what they are feeling and that is something that addiction doctors do, I think, really well.

And so a lot of it is getting information from the patient. And then, again, if there's any

ambiguity -- some people are able to give you a very accurate history it's very clear that they are not at all feeling -- just that they are able to give you a really accurate history that is -- that they understand as well.

Some people have more understanding of health issues than others so some people need more cross-referencing than others. You know, when there is ambiguity, when people aren't sure, that's when I need to do some more checking; and with their permission, reach out to other people, and other people in their circle of care, to be asking and double-checking things.

But these, again, are generally patients that you get to know over weeks and months. Sometimes I would see people three times a week. You get to know folks really, really well. Like, I know about their struggles, you know, oftentimes in the past as well as the present; medical issues that they've let go to the wayside.

Other things are their goals as wanting to get healthcare issues taking care of.

These are not people that I meet on a one-off. These are patients that I know, I know really well, because addictions doctors see patients, again, like I said, sometimes multiple times a week.

So it is an ongoing part of their medical

history is something that you get on an ongoing basis.

84 Q. Thank you.

Mr. Diacur asked you about the medical history that you had for Sherri Ogden. And you indicated that every time she came to see, you would also see the fact that she had significant undiagnosed mental health issues.

What did you mean that you could see that she had significant undiagnosed mental health issues?

A. So she -- let's see, you know, there's a large part of -- so sometimes people have, for example, personality disorders, right?

So that is something, again, that takes and is often a process to diagnose. It might take quite a while of getting to know someone and observing how they interact with other people and the world around them.

Personality disorders. So I think you often as a doctor you often get a feel for someone having access to issues or personality disorders that have affected their way of interacting with the world and made things difficult for them.

I had a feeling that, and I'm quite sure that she has a personality disorder, and it's not really important for me to write that on her chart and formally diagnose that. It's just not, again, I wasn't her main

A1121

family doctor.

Also, again, I think that there is an intellectual disability. So that was obvious also with me interacting with her, speaking with her. I am suspicious -- and I have many patients who have Fetal Alcohol Syndrome, for example. Again, that is a really hard thing. That's really not diagnosable unless you know birth history and things like that; and neither is it really super relevant for the things that I was helping her with.

So she is coming to me with issues. I am in the background recognizing there's a whole lot of other stuff going on here, but that is undiagnosed that is not on -- it is not her priority right now to deal with. And it's not my place. It's not important for me to be writing down labels on her chart. I know.

I know that this is part of the whole picture of the person that I'm seeing in front of me and I can park that and go ahead with what her issues are on that day.

85 Q. What is your memory of Ms. Ogden and how she presented?

A. She was very, very vulnerable and mainly because she was so extraordinarily naïve. And I think that points to her repeated trauma that she would

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experience. She -- I remember just feeling sick sometimes knowing that she was being taken advantage of by people on the streets because she just didn't have a strong voice for herself.

And, again, I think it -- she was also very small she's a very small person and she has a bit of a phenotype for Fetal Alcohol Syndrome. And I just was always thinking there's intellectual disability here. There is -- and she's got so many stacks against her.

And her whole thing, you know, she was just struggling with some of the most basic, basic issues like housing. Like staying warm at night. And then, you know, she had a mom and sometimes she would be putting her tent in her mom's backyard and it really spoke to intergenerational trauma and issues.

She is also part of a family that has -- I know that in the community, that there is, again, very much intergenerational trauma, and addictions, and mental health struggles.

86 Q. Thank you, Dr. Wiwcharuk, those are my questions.

A. Okay.

--- The examination concluded at 1:38 p.m.

I hereby certify the foregoing is a full, true, and correct transcription of all of my oral stenographic notes to the best of my ability so taken at the Continued Cross-Examination of DR. JILL WIWCHARUK, given under oath before me on the 6th of September, 2024.

Amy Armstrong, CVR-RVR

Certified Realtime Verbatim Reporter #7305

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Certified this 8th of September,2024

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Heegsma et al
Applicants

-and-

CITY of HAMILTON
Respondents

Court File No. CV-21-00077187-0000

Ontario
Superior Court of Justice

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