

ONTARIO
SUPERIOR COURT OF JUSTICE

B E T W E E N:

THE NEIGHBOURHOOD GROUP COMMUNITY SERVICES, KATHARINE
RESENDES and JEAN-PIERRE AUBRY FORGUES

Applicants

and

HIS MAJESTY THE KING IN RIGHT OF ONTARIO

Respondent

APPLICATION UNDER Rule 14.05 of the *Rules of Civil Procedure*

AFFIDAVIT OF DR. NATHANIEL DAY

I, Nathaniel Day MD CCFP Dip. ABAM CHE, of the Town of Ponoka, in the Province of
Alberta, AFFIRM:

My qualifications and experience

1. I am a specialist in addiction medicine. My curriculum vitae is attached as **Exhibit "A"**.
2. I obtained my MD degree from the University of Alberta in 2005. I was certified in family medicine by the Canadian College of Family Physicians in 2007. Thereafter, I obtained my Diplomate in Addiction Medicine from the American Board of Addiction Medicine in 2010.
3. I have served on provincial panels to support improved addiction care in Alberta including the Minister's Opioid Emergency Response Commission (Member) and the Recovery Expert Advisory Panel (Co-Chair).

4. I am the medical director of addiction medicine for Recovery Alberta, previously the medical director of addiction medicine for Alberta Health Services, previously the medical director of Alberta's Virtual Opioid Dependency Program, an Alberta initiative to improve access to medical treatments that are proven to be effective for the treatment of opioid use disorder.

5. I oversee addiction medicine programming including oversight of some of the harm reduction services offered in Alberta.

6. I am an expert in addiction medicine, including the treatment of opioid use disorder and the design, implementation and evaluation of programming and interventions to support the treatment of opioid use disorder. I understand that my role is to provide opinion evidence that is fair, objective and non-partisan, related only to matters that are within my area of expertise and to provide additional assistance as the court may require. My signed Acknowledgement of Expert's Duty is attached as **Exhibit "B"**.

7. I have been asked by counsel for the Respondent in this proceeding to provide the court with information about the treatment of opioid use disorder, the efficacy of supervised consumption services, and to assist the court in contextualizing the information provided in the affidavit of Dr. Ahmed Bayoumi dated January 8, 2025 and the affidavit of Dr. Dan Werb, dated January 9, 2025.

Evidence in support of the treatment of opioid use disorder compared to evidence about supervised consumption sites

8. The treatment of opioid use disorder has been supported by evidence-based, proven therapies that have undergone rigorous evaluation including randomized trials over many years

and at many investigation sites. These treatments can generally be referred to as opioid agonist treatment (OAT).

9. OAT includes medications such as buprenorphine products and methadone. Research and my experience show that OAT are known generally to increase a person's likelihood of achieving recovery from opioid use disorder, and importantly appear to reduce a person's risk of death from any cause, including overdose, by as much as 50%.

10. Traditionally, access to these treatments has been relatively poor particularly for people outside of large urban centres. For this reason, in Alberta, in 2016 we established a virtual model of care that provides access for people in all communities on the same day those services are requested. This program includes access for people arrested and in police custody, people residing in rural Indigenous communities, people in shelters, and many other settings.

11. Unlike the research and evidence-based opioid agonist treatments, there has never been an experimental study of the effectiveness of supervised consumption sites (SCS) as a method of treating addiction. All the studies cited in this area are what are known as correlational studies that unfortunately cannot prove any causal association between the SCS and outcomes. In contrast, addiction treatment, which the proposed HART hubs will provide, has substantial clinical trial evidence to support its efficacy.

12. A correlational study is one in which two or more variables are examined to see if they may be related. In other words, there are correlations made between certain things, but these do not, and cannot, determine a cause of the relationship. Despite the limitation of this type of scientific research, Dr. Bayoumi and Dr. Werb treat associations as if they establish a causal connection. Assuming causation is a key error in evaluating correlational research. Other errors

include ignoring confounding variables, or in other words other factors that could better explain an association, and attributing statistical significance with meaning when it may have no or limited practical relevance. Scientific literature also acknowledges something called “the ecological fallacy” which occurs when conclusions about individuals are drawn from group-level data, ignoring individual variability. For example, a study could find that neighbourhoods with higher average incomes have lower crime rates. Assuming that all higher income people commit less crime is an example of ecological fallacy as the relationship applies to the group (neighbourhoods), not necessarily any specific individuals within it.

13. In my experience, and in the medical literature about the quality of research, treating correlations as causal is not generally done. In general, regulators across North America and the developed world do not certify medical interventions as safe or effective without randomized clinical trials.

14. Correlations can exist for many reasons other than a causal relationship and Dr. Werb acknowledges this (pg. 925). Dr. Bayoumi (95) notes that the high crime rate around SCS (a correlation) is not causal but in this case, he identifies the weakness as due to a third variable, namely the neighbourhood.

15. I observe that Dr. Bayoumi and Dr. Werb each assert certainty in the significance of associations when those associations favour their opinion but discount the associations as being without merit when those associations do not favor their opinion. When a researcher discounts correlations when they do not fit their narrative, and accepts them as causality when they do, I believe that the research is flawed and is no longer a scientific or evidence-based conclusion but is instead more readily identified as a political or social argument.

My criticisms of the studies relied on by Dr. Werb and Dr. Bayoumi

16. Both Dr. Bayoumi and Dr. Werb cite an article that they themselves published in the peer-reviewed journal *The Lancet – Public Health*, titled *Overdose mortality incidence and supervised consumption services in Toronto, Canada: an ecological study and spatial analysis*, published in February 2024. This article reports an association between a reduction in overdose mortality in neighbourhoods before and after implementation of 9 SCS sites in Toronto.

17. The February 2024 study implies that the authors reviewed overdose deaths in Toronto between May 1, 2017 and Dec 31, 2019. However, on closer review, the report is based on a comparison between overdose mortality rates during two 3-month periods: May 1-July 31, 2017 and May 1-July 31, 2019.

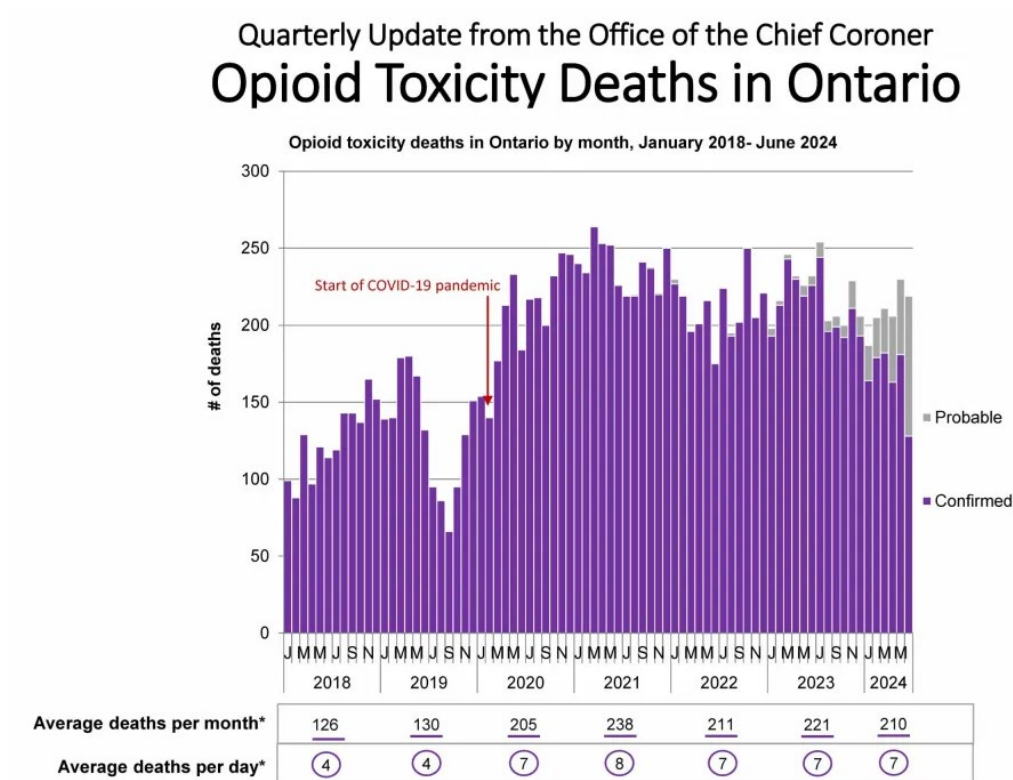
18. As reported in their reports filed in this proceeding, the authors claim to have found a decrease in mortality between the two periods. They attribute this reduction in mortality to SCS implementation. Furthermore, they reported on an unanticipated finding that the effect of the reduction spread as far as 5000 meters from the SCS sites.

19. Ecological research models generally study the relationships between individuals, communities and larger systems. These models can offer big picture views of complex issues. These models have been known to produce interesting correlations. For example, in a common example used to describe the effect of an ecological model, ice cream sales can be positively associated with fatalities from drowning. One possible interpretation is that ice cream sales cause drowning (though no causal relationship can be proven by an ecological model). Another possible interpretation is that on hot days, more people eat ice cream and more people swim. An investigation into drowning could reveal that increased numbers of people swimming likely results

in more drowning incidents, so we can conclude that ice cream consumption is merely correlated with and does not likely cause drowning.

20. I respectfully observe that the information provided by Dr. Bayoumi and Dr. Werb from their own research article reveals another weakness in their conclusion. In addition to being an ecological study that cannot prove causal relationships, the authors also chose two specific timeframes for their study that are particularly helpful in producing a correlation that supports what appears to be their desired outcome: that there is an association between the SCS sites and reduced overdose mortality. The selection of these two timeframes, without explanation or caveat, is of grave concern to me as a medical researcher and I would urge the Court to view it with caution.

21. I will explain my concern. Here is a graph taken directly from the Office of the Chief Coroner in Ontario, published in October 2024.



22. Rather than looking at the whole of 2019 and making a statistical account for seasonal variability, or evaluating trends as SCS sites came on stream through 2017-18 and then through 2019, the authors selected a timeframe during which Ontario as a whole had a temporary but large reduction in overdose mortality.

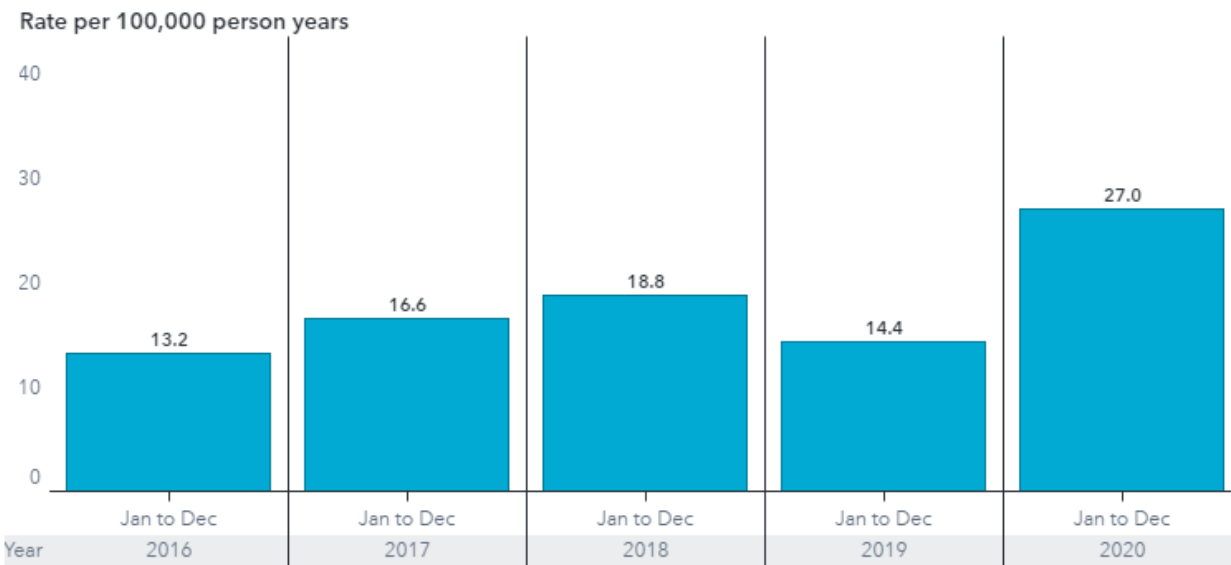
23. In their article, Dr. Bayoumi and Dr. Webb made no reference to this reduction in provincial mortality. Without comment on this significant variable, the authors attribute SCS implementation as the likely cause of the association of reduced mortality and the SCS and express surprise that the sites may have had effects as far reaching as 5km from the sites.

24. As noted, this study was published in February 2024. It is possible that the authors were unaware of the data showing provincial overdose trends, or they were aware of the data and withheld that information. Either way, this important flaw seriously limits our ability to understand what actually happened in Toronto during and after SCS implementation.

25. Based on the limited data Dr. Bayoumi and Dr. Werb presented, it is impossible to know what caused this decline in overdose mortality. One possible theory would be that opioid access temporarily declined, or that the potency of street opioid concentrations temporarily declined.

26. In Alberta, despite roughly a 3500km distance between us and the nearest Toronto SCS, there was also a reduction in overall overdose mortality between 2017 and 2019, as shown here:

Rate of drug poisoning deaths per 100,000 person years by month



[Substance use surveillance data | Alberta.ca](#)

27. The court will also note that Dr. Bayoumi and Dr. Werb assert in their reports in this proceeding that people who are outside a 500m radius of an SCS will not likely use the site, and that this will result in higher incidence of overdose deaths. There is no evidence to support this assertion and their own data from the February 2024 Lancet article, if it were to be given weight, undermines their opinion since it suggests that even being 5km away from an SCS is protective.

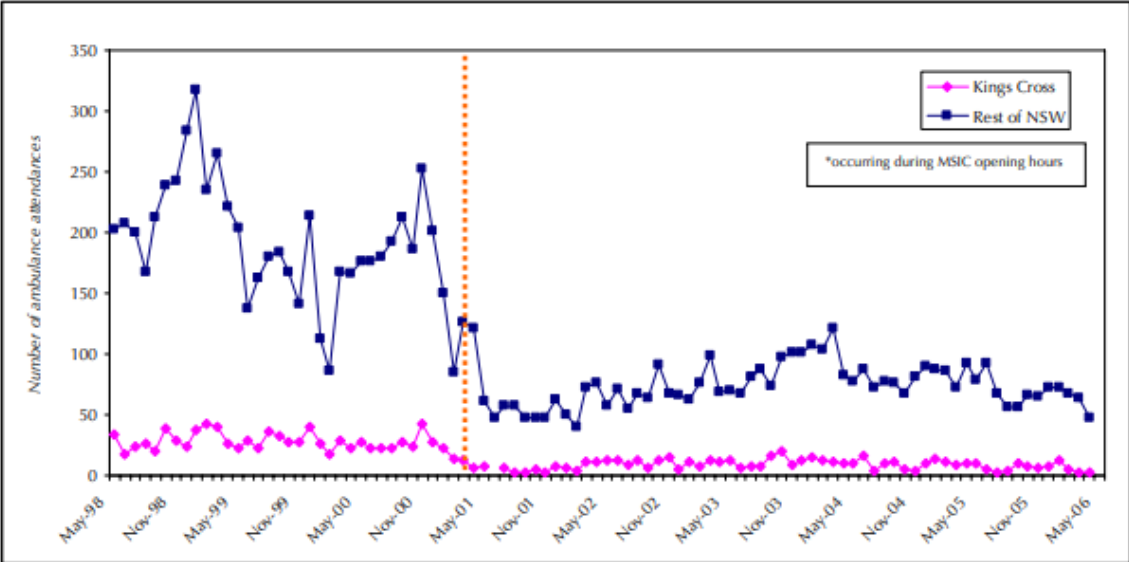
28. The reports presented by Dr. Bayoumi and Dr. Werb also reference research from Australia. I will review briefly a publication they reference from the Sydney Medically Supervised Injecting Centre (MSIC), *Evaluation Report No. 4. Evaluation of service operation and overdose-related events*, published June 2007.

29. In this Australian report, the authors note a significant reduction in ambulance attendances for suspected opioid overdoses within the MSIC opening hours between May 1998 and April 2006.

However, the authors acknowledge that there were significant reductions in drug supply in Australia that coincided with the introduction of MSIC or supervised consumption services. They note that reductions in overdose ambulance calls occurred not only in the vicinity of the site, but throughout the entire state of New South Wales.

30. Presented below is a chart from the report showing the reductions at both the surrounding area of the SCS (King’s Cross) and the entire state of NSW.

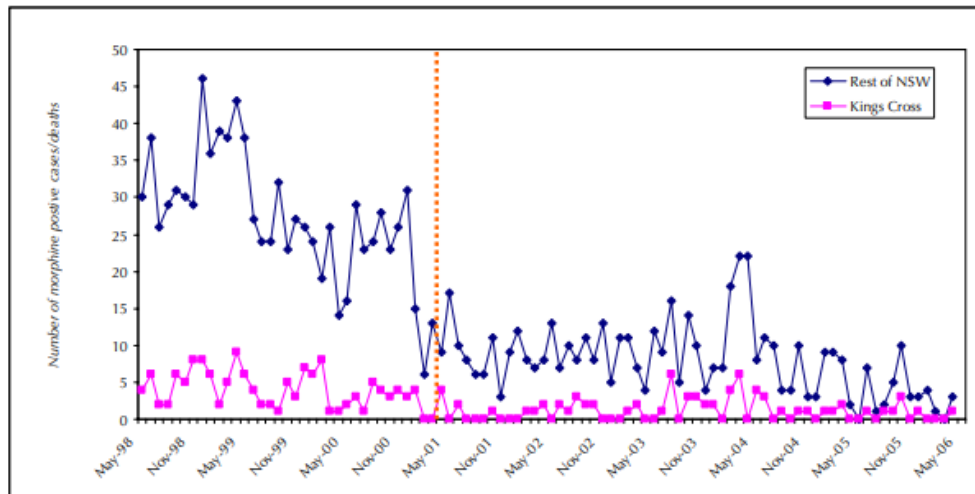
Figure 6: NSW Ambulance attendances at suspected opioid overdoses, within MSIC opening hours: May 1998 to end April 2006



31. While there were statistically significant differences in EMS overdose responses between the SCS location and other locations nearby, with greater reductions in the area around the SCS, an attribution of a causal connection to an SCS is impossible.

32. Similarly, with respect to mortality, the area around the SCS in Sydney saw a decrease in overdose mortality, but so did the rest of the state. The differences in reduced mortality between the two were not statistically significant:

Figure 8: Opioid-related deaths: May 1998 to end April 2006



33. In my opinion, any claim that SCS implementation in Australia has caused a reduction in overdose EMS calls or overdose mortality is not founded in the evidence. The Australian authors themselves report “the opening of the Sydney MSIC in May 2001 coincided with the peak period of a nationwide reduction in heroin availability, an event associated with significant decreases in opium-related harms.”

34. I will also now review an additional study referenced by Dr. Bayoumi and Dr. Werb. Starting in 2006 until 2017, a study was undertaken looking at all cause mortality for SCS users in Vancouver, British Columbia called *Supervised injection facility use and all-cause mortality among people who inject drugs in Vancouver, Canada: A cohort study*. This study was published in 2019.

35. This study was a non-random sample of people using SCS in Vancouver. The study specifically excluded people who stopped using SCS and compared people who were frequent users of the service against people who were occasional users of the service. The treatment group of 432 people who used the services (by self report) at least weekly was compared to the non-

weekly use group of 379 people. Mortality from all causes was looked at, using linked administrative data.

36. While there were several significant differences between the two groups of people, I will focus on two areas of concern. HIV seropositivity and at least daily heroin injection.

HIV seropositive*				
Yes	246 (30.3)	109 (25.3)	137 (36.2)	0.60 (0.44–0.81)
No	566 (69.7)	322 (74.7)	242 (63.9)	

Heroin injection*				
At least daily	342 (42.2)	228 (52.9)	114 (30.1)	2.61 (1.95–3.49)
Less than daily	469 (57.8)	203 (47.1)	265 (69.9)	

37. The court will note that patients in the “treatment group” (frequent SCS use) were less likely to have HIV and were more likely to inject heroin at least daily, both by wide margins. HIV was present in frequent SCS users at 25.3% compared to 36.2% in infrequent SCS users. At least daily heroin injection was reported for 52.9% of frequent SCS users compared to 30.1% of less frequent SCS users.

38. The authors of this paper report that people who used SCS frequently, the treatment group, were statistically significantly less likely to die from any cause. That relationship showed an adjusted hazard ratio of 0.46, or about 54% less likely to die from any cause.

39. However, people with HIV were much more likely to die, with an adjusted hazard ratio of 4.28, which implies that people with HIV were 428% more likely to die from any cause.

40. It is well known to me and addiction medicine specialists that people who use opioids regularly, develop tolerance to the drug. This tolerance can be protective against overdose. Daily use of heroin will create protective tolerance in my experience. Intermittent heroin use will not

create the same degree of protective tolerance. This study showed that people who used heroin at least daily had an unadjusted reduction in mortality of 0.58. The authors did not calculate an adjusted protective effect from daily heroin injection. I will add that the unadjusted protective effect of at least weekly SCS use was 0.57, very similar to the “protective effect” of daily heroin use. While I have not had access to the data, there appears to be validity to an argument that at least daily heroin use was nearly as protective against death as frequent SCS use.

At least weekly supervised injection facility use*				
Yes versus no	0.57 (0.34–0.94)	0.029	0.46 (0.26–0.80)	0.006
At least daily heroin injection*				
Yes versus no	0.58 (0.34–0.99)	0.045		

41. Furthermore, the effect of differences of HIV infection rates and the differences between the two groups for both HIV infection and daily heroin use is troubling.

42. The study does not examine the effect of opioid agonist treatments, which as previously noted are known to reduce all cause mortality by as much as 50%. This variable was completely ignored, other than possibly being lumped in with “prescribed opioid use,” which again favored the SCS treatment group.

43. There remain significant unanswered questions regarding the efficacy of SCS. The current literature is of low quality and remains without the ability to determine causal benefits.

The Alberta experience with SCSs

44. To assist decision makers, Alberta passed legislation mandating the collection of the personal healthcare information of SCS users in our jurisdiction. SCS grants were also moved to oversight with Alberta Health Services (AHS), and now Recovery Alberta (RA).

45. In my role at AHS previously and RA now, I am aware of tracking that has been completed to assess the outcomes of individuals accessing SCS services. While this data has not been released publicly nor has it been published yet in peer-reviewed literature, I am aware that our qualified and experienced data teams have looked rigorously to find benefits for users of SCS services.

46. While there are flaws with the data, and in particular some sites have not cooperated fully with healthcare information tracking, though that is improving over time, there are trends that we have observed.

47. In my observation of the data so far available, I conclude SCS use does not seem to be associated with reduced emergency department visits over time. In fact, the people who access SCS most frequently appear to use the emergency department most frequently. SCS use does not appear to have an impact on physician services utilization, suggesting that those who access SCS do not appear to be more engaged with health care as time goes on.

48. SCS use appears to not have an impact on continuity of care, that is, people who use SCS the most seem no more connected with consistent care than those who use SCS the least. Those who use SCS the most trend towards being less likely to access withdrawal management, bed-based treatment or addiction treatment services. As with other observational data, these associations cannot be causally attributed to SCS use.

49. Mortality data for SCS users is an area of active review and must be tracked over longer periods of time due to the relatively lower numbers of deaths compared to other areas of tracking.

50. Finally, SCS use does not appear to save healthcare costs. Depending on how mortality data emerges and how mortality costing is attributed, and calculations of costs saved due to potential reductions in HIV and Hep C prevention these calculations can change.

51. However, using the most generous calculations for costs averted by overdose response, (i.e. for every intervention for overdose, including simply applying oxygen and waiting, or providing naloxone), an ambulance trip and emergency department visit and average hospital costing averted is assumed to have been saved. Using these assumptions, SCSs in Alberta appears to recover costs at rates between only 3 and 30 cents per dollar spent on the SCS, depending on the SCS location.

52. In my professional opinion, despite decades of SCS use in Canada, there is no causal or compelling evidence to support the mandatory provision of these services.

53. On the issue of harm to children and youth in communities with SCS, again, I am unaware of research done to evaluate the possibility of harm to children specific to the presence of an SCS.

54. I understand that there are fewer than 200 known SCSs operating in the world today. Whether some sites in Toronto close or not, Ontario will continue to have one of the highest per capita rates of SCS sites in the world. In my professional opinion, Ontario does not have appear to have higher numbers of opioid dependent citizens than other provinces or states, nor does it appear to have better outcomes despite the high number of SCS.

55. The claim of Dr. Bayoumi and Dr. Werb that there will be great harm from the proposed new restrictions on the location of an SCS necessarily compares the current SCS services to doing nothing for people who use narcotic drugs. However, I understand the HART hubs are another

option for individuals who use SCS. As such, the question is not whether SCS benefit current attendees, but whether they will benefit from the new services less or more than the old. The evidence supporting the benefit of other addiction interventions is significant and far more robust than the evidence associated with SCS outcomes.

56. Further, whether this policy produces net harm for the people of Ontario as a whole also needs to consider people who will benefit from the new hubs who do not use SCS, and that consideration appears absent from the reports of Dr. Bayoumi and Dr. Werb. Their reports are written as if the current users of SCS are the only people struggling with addiction with whom the province must be concerned with. In my opinion, provincial ministers of health and provincial governments in Canada have broader responsibilities than that limited population.

57. Indeed, I am aware that the proposed new HART hubs are criticized in ways that apply equally to SCS since they may not do everything and will have limits of capacity. In my experience in addiction medicine, this is true of every service.

AFFIRMED by Nathaniel Day of the Town of Ponoka, in the Province of Alberta, before me at the City of Toronto, in the Province of Ontario, on January 24, 2025 in accordance with O. Reg. 431/20, Administering Oath or Declaration Remotely.



Commissioner for Taking Affidavits
(or as may be)

DR. NATHANIEL DAY

This is Exhibit "A" referred to in the Affidavit of Nathaniel Day sworn by Nathaniel Day of the City of Edmonton, in the Province of Alberta, before me at the City of Toronto, in the Province of Ontario, on January 24, 2025 in accordance with O. Reg. 431/20, Administering Oath or Declaration Remotely.

A handwritten signature in black ink, appearing to be 'JTC' or similar, written in a cursive style.

Commissioner for Taking Affidavits (or as may be)

J. THOMAS CURRY

DR. NATHANIEL DAY

EDUCATION

University of Alberta Doctor of Medicine	2005
University of Alberta Residency in Family Medicine	2007
Canadian College of Family Physicians CCFP Designation	2007
American Board of Addiction Medicine Diplomate in Addiction Medicine	2010
Alberta Health Services -Executive Education Program Certified Health Executive (CHE)	2018

RECENT AWARDS

META Recovery Capital Conference of Canada Lifetime Achievement Award	2024
Queen Elizabeth II Platinum Jubilee Medal (Alberta)	2023
WCAF – Innovator in Addiction Medicine	2022
HSO – Leading National Practice (Program)	2021
HQCA – Patient Experience Award (Program)	2020

RELATED EXPERIENCE

Canadian Centre of Recovery Excellence	
Chief Scientific Officer	2024-Present
Recovery Alberta	2024-Present
Alberta Health Services	
Medical Director – Addiction, Provincial Addiction and Mental Health and Corrections Health Service	2023 - 2024
Medical Director – Virtual Opioid Dependency Program	2017 – 2023
Facility Medical Director Centennial Centre for Mental Health and Brain Injury	2013 – 2022
Government of Alberta	
Recovery Expert Advisory Panel – Co Chair	2023
Minister’s Opioid Emergency Response Commission	
Commission Member	2018-2019

SELECTED RECENT PUBLICATIONS AND PRESENTATIONS

Day, N, (2024, Sept 23-26). Assessment and Treatment of Opioid Use Disorder in Every Town and for Any Person. Alberta (Canada)’s Virtual Opioid Dependency Program. The International Society for Biomedical Research on Alcoholism International Congress, Melbourne, Australia.

Day, N, (2024, Sept 23-26). The evolution and future of opioid agonist treatment, Keynote Address. The International Society for Biomedical Research on Alcoholism International Congress, Melbourne, Australia.

Day, N, (2024, Sept 23-26). Correction Corrections’ Opioid Prescribing. How Alberta (Canada) is working to improve addiction treatment for people coming out of the corrections system. The International Society for Biomedical Research on Alcoholism International Congress, Melbourne, Australia.

Day, N (2024, April 3-4). The Alberta Recovery Model – The relentless pursuit of a Recovery-Oriented System of Care, Keynote Address. Recovery Capital Conference of Canada, Calgary Alberta.

Day, N., Wass, M., Vetland, C. (October 19-20 2023) Opioid Agonist Treatment in Corrections/Law Enforcement: Synchronous and Asynchronous Virtual Care. Canadian Society of Addiction Medicine and International Society of Addiction Medicine Joint Conference. Victoria, British Columbia.

Day, N., Wass, M., & Smith, K. (2022, July 28). Virtual opioid agonist treatment: Alberta’s virtual opioid dependency program and outcomes. *Addict Sci Clin Pract* 17, 40 (2022). <https://doi.org/10.1186/s13722-022-0032304>

Day, N., Wass, M., & Smith, K. (2021, October 23). *Innovation without Disruption – The Virtual Opioid Dependency Program and the COVID-19 Pandemic*. Oral Presentation (Research Brief) at the CSAM-SMCA 2021 Scientific Conference, online.

Day, N., Staniforth, C., Wass, M., & Smith, K. (2021, April 22). *Low Barrier Same Day Access to Opioid Agonist Treatment via Telehealth/Telemedicine*. Oral Presentation (Focus Session) at the ASAM 2021 Virtual Conference, online.

Day, N. (2021, March 3). *The Virtual Opioid Dependency Program (VODP): Safe Immediate Access to Opioid Agonist Treatment Using Technology*. Oral presentation at the 10th Annual E-Mental Health Conference, University of British Columbia, online.

MEMBERSHIPS

College of Physicians and Surgeons of Alberta
American Board of Addiction Medicine
American Society of Addiction Medicine

Unrestricted License
Certification in Good Standing
Fellow

This is Exhibit "B" referred to in the Affidavit of Nathaniel Day sworn by Nathaniel Day of the City of Edmonton, in the Province of Alberta, before me at the City of Toronto, in the Province of Ontario, on January 24, 2025 in accordance with O. Reg. 431/20, Administering Oath or Declaration Remotely.

A handwritten signature in black ink, appearing to be 'JTC' or similar initials, written in a cursive style.

Commissioner for Taking Affidavits (or as may be)

J. THOMAS CURRY

ONTARIO
SUPERIOR COURT OF JUSTICE

B E T W E E N:

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Applicants

and

HIS MAJESTY THE KING IN RIGHT OF ONTARIO

Respondent

APPLICATION UNDER Rule 14.05 of the *Rules of Civil Procedure*

ACKNOWLEDGMENT OF EXPERT'S DUTY

1. My name is Nathaniel Day. I live at the Town of Ponoka, in the province of Alberta.
2. I have been engaged by or on behalf of the Respondent, His Majesty the King in Right of Ontario to provide evidence in relation to the above-noted court proceeding.
3. I acknowledge that it is my duty to provide evidence in relation to this proceeding as follows:
 - (a) to provide opinion evidence that is fair, objective and non-partisan;
 - (b) to provide opinion evidence that is related only to matters that are within my area of expertise; and
 - (c) to provide such additional assistance as the Court may reasonably require, to determine a matter in issue.
4. I acknowledge that the duty referred to above prevails over any obligation which I may owe to any party by whom or on whose behalf I am engaged.
5. I certify that I am satisfied as to the authenticity of every authority or other document or record to which I have referred in the expert report accompanying this form, other than:
 - (a) documents and records provided to me by or on behalf of the party intending to call me as a witness and consisting of evidence or potential evidence in the court proceeding that I have analysed or interpreted in my report;

- (b) authorities and other documents and records to which I have referred in my report only in order to address how another expert witness in the same court proceeding has used them in their report; and
- (c) the following authorities, documents and records, for which I have doubts as to their authenticity as detailed within my report:

[list authorities, documents and records]

Note: Under the Rules of Civil Procedure, an authority or other document or record that is published on a government website or otherwise by a government printer, in a scholarly journal or by a commercial publisher of research on the subject of the report is presumed to be authentic, absent evidence to the contrary. If you are aware of evidence to the contrary, list the authority, document or record under 5.c. and provide further details in the accompanying report.

Date January 24, 2025



Signature

NOTE: This form must be attached to any expert report under subrules 53.03(1) or (2) and any opinion evidence provided by an expert witness on a motion or application.

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HIS MAJESTY THE KING IN RIGHT OF ONTARIO

Respondent

Court File No. CV-24-00732861-0000

**ONTARIO
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PROCEEDING COMMENCED AT TORONTO

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RCP-F 4C (September 1, 2020)

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Court File No. CV-24-00732861-0000

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AFFIDAVIT OF DR. NATHANIEL DAY

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CP-F 4C (September 1, 2020)

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RESPONDING APPLICATION RECORD
(VOLUME 4 OF 5)

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