Court File No. CV-22-00683592-0000

ONTARIO
SUPERIOR COURT OF JUSTICE

SC/rl

B E T W E E N:

WILLIAM ADAMSON SKELLY and ADAMSON BARBECUE LIMITED

Applicants

- and -

HIS MAJESTY THE KING IN RIGHT OF ONTARIO, CITY OF TORONTO, BOARD OF HEALTH FOR THE CITY OF TORONTO, and EILEEN DE VILLA

Respondents

- - - - - - - - - -

This is the Cross-Examination of MATTHEW HODGE on his Affidavit sworn the 19th day of November, 2024, taken via videoconference at the offices of VICTORY VERBATIM REPORTING SERVICES INC., 222 Bay Street, Suite 900, Toronto-Dominion Centre, Toronto, Ontario, on the 24th day of November, 2025.

- - - - - - - - - -

APPEARANCES:

IAN PERRY JULIAN SHEPHARD	--	for the Applicants, William Adamson Skelly and Adamson Barbecue Limited
PADRAIC RYAN	--	for the Respondent, His Majesty the King in Right of Ontario
PENELOPE MA	--	for the Respondents, City of Toronto, Board of Health for the City of Toronto and Eileen De Villa

Also Present:

William Adamson Skelly

INDEX OF PROCEEDINGS

--- upon convening at 10:00 a.m.

--- upon commencing at 10:06 a.m.

MATTHEW HODGE, affirmed

CROSS-EXAMINATION BY MR. PERRY:

1. Q. Morning, Dr. Hodge.

A. Morning.

2. Q. Dr. Hodge, you understand that you have been produced today to answer questions in relation to the evidence that you have given in this proceeding, being the application of my client, William Skelly and Adamson Barbecue, in relation to the COVID restrictions of November of 2020?

A. Yes.

3. Q. And do you agree that you have also submitted as evidence in this proceeding the affidavit that you swore in May of 2021 in answer to a very similar proceeding that was commenced by these Applicants?

A. Yes.

4. Q. Okay. Are you here today as an independent witness?

A. Independent of what?

5. Q. The provincial government.

A. I have a contract with the government for this work.

6. Q. You also are employed by the government, correct?

A. In a separate role, yes.

7. Q. Since 2022, you have earned over half a million dollars from the provincial government, correct?

A. I have been paid that as a salary, yes.

8. Q. Right. And you appear today independent of your employer?

A. Independent...I'm afraid your sophistry is getting me out of my expertise. I have been retained in this matter dating back to the original proceeding. In the interim, I became an employee of the provincial government in the Ministry of the Solicitor General.

9. Q. You understand that if you...I'll withdraw that. You understand that as part of the scope of the questions you were asked in 2021 and again in 2024...the scope of those questions could have required you to be critical of your employer, correct?

A. I...perhaps. My employment with

the government is in a completely different ministry with a different domain focus, so you're attempting to compare apples and bicycles from my perspective.

10. Q. Well, I don't think I am attempting to compare..."bicycles and apples", did you say?

A. Yes.

11. Q. Your employer is the provincial government, correct?

A. I am currently employed by the Ministry of the Solicitor General, yes.

12. Q. The provincial government is a named Respondent in this proceeding, correct?

A. Yes.

13. Q. If you were to go against what the provincial government did in 2020 in relation to these lockdowns, in other words, if you were critical of these lockdowns, that would jeopardize your employment with the provincial government, wouldn't it?

A. Not from my point of view, no.

14. Q. It would be difficult to criticize your employer today and return to work tomorrow, would it not be?

A. No.

15. Q. You were also part of the Peel Regional Police...excuse me, the Peel regional body of public health prior to your involvement as an expert witness for the provincial government, correct?

A. I had a contract with them, yes.

16. Q. And during your tenure with Peel, you recommended the closure of indoor dining or were part of that oversight committee that gave that recommendation?

MR. RYAN: Sorry, Counsel, could you just...that was a compound question. Could you correct whether you're asking whether he recommended it or whether he was part of the oversight body?

BY MR. PERRY:

17. Q. Certainly. During your tenure with Peel in a public health capacity, you recommended the closure of restaurants and indoor dining?

A. If that's your opinion, that's not actually consistent with the facts.

18. Q. So...well, you're here today, you

understand, to answer my questions, right? So, if I'm mistaken, please tell me otherwise. You did not recommend the closure of restaurants and indoor dining?

A. That is correct.

19. Q. Okay. Did you agree with the closure of restaurants and indoor dining in Peel when it was done during your tenure?

A. So, it was done as a provincial measure, and the role in Peel was to implement the law and the directives of the provincial bodies. So, my position with respect to restaurant closures is that of a public health physician, and if you wish to explore the practice and science that went into that decision, I'm happy to do that with you.

20. Q. You were not employed in the same capacity with the provincial government when you first gave your testimony in May of 2021, correct?

A. That is correct.

21. Q. You have since been employed in that role?

A. The job began in January of 2022.

22. Q. And I take it from your affidavit

in 2024 that you basically see nothing wrong that was done by the provincial government during the relevant time periods that we'll be talking about today, and I'm talking primarily between October 2020, and November of 2020, right?

A. That's a very wide-ranging statement. I think it would be helpful if you could be more specific.

23. Q. Well, I have reviewed your affidavit...both of them. I see nothing within those affidavits that is critical, or critiques the actions taken by the provincial government in response to COVID-19, not one in your affidavits. If you...and if I'm mistaken, please point me to them, but am I wrong in that regard?

A. I think you're proposing a scope that was actually not the questions that were asked in the affidavit. So, maybe we could turn to those questions, and then we could explore whether the positions can answer your question. So, I see in the November 2024 affidavit, there were basically three questions in paragraph 2, and none of those speak to criticism or not of the provincial government.

24. Q. Question 2(b) of that paragraph.

"...Please review your affidavit affirmed May 14th, 2021 and your cross-examination on that affidavit. Do you continue to hold the opinions that you expressed in your affidavit and cross-examination? Why or why not?..."

When I look at that question and I look at your affidavit, I understand that you continue to hold the opinions that you expressed in your affidavit and cross-examination, correct?

A. Yes. We can turn to the scope for that one, because that was essentially about the science of COVID.

25. Q. Okay. This is going to go a lot faster if you just answer my questions, okay? I'm respectful of your time and I'm mindful of the fact that you have already been examined for, I think, three days...or a period of three days in the other matter, okay? I asked you in relation to 2(b) to please summarize your opinion. It says,

"...2(b). Please review your affidavit affirmed May 14th, 2021, and your cross-examination on that affidavit. Do you continue to hold the opinions that you

express in your affidavit and cross-examination?..."

Now, I have reviewed this affidavit, and I understand that you continue to hold the opinions that you express in your affidavit and cross-examination, correct?

A. So, let's turn to paragraph 11, where I state...exactly as you propose...

"...I confirm that I continue to hold the opinions expressed therein, and I note that there is, however, one exception..."

And in paragraph 12, I discuss aerosol transmission.

26. Q. So, the answer to the question that you continue to hold the opinions expressed in your 2021 affidavit is yes?

A. That's correct.

27. Q. Okay. Now, in your 2024 affidavit, you state nothing that is critical or critiques the provincial government's response to COVID-19 during the relevant time period, correct?

A. If that's your opinion, yes.

28. Q. Yes. I'm asking, is your answer

to that question yes, or are you parroting back my question and saying, "Yes, that's the question I have just asked you"? I'm not following.

A. You're asking me about something that is out of the scope of the affidavit for which I have been retained, so that's where I'm struggling to answer your question or, as you say, parroting.

29. Q. Can you please point me to something within your May...or within your 2024 affidavit which critiques or criticizes the response of the provincial government to COVID-19?

A. I think that you can look in the cross-examination that was done by your... I'll say "professional colleague"...Dr. Swinwood, where I spoke about the challenges which the Auditor General had identified, and they aligned with my perspective around how to make emergency situation decisions.

30. Q. Your cross-examination that you're referring to was given in 2021.

A. In the 2024 affidavit, I was not asked questions about that, and I have not been critical of the government in that affidavit.

31. Q. We have already been through it. You were asked if your opinion remains the same. You had the opportunity to revise it, correct?

A. I was asked if my opinion about the matters in 2021 remain the same, and if you look at the scope of 2021, it was an affidavit about the science of COVID. Is COVID real? How is it transmitted? What are the measures that are taken to protect Ontarians?

32. Q. You were given an opportunity to revise your opinion.

A. And I cited that the change in understanding of aerosol extraction represented a change.

33. Q. And over the years, since 2021, all we have learned about the impacts of these lockdowns, the effectiveness of these lockdowns, how COVID was spread, the risks of COVID-19, everything we have learned since 2021, when you had given your evidence, you don't feel the need to critique or criticize any aspect of the government's actions, correct?

A. Actually, I think you're engaging in time travel because the events at issue were in November 2020, so we should be discussing the

state of the knowledge in November 2020. In November 2020, Ontarians did not have access to a vaccine. Hospitals were overwhelmed. The government took reasonable measures to reduce the transmission of COVID-19. I stand by that opinion with respect to the events of November 2020.

If you're asking me, would I, in 2025, advise the government of Ontario, based on current COVID knowledge and current COVID transmission, to implement the measures they did in November 2020, the answer is obviously no, but that's not material to this. In November 2020, there were no vaccines. Hospitals were overwhelmed. Non-pharmacologic interventions were the only things available, and, in my view, the government acted upon the science that it was provided, which is summarized in the affidavits.

34. Q. "If I were to do this again in 2025 and...knowing what we know about COVID-19, would I recommend the same steps? The answer would be no". Why would the...

A. I actually said if we have the current levels of transmission, which is different. There are two elements to it, what we

know and current COVID levels of transmission. Both of those were different in November 2020. We knew different things. We knew less, and we had very different patterns of transmission.

35. Q. So, you're saying that if you were to do it today in 2025, in light of where we're at with COVID today...

A. That's right.

36. Q. ...you would do things differently?

A. And you can see that.

37. Q. Okay.

A. You're not wearing a mask. We could be doing this in person.

38. Q. So...

A. You can go to any restaurant you like.

39. Q. ...how prevalent is COVID in the community right now?

A. We actually don't have measures for measuring that in Ontario at this time because we don't know...

40. Q. Okay.

A. There's not access to significant levels of testing for people who have mild

disease.

41. Q. You're not even measuring it anymore?

A. It's not my role to measure it, sir. You could ask Public Health Ontario that one.

42. Q. What's your experience been within the Scarborough Hospital? Are you seeing COVID cases a lot, or no?

A. There's two kinds of COVID cases. There are people who are sick enough that they require admission to hospital, and they typically get tested because that becomes important for cohorting them within the hospital, and then there's people who come in with an upper respiratory tract infection. They don't require hospital admission and they're typically not going to be tested for any virus. They're given advice about how to manage their symptoms and told to...what the danger signs would be to prompt them to return to the hospital. So, there's no systematic data collection that would enable us to answer that question.

What we know is that if we look at the limited information available, COVID-19 is

present among a small number of patients admitted to hospital. And if you ask me how many, I don't know.

43. Q. Do you have no way to tell whether COVID is as prevalent today as it was in November of 2020 because we're not tracking those numbers?

A. Well, I can tell you it's less prevalent because the hospitals are not overwhelmed with patients with positive COVID tests requiring oxygen and intensive nursing care. And that's a tautology, but it might be useful for you if you were unaware of that.

44. Q. Do you have evidence to support that hospitals are not as overwhelmed, or is it just your observations at Scarborough?

A. Well, I think you could go to Critical Care Ontario, and that evidence would be available through their dashboards. It's not information that I would generally access because I don't do critical care.

45. Q. So, you haven't done that? You haven't accessed that data.

A. No, we have a gestalt sense as practitioners.

46. Q. Didn't you fault some of the other experts that we have submitted for using their observations, for example, in rural communities of the prevalence of COVID as being an unsound basis to assess the prevalence of COVID in the greater community?

A. Well, I think that there's a hierarchy of evidence. Perhaps in your field as well, but I can speak as a physician. Where we have systematic data collection, that's going to be higher-quality evidence than the practitioner gestalt or opinion. I believe the matter...the person you're referring to, who I understand is no longer practising medicine...he was denying the stronger evidence in favour of his own impressions.

If you can find some stronger evidence about the prevalence of COVID, I'm happy to review it with you. But right now, Public Health Ontario and the Government of Ontario have not committed to that structured data collection...I don't think the public would tolerate it, quite honestly...of being required to be swabbed or to go for testing every time they had a runny nose or a cough. So, that hierarchy of evidence is

actually central to being a physician, perhaps different from your field.

47. Q. All right. The doctor you were just referring to that faced professional consequences for his opinions on COVID-19... that's Dr. Trozzi, correct?

A. Yes. I presume that's who we're talking about, yes. Thank you for confirming.

48. Q. Well, you cited it in your affidavit. You felt necessary to include the disciplinary decisions of your colleague within your affidavit.

A. They were a matter of public record and seemed to turn on my assessment of his expert evidence.

49. Q. Well, I also want to talk to you about why he was disciplined. You cited it within your affidavit. You are also a licensed member of the College of Physicians and Surgeons of Ontario, right?

A. I am.

50. Q. You are? Do you keep up with the pronouncements of the College, its directions to physicians and its rules of professional conduct?

A. Yes.

51. Q. Okay. You gave your first sworn statement in this proceeding in May of 2021, correct?

A. With respect to this proceeding, yes.

52. Q. Well, I should say the separate proceeding. We have commenced it as a result of that previous proceeding...this one. But your first time swearing evidence in relation to the issues around my client was May 14th, 2021, correct?

A. Yes.

53. Q. Okay. I'm going to show you something on the screen here. Can you see the screen now?

A. Yes.

54. Q. Okay. Did you know that the College of Physicians and Surgeons...the College...I'm just going to call it the CPSO so I don't have to keep repeating myself. But did you know the CPSO released a statement on public health misinformation on April 30th, 2021?

A. Yes.

55. Q. You were aware of this statement when it was released, correct?

A. I was, yes.

56. Q. Okay. And you see here how it says,

"...The College is aware and concerned about the increases..."

Let me withdraw that. This is from the...what was formerly known as Twitter...X account of the CPSO. Do you have any reason to disagree with that?

A. No.

57. Q. Have you seen this statement before?

A. Yes.

58. Q. Okay. Could we have this entered as an exhibit, please?

MR. RYAN: Mr. Perry, you haven't asked him if he recognizes it and authenticates it. You have asked him if he has any reason to disagree with your screenshot. Do you want to ask him to authenticate it?

59. MR. PERRY: I just asked him if he has seen the statement before, and he said yes.

MR. RYAN: Can you ask him to confirm

that this is the same statement he has seen in the past?

BY MR. PERRY:

60. Q. I suppose, if you want that to be done. Is this the same statement you have seen in the past, Dr. Hodge?

A. I mean, we can take a break and I can go look at the CPSO's Twitter account, but I'm willing to accept this as the accurate statement by the CPSO in April of 2021.

61. MR. PERRY: Any other concerns, Mr. Ryan, before we enter this as an exhibit?

MR. RYAN: That's fine.

62. MR. PERRY: Thank you. Okay. Exhibit 1, statement of the CPSO via Twitter, dated April 30th, 2021. And, Mr. Ryan and Ms. Ma, I will circulate a screenshot of this following the cross...or, sorry, a printout of this following the cross. All right.

--- EXHIBIT NO. 1: Statement of the CPSO via Twitter, dated April 30th, 2021

BY MR. PERRY:

63. Q. So, you were aware, then, that just two weeks before you swore your statement on May 14th, 2021, the College said this,

> "...The College is aware and concerned about the increase of misinformation circulated on social media and other platforms regarding physicians who are publicly contradicting public health orders and recommendations. Physicians hold a unique position of trust with the public and have a professional responsibility to not communicate anti-vaccine, anti-masking, anti-distancing and anti-lockdown statements and/or promoting unsupported, unproven treatments for COVID-19.
>
> Physicians must not make comments or provide advice that encourages the public to act contrary to public health orders and recommendations. Physicians who put the public at risk may face an investigation by the CPSO and disciplinary action when warranted. When offering opinions, physicians must

be guided by the law, regulatory standards and the code of ethics and professional conduct. The information shared must not be misleading or deceptive and must be supported by available evidence and science..."

You read that statement, Dr. Hodge. You were aware of that statement, Dr. Hodge, before you signed and swore to your May 14th affidavit?

A. Yes.

64. Q. Thank you. You understand that Dr. Trozzi was disciplined and had his licence to practise revoked by the College for the statements and positions that he took that were contrary to the guidance that the CPSO offered in this statement, right?

A. And he failed to meet the standard of practice, and he failed in his duty to cooperate with the College's investigations and the College is of the opinion he's incompetent. That's paragraph 1 of the decision. So, you're offering me half a loaf. I think it's more than what you're saying.

65. Q. And,

"...The College alleges that he has made

misleading, incorrect, or inflammatory statements about vaccinations, treatments and public health measures for COVID-19 in social media postings, on his websites and in interviews..."

You understand that had you sworn to anything other than support for the government's lockdowns in your May 14th, 2021, affidavit, that you could have been subject to disciplinary actions by the CPSO, correct?

A. Yes, but that's a risk we all take. When I agreed to a licence to practise medicine, I accepted the governing authority of the College of Physicians and Surgeons of Ontario, so...

66. Q. Okay, all right. In preparing your affidavits in April...excuse me, May of 2021 and this other one in November of 2024, were you given access to any of the decision-makers at the provincial level who would have actually been responsible for the *Reopening Ontario Act* or the imposition of the restrictions on indoor dining in November of 2020?

A. No, I was not.

67. Q. Did you ask to speak with any of

them?

A. No. That wasn't the scope of my role.

68. Q. So, for example, in May...for your affidavit of May 2021, in answering the questions,

> "...Why do limits on restaurant operations contribute to reducing COVID-19 transmission and harms from COVID-19?..."

You didn't feel it was necessary to speak to the provincial government to get their support or what they were relying on for the basis of these lockdowns?

A. So, I was retained as an expert based on my experience as a public health physician, and in my affidavit, I turned to the information that I had available about the science, and that informed the recommendations that were fed into the government's process. I wasn't there at the table, I don't know how they made these decisions...you would need a different witness for that. But the evidence that public health specialists gathered and marshalled was described in that affidavit. So, if we want to

go to the relevant pages, I can walk you through the evidence.

69. Q. So, you never spoke with any of the officials. You weren't at the table. You have no idea, then, whether or not the considerations that you outline in either of your affidavits were actually considered by the provincial government when formulating the legislation of the *Reopening Ontario Act* or imposing lockdown restrictions, correct?

A. I would say that nobody asked me. I'm a minnow. The sharks do what they wish. I would say that perhaps as in there's a body of precedent in the law, there's a body of scientific evidence which was gathered, summarized, analyzed and fed into the process, and that evolved into the science table which, in fact, made that information public in Ontario. So, I don't know what happened in the room, but I'm pretty sure they were looking at pretty much the same papers I was looking at.

70. Q. You don't know what happened in the room, but you're pretty sure that they were looking at the same papers, but you don't know whether that's the case or not?

A. I wasn't there. I can't speak to that.

71. Q. Has anyone from the provincial government offered to facilitate access to you to the relevant decision-makers of Public Health Ontario that would have been instrumental in these restrictions over the course of your tenure as this expert?

A. I'm not aware of decision-makers at Public Health Ontario. These decisions were made by the cabinet and the government. Public Health Ontario is a Crown agency, so you may want to restate your question so I can try to answer it.

72. Q. Who is Dr. David Williams?

A. He's the Chief Medical Officer of Health of Ontario at the time of the onset of COVID, and he was an employee of the Ontario Legislative Assembly at the time.

73. Q. You have not talked to David Williams at any point between May of 2021 or November of 2024 in formulating your evidence, have you?

A. No.

74. Q. David Williams would have been

instrumental in the decision to restrict indoor dining in November of 2020, correct?

A. I have no opinion about the matter. He was one among a number of players who would have provided evidence to the political leadership that informed their decisions. And, in fact, you can find in the media at that time critiques of his performance that he actually wasn't providing much influence or having much influence. So, you should ask Dr. Williams if he was present.

75. Q. Well, we don't have evidence...we don't have any evidence from Dr. Williams. It doesn't sound like you have ever spoken to him, right?

A. Not about these matters, no.

76. Q. Okay. At any point in your retainer as an expert for the provincial government, did you avail yourself to the recommendations that Dr. Eileen de Villa was making in October of 2020 with respect to indoor dining restrictions?

A. Do you mean Eileen de Villa, the chief...the Medical Officer of Health of Toronto?

77. Q. I may have had a slightly

different pronunciation...

A. I want to make sure we're talking about the same person. So...

78. Q. Yes, we're talking about the same person, Eileen de Villa. She has been cross-examined in this proceeding.

A. Okay.

79. Q. Have you read her transcript?

A. No.

80. Q. Were you aware that she was cross-examined a few weeks ago?

A. Yes.

81. Q. Why didn't you read her transcript?

A. It...I didn't...I don't know. I deferred to Dr...Mr. Ryan.

82. Q. You didn't feel that it would help form your opinion about the justifications of lockdown restrictions in the City of Toronto by reading the testimony and evidence of the Chief Medical Officer of Health for the city around that time period?

A. The events of November 2020 were in the past. So, in my preparation for this work, I sought to review the affidavit and the

material that was relevant to November 2020. The decisions of the City of Toronto were not decisions in which I was involved, other than the fact that I reside within the City of Toronto.

83. Q. It's interesting how you say you're not...you should not now go back to 2020, when you accused me of engaging in time travel at the outset of this examination, that we can't...

A. I'm happy to use your time...

84. Q. Let me finish my question. Let me finish my question.

A. Sure.

85. Q. Let me finish my question for the purposes of the transcript. You told me that what was relevant to this proceeding and your opinion was what was happening in 2020, not what can be looked back on in hindsight. I'm paraphrasing. You don't feel it was necessary to read the evidence of the Chief Medical Officer of Health, who had boots on the ground in the City of Toronto for the relevant time period?

A. So, you're actually mixing two roles. The Chief Medical Officer of Health is a provincially appointed and employed official. At the municipal level, there are Medical Officers

of Health, and Dr. de Villa was the Medical Officer of Health for the City of Toronto at the time of the events we're discussing.

So, your question to me is, did I read the transcript of the City of Toronto Medical Officer of Health testimony in relation to this proceeding now? I just want to be clear about that. That is your question, and my answer is no.

86. Q. Okay, all right. And did you know, then, that in October of 2020, Dr. De Villa was saying,

"...I am urging the province to limit restrictions on indoor dining..."

And the province was responding by saying,

"...We need to see hard evidence of that before we do it again..."

Did you know that?

A. I was unaware of that, but I'm not surprised inasmuch as there was a general discourse among public health where there were many different voices with different perspectives, all seeking to clarify what is the evidence that can make the best decision, and the best decision is unlikely to be one that makes

everybody happy. So, in October 2020, transmission rates in the City of Toronto were much higher than other parts of the province, so I'm not surprised that Dr. de Villa would be more assertive about the need for tighter restrictions in the City of Toronto than in...Medical Officers of Health in regions where there were lower levels of transmission, lower burdens on the health system.

87. Q. Are you surprised to learn that as of October 2020, the provincial government was saying we need to see hard evidence before we do these lockdowns again?

A. No. I think that in general, when we look across jurisdictions, the Government of Ontario was among the more evidence-informed decision-making bodies.

88. Q. And by the time October 2020...by the time of October of 2020, we had known more about the virus than we did in March of 2020. Fair to say?

A. Yes.

89. Q. Are you aware of any hard evidence that the provincial government received from the City of Toronto before it implemented

the restrictions on indoor dining in November of 2020?

A. No. That's a City of Toronto-provincial government relationship. I wasn't part of that.

90. Q. You never asked to see that as part of your expert opinion?

A. Well, my expert opinion was actually focusing on the broader scientific set of questions around, "Why would we implement this sort of restriction?" And I think that's covered in the affidavit related to how people who go to restaurants...while there may be relatively few outbreaks in a restaurant, those people then go to work in hospitals, they go to work in long-term care, and that can create significant burdens for the population.

91. Q. Yes, let's move to that now. I was surprised, frankly, in reading your affidavits that...and admittedly, I'm a layperson when it comes to these things in terms of the public health measures, but I lived through the pandemic, as everybody here in Ontario did. I was surprised to learn that you state that one of the primary reasons why restrictions on indoor

dining was imposed when it was was not to prevent the spread amongst the dining customers who may be present but to prevent those individuals from infecting those in long-term-care facilities and those who may work in long-term-care facilities. Do you still agree with that?

A. It's a both/and. Like, you have to prevent the transmission at each opportunity because it's the chain of transmission that has the potential to increase death rates, overwhelm the health system. So, that chain needs to be broken, or whichever verb you want to use...let's say "broken"...at the earliest possible moment, and anywhere that people gather...healthy people gather and congregate is likely to be a place where transmission occurs. So, the restrictions were intended to break those transmission chains upstream, if you will, because once the virus is in a long-term-care facility, as we saw during 2020, it's...the deaths are devastating. Once it's in a hospital, if you don't have any nurses, good luck if you have a heart attack or your mother needs a hip replacement, because there's nobody to take care of anyone.

92. Q. Okay. I'll pause there for a

moment. "The deaths are devastating in long-term-care facilities". You said in your transcript... you said in your cross-examination for which you filed the transcript that in looking at a COVID death, you cannot tell whether or not the death was caused by or contributed to from COVID-19, correct?

A. That's a statement of the approach to death coding. That's not a...that's just a practice standard, if you will, or a practice...a way of practice.

93. Q. Right, but when you look at deaths in long-term-care facilities, for example, if somebody was marked as a COVID death, you cannot tell whether or not COVID was the cause of that death or whether COVID contributed to that death, correct?

A. In some cases, that may be correct, yes.

94. Q. Okay. And when we talk about "contributed to", you can't tell the extent to which COVID-19 played a contributing role to the death, correct?

A. I suppose one could have a process for doing so, but in practice, that is...

if you're looking for a number or a percentage, that is generally not the way that contributing causes are assessed.

95. Q. Right. You understand that long-term-care facilities generally have a higher rate of death than, let's say, a general hospital, correct?

A. Well, adjusted for age and gender, yes.

96. Q. Right. That long-term-care facilities typically host elderly populations, right?

A. They do.

97. Q. And most commonly, those patients do not get discharged from their facility. They die in the facility, correct?

A. Or they die in an acute-care hospital, yes.

98. Q. Fair enough. All right. So, when we talk about these restrictions and we talk about why restrictions were done on indoor dining, you're telling me that one of the primary motivators was to stop deaths in long-term-care facilities?

A. Actually, I said that the primary

motivator is to stop transmission. Stopping transmission translates into protecting people who rely on others for their basic needs, whether in long-term-care facilities, Ontario's prisons, group homes. It also reduces the risk that hospitals will be unable to staff their facilities.

99. Q. You are...you have a postgraduate degree as a public health and preventive...excuse me, in public health and preventive medicine, correct?

A. It's not a degree. It's a residency training, so it's a specialty training.

100. Q. I see. Five years after residency you took to complete that, right?

A. Four. I had received credit for a previous PhD in epidemiology.

101. Q. All right. As part of that training, you were educated and trained on assessing community-wide impacts on public health measures, correct?

A. For many communities, yes. Depends how you define "community".

102. Q. Well, it would also include considerations for the broader community when

you're imposing public health measures.

A. I'll let you go on. I'm not sure where you're going. I didn't hear a question.

103. Q. Is that correct, that you're trained and part of your expertise is that you can look at the broader community, given your education, and say, "This is how these public health measures will impact a community at large"? Right?

A. Yes, that could be part of what people do in the field. So, there's...if you think of a...there's a nested group of communities that have differing levels of risk depending what the health issue in question is.

104. Q. Okay.

A. COVID-19 was a situation where Ontario essentially asked the broadest community, all of Ontario, to follow certain directions so that those at highest risks might not die.

105. Q. So, when you look at restrictions on indoor dining, one of the community considerations is on how that might mitigate spread amongst long-term-care facilities, that community connection, right?

A. The chain of transmission. I'll

say it again. It's reducing...moving upstream to reduce transmission events. That means that the virus is introduced into fewer places with high vulnerability. The virus is not wiping out workforces. The virus is not overwhelming the hospitals.

106. Q. And what about the larger community impact on those business owners and the impacts that may have on their mental health or their physical wellbeing? Do you consider that?

A. Personally, yes. I mean, I think those were important considerations. And I think what we saw with the *Reopening Ontario Act* and the different levels, the red, yellow, green, was an attempt to balance the intended benefits of non-pharmacologic interventions with the adverse consequences.

107. Q. You...

A. Whether that...sorry, go ahead.

108. Q. ...didn't talk to anybody from the province that this was...these coding systems were done with the mental health of business owners in mind? You're speculating at this point, correct?

A. I'm not speculating. I mean, it

was quite...the government's public statements were that they wished to...quite reasonably, this is the challenge of government, right? How do you balance the intended effects of a policy with the adverse consequences? I just read the newspaper.

109. Q. Well, this is...I think, one of the main issues of this entire application. You have nothing in your report in 2021 or 2024 that demonstrates that balancing act, correct?

A. It was not the scope of the questions I was asked as an expert.

110. Q. But as your training...you're here today as an expert trained in public health and preventative medicine, and you have told me that your consideration of restrictions imposed on a community level would consider the...let me withdraw that. Your training is in public health and preventative medicine. You have told me that as part of that training and your expertise, you are to consider a total community impact on health restrictions. In assessing the reasonableness of restrictions on indoor dining, then, you ought to have considered the impact on those business owners in making your assessment

on the reasonableness of those restrictions, correct?

A. So, in November 2020, I would agree with you, and I think that that's where that...the opinion that they're reasonable from a scientific point of view is grounded in that reality. The...in November 2020, the...finally, there was the decision to set up a patient transfer system because at Scarborough, Brampton Civic, we had patients literally in the cafeteria because we were overwhelmed with patients who were sick with COVID. So, that context was such that the health system was in...let's say, facing significant challenges, and the vaccine was on the horizon but not available. We had high levels of transmission, as evidenced by the test positivity rates. In Scarborough in early October of 2020, we were up to 20 percent test positivity, and that predicted hospital admissions 10 to 14 days later. We built a model that did that.

So, the role of the public health physician is to summarize the public health evidence. The extent of the harms or adverse consequences would be better summarized by those

with expertise in economic development, retail management, fields that are not public health. Then it is the role of government and the bodies they set up to make decisions to essentially trade off the...if I can say it this way, you have got two bad choices. Which is the least worst?

111. Q. In forming your evidence for the other proceeding in 2021 and this proceeding, you have nothing to support the assertion that the province of government...the provincial government ever consulted with any economic experts, business experts, anything like that when imposing the indoor dining restrictions, correct?

A. As I say, I wasn't present at those tables. I don't know who was consulted.

112. Q. Okay. If they did not consult those individuals and just considered one aspect, spread in long-term care, that would be something that you would see as a reason to change your opinion, correct?

A. No. My opinion is about the science about why non-pharmacologic interventions were the only things available to us in November

of 2020. That the government's policy process admits or doesn't admit other voices...that's not a matter of my expertise.

113. Q. Okay, thank you. As you sit here today, are you able to tell me how many businesses have closed...how many restaurants, excuse me, have closed in Toronto, since January 1st of 2021?

A. No.

114. Q. You have no evidence, then, on the impact that these lockdowns had on small business owners in Canada?

A. Small businesses open and close at some baseline rate, and that rate varies. So, I think that we would need to do a whole other analysis around what is the effect of the lockdown, as you describe it, distinct from the regular success and failure of small businesses. So, it's not my area of expertise. I'm not a restaurant...I don't study restaurants.

115. Q. But these provincial health restrictions that you're appearing here in support of on a community level impacted restaurants, correct?

A. They also impacted hospitals.

They impacted schools. They had massive impacts. That's why it was a pandemic, sir. That means that everybody's affected.

116. Q. Okay, but you have not given any consideration to anyone other than hospitals that may have been affected?

A. I'm not following your question. You asked me about whether I know how many restaurants have closed.

117. Q. "Businesses close all the time", was the answer you just gave me. You...

A. What I actually said was that we need to understand the opening and closing background rates so we could separate out the effects of the COVID pandemic.

118. Q. And you don't feel that would be a detail that you would want to know before you recommend the same course of action being taken today, which is what you told me at the outset of this examination? You don't even know how many restaurants have closed, the impact that these restrictions had on those business owners, and you're saying again, "In 2025, I would do it all again"?

A. It's not...

119. Q. Do you not see the problem with that?

MR. RYAN: Counsel, the witness was trying to answer.

BY MR. PERRY:

120. Q. Go ahead.

A. Maybe you misunderstood what I said, so I'm going to try again in really basic terms.

121. Q. Please.

A. In November 2020, we had no vaccine, we had hospitals that were overwhelmed and we had rising transmission in Ontario. The measures that were put in place to restrict restaurant...in-restaurant dining in November 2020 were reasonable in November 2020 based on what we know...what we knew in November 2020 and the pattern of transmission.

What I said to you was that today, because we have no new information about November 2020 from a public health perspective, those measures remain reasonable for the circumstances in November 2020. Today, in November 2025, we have different circumstances. We have a vaccine

that's widely available. The virus has evolved. We do not have a health care system in crisis. So, if you ask me today, "Would I go to the Premier and say, 'Mr. Ford, we need an emergency committee meeting because we're going to put in place in-dining...sorry, in-restaurant dining restrictions?'" That's absurd. I mean, I think we would both agree that's nuts, and I'm not saying that, and I didn't say that.

What I said was, in November 2020, we had no vaccine, high rates of transmission, health care system overwhelmed. Restrictions on in-restaurant dining were reasonable in November 2020.

122. Q. You understand that restricting some restaurants to indoor dining could mean the end of that business, right?

A. I understand that did happen, yes.

123. Q. Okay.

A. I would also note that some restaurants thrived. So, there are probably restaurant-specific features of which I'm unaware that explained why some did well and some did not.

124. Q. Which restaurants thrived during the pandemic?

A. The ones that are still around, I presume.

125. Q. Well, you told me, "I'm aware of restaurants that thrived during the pandemic". Could you please give me one example of that restaurant?

A. Let me restate it. I'm aware that restaurants survived the pandemic and restaurants didn't survive the pandemic, so there must be differences between them.

126. Q. So, you want to correct your answer? You're not aware of any restaurant that thrived during the pandemic, right?

A. Well, I think I would like to make it more clear that "thrive" raises a question that I can't answer, so I wanted to be more specific in my response. Some restaurants survived. Some did not. There must be features of those restaurants that survived that are different from those that did not.

127. Q. Like being predominantly takeout-based, like a fast-food chain?

A. Out of my expertise, I'm afraid.

128. Q. Have you read Mr. Skelly's affidavit, the one he has filed in support of this application?

A. Yes.

129. Q. Okay. You can agree with me that the restrictions on indoor dining were unprecedented, right?

A. Unprecedented in what sense?

130. Q. That apart from...I mean, if we're looking at a COVID-19 level, that prior to March of 2020...certainly not in my lifetime, maybe yours...that the public provincial government or municipal had never imposed restrictions of this nature on restaurants.

A. There have always been public health restrictions on restaurants. They get closed because they fail to meet standards. You're talking about the...

131. Q. I'm talking about the restrictions of closing your business to operations that would otherwise serve your bottom line, indoor dining, restrictions on gathering, restrictions on indoor dining and the service of customers within the restaurant. I'm not talking about public health certifications. You know

very well what I'm talking about from March of 2020 onwards. You can't agree with me that these restrictions were unprecedented?

A. This was the first time I'm aware that there were restrictions of this extent on indoor dining in Ontario.

132. Q. And what does the word "unprecedented" mean to you?

A. It did not happen before.

133. Q. Right. So, these restrictions that we're talking about today that are the subject of this application were unprecedented, agreed?

A. As was a virus that killed millions of people. So, again, it's the choice between two bad outcomes.

134. Q. Sorry, a virus killing millions was unprecedented?

A. M'hmm.

135. Q. M'hmm? Yes? That was unprecedented? Did we never see...we have never seen a respiratory virus go through the province of Ontario killing individuals prior to March of 2020? That's your evidence?

A. No, I think you're...if you'll

let me finish...

136. Q. Please.

A. ...in the modern era, we have not seen globally a virus that behaved like COVID-19. So, we can go back and talk about Spanish influenza in 1919 if you want. That was a global spreading virus, but it was a very different era. The number of restaurants that would have been closed if the government chose to do that was of an order of magnitude different than in 2020.

137. Q. How about influenza?

A. That's...

138. Q. Does influenza not go through and transmit itself through the population year after year, every year, since at least my year of birth?

A. So, influenza is an annually recurring virus, yes.

139. Q. Right, and...to the layperson, it looked very similar to COVID-19. Would you agree with that?

A. My role here is as an expert, so I wouldn't want to agree or disagree with what laypeople felt. I think that when we look at the data on deaths, COVID-19 was killing at five

times the rate of influenza, and the government of Ontario considered public health in the sense of non-pharmacologic interventions because that was unprecedented. That's a five-fold increase in deaths. We may disagree as laypeople whether that is acceptable or not. Probably depends partly on whether our friends or family were affected. But as an expert in public health, that's an unprecedented death rate.

140. Q. Okay, five times the death rate. We have already been over this. When you look at a COVID death, you cannot tell me whether COVID caused that death or contributed to that death, and when we talk about contributing to that death, you cannot tell me to what extent it contributed to the death. So these death numbers that I expected you to throw back at me, they mean nothing in terms of actual impact of COVID-19 and how much death COVID is causing, right?

A. Is causing, or was causing? Because we're talking about 2020, sir, so I would like to focus on 2020, and I would propose...

141. Q. Was causing, was causing.

A. So, we're going to focus on 2020, then?

142. Q. You told me at the outset of this examination that...you accused me of time travel. So, you can presume that unless I say we're talking about now, we're talking about the time period that's relevant to this application.

A. I direct you to the exhibits from the affidavit which cite the data which showed a substantial increment in deaths at the arrival of COVID-19.

143. Q. Please bring it up.

A. Okay, let's...it's going to take me a minute here.

144. MR. PERRY: Why don't we take a five-minute break?

THE DEPONENT: We can go to page 113.

BY MR. PERRY:

145. Q. Are you referring to page 113 of the full record of the Crown?

A. The 425-page document. Just give me a second. I have got a coded table. I'll just...

146. Q. I have got a document, Dr. Hodge, of 501 pages in front of me constituting the Crown's record.

A. Okay, so this is...just give me a second. It's going to be...so, Exhibit N in the affidavit of May 2021.

147. Q. I don't have that. I have your affidavit in May 2021 filed as an exhibit. I don't have those exhibits attached to it. Okay, can you point me to something in the record of this application that supports that conclusion?

THE DEPONENT: Mr. Ryan, can you give us some advice here?

MR. RYAN: So, I have the exhibits from the previous proceeding, Mr. Perry, if you want Dr. Hodge to provide those.

BY MR. PERRY:

148. Q. Dr. Hodge, you can't find anything within the record that you have filed in response to this that confirms what we're talking about, these death rates?

A. I'm sorry, I'm not following your question. I'm reading from paragraph 13 of the May 2021 affidavit. So, perhaps you can pull that up on the screen, and that would help guide us.

149. Q. No, I have the...I would like you

to refer to the record that was filed in answer to this application, which was dated November 29th, 2024. Which you provided your affidavit of November 19th, 2024, citing your affidavit of May 14th, 2021, as Exhibit F. I would like you to show me where in the evidence that's for this court in this application that you're going to be pointing me to a conclusion that COVID was as deadly as you have described it, and with the certainty that you have described it, that it was being caused by COVID. For the purpose of the transcript, it has been a long period of silence as Dr. Hodge looks for support for these conclusions on deaths.

A. So, in the 501-page document... we're both in the same document...if you look at page red number 55, in paragraph 15, it states,

> "...The COVID-19 pandemic's effects on mortality are evident in the increase in excess mortality noted in 2020 compared to 2019. Using data from January 2020 through mid-December 2020, Statistics Canada reported an estimated 13,798 deaths beyond what would have been expected without the COVID-19

pandemic..."

And that's supported by Exhibit N, Statistics Canada, the daily provisional death counts and excess mortality, January to December 2020, that was accessed on March 10th, 2021.

150. Q. So, your conclusion that COVID was five times deadlier than the common flu is that we saw excess deaths of 13,798 people between January 2020, and December 2020?

A. No. That was in response to your question about, "How do I know there were more deaths?" The specifics of the influenza piece...I can look for that.

151. Q. Well, no. My question was, how do you know that these deaths that you're citing...that you relied on heavily in your testimony and your affidavit evidence, how do you know that these are deaths caused by COVID-19? And you pointed me to these statistics in paragraph 15, right?

A. How do I know? Because as a professional in my field, Statistics Canada is a trusted source of accurate information. So that's why the exhibit cited here is considered reasonable evidence for that statement in the

opinion.

152. Q. I'm not doubting that Statistics Canada reported 13,798 excess deaths. I'm asking you how you conclude that these 13,798 deaths were caused by COVID-19. How do you do that?

A. Well, you do it by a various range of analytic techniques. In fact...

153. Q. Enlighten me.

A. Pardon?

154. Q. Enlighten me, please.

A. Well, there's a baseline level of deaths over a period of years. It has a seasonality to it. And so, as deaths are reported by the provinces and territories, Statistics Canada looks for changes from that baseline scenario, and that's adjusted each year for the aging of the population, for factors related to inbound immigration, outbound emigration, how that population changes the age and gender structure.

And so, then, the reasonable explanation at this time was there's clearly some kind of excess deaths going on. It corresponds to the COVID-19 pandemic. We saw dramatic increases in mortality in long-term care, in hospitals. Can I

assure you with 100 percent certainty that there wasn't some mystery potion in the air? No, but if there was, I don't think either of us would be here. We would have either died or made our careers on exploring the mystery potion.

So, science advances because the most reasonable explanation withstands experimentation, withstands new data. At the time of November 2020, the best information we had, albeit incomplete, was that there was a significant increase in deaths. It corresponded to the arrival of COVID-19. It was mirrored in death counts rising in long-term care, in-hospital mortality rising. Did the numbers exactly add up? No, and, in fact, if you read the document, you'll note that it acknowledges that there were deaths from overdoses and deaths from heart disease, probably related to health services not being available because hospitals were caring for people with COVID-19.

155. Q. So, you're telling me that you look at those 13,798 deaths recorded in 2020, the excess deaths, and the only reasonable explanation that you conclude is that these deaths were caused by COVID-19?

A. I would say slightly differently. Let me try and make it more clear for you. The most reasonable explanation, based on the information available in this case in May 2021, when we prepared this affidavit, was that the body of information we had corresponded to COVID-19 being the driver of these deaths, the main driver.

156. Q. And as of May of 2021, you had not considered whether or not suicides had increased dramatically as a result of these restricted lockdowns?

A. We actually did. Suicides declined in 2020 across Canada, so...

157. Q. Really? Do you have support for that conclusion?

A. You can find it in publicly available data from Statistics Canada.

158. Q. I would like you to get it for me, please.

A. Mr. Ryan?

MR. RYAN: We'll take that under advisement. U/A

BY MR. PERRY:

159. Q. Okay. You don't think in 2020 to 2020 [sic], the closure of hospitals caused or contributed to deaths unrelated to COVID-19?

A. Which hospital closures did you have in mind?

160. Q. Well, maybe not full-out closures, but closures to elective surgeries, non-invasive surgeries, things that weren't entirely urgent. People were cautioned and outright told that certain things at the hospital would no longer be performed in preference for COVID-19. Is that not true?

A. Yes, hospitals were directed to reduce selective services. I didn't follow your question, though. You're saying that the people...

161. Q. Let me ask it again, then. You don't believe that those restrictions on hospitals caused or contributed to the additional 13,798 deaths?

A. It's possible there was a contribution. As was noted in Ontario, there were actually increases in mortality from heart disease, and it is possible that some of those people, if they had had a procedure, would have

lived longer. But the extent of the deaths and the pattern of age and gender and the subsequent information on the causes of death point to a significant effect of COVID-19 on increasing mortality.

162. Q. But you're just saying those things, that the additional things that we looked at...there's nothing in your affidavit other than a raw number of 13,798 deaths. And you're telling me that it's reasonable for you to conclude that that's a sign that COVID was deadly?

A. In November 2020, there...

MR. RYAN: Counsel? Excuse me, Dr. Hodge. Counsel, the affidavit cites a source. It's not just a bald statement in the affidavit. If you want to ask him questions about the source, we would be happy to provide it to you now. Do you want to see the source that Dr. Hodge relies on for this opinion in paragraph 15 of his original affidavit?

BY MR. PERRY:

163. Q. Dr. Hodge, what other documents

did you rely on in concluding that the excess deaths of 13,798 deaths was a sign that COVID was as deadly as it was...or you're telling me it was?

A. So, I think I'm struggling to answer your question because the way the affidavit is structured, it says that hospitalizations increased, ICU admissions increased, deaths increased. And so, the reference at footnote 10, Exhibit N, was to... people get sick, they go to hospital, they get sicker, they go to the ICU, they die, unfortunately, sometimes. And so, this was intended to provide more than just "Matthew says", data that highlight the significant impact of COVID-19 at the time of the events that are in question in this proceeding. So, I trust Statistics Canada as a professional. The Information available there was what was available at the time we were preparing the May 2021 affidavit. So, if there's...I'm not sure what more information you imagined we would use.

164. MR. PERRY: Okay, why don't we...I want to propose a 15-minute break for the morning break. We'll come back

at...why don't we just come back at 11:30, if that's agreeable?

THE DEPONENT: Sure.

165. MR. PERRY: Thank you.

--- upon recessing at 11:11 a.m.

--- A BRIEF RECESS

--- upon resuming at 11:31 a.m.

MATTHEW HODGE, resumed

CONTINUED CROSS-EXAMINATION BY MR. PERRY:

166. Q. Dr. Hodge, before we took a break there, we were just looking at some of your evidence concerning deaths. I want to now move on to talk about this particular incident with my clients in November of 2020. We touched a little bit on it in the first part of the questioning, but I want to go back to what was happening and the tensions that were apparent between the City of Toronto and the provincial government in October of 2020, okay? Are you aware of a statement that Dr. Eileen de Villa...I'm going to call her "Dr. de Villa". I don't want to mispronounce her first name...Dr. de Villa released, on October 2nd, 2020, asking the

province to "break the dangerous chain of COVID-19 transmission" and reduce the risk of further illness? And she goes on to recommend the closure of indoor dining. Are you familiar with that?

A. I recall it as a...like, a person who lived in Toronto. I haven't studied her statement in any depth.

167. Q. Okay. And I'm going to show you one of the articles that's cited in Mr. Skelly's affidavit. I'm just going to show you Exhibit M of that affidavit. When you reviewed Mr. Skelly's affidavit, did you read the exhibits attached or review the exhibits attached?

A. Yes, I did.

168. Q. Okay, and so then you have reviewed this article from CTV News at Exhibit M dated October 5th, 2020?

A. Yes.

169. Q. And the heading you see on the screen there,

"...Ontario Premier needs to see hard evidence before shutting down indoor dining in Toronto..."

Right?

A. Yes.

170. Q. Okay. And just again, excerpts just for context here within this article, and I'll ask you a few specific questions. You see here that,

> "...Ontario Premier Doug Ford says he needs to seek 'hard evidence' before agreeing to shut down indoor dining in the country's largest city, which continues to see a rapid surge in new COVID-19 infections..."

He's quoted later at paragraph three here, saying,

> "...These are people that have put their life in these small restaurants and they put everything they have and I have to be 100 per cent. I've proven before we will do it in a heartbeat, but I have to see the evidence before I take someone's livelihood away from them..."

You have read Mr. Skelly's affidavit. You have seen Exhibit M. You have not asked to see the hard evidence that was provided from the City of Toronto to the province informing your opinion today, correct?

A. That is correct.

171. Q. Okay. You do not know whether or not the City of Toronto ever provided that hard evidence, correct?

A. That is correct.

172. Q. Okay. Turning now to Exhibit L of Mr. Skelly's affidavit, and he advises that this is an email that he sent to premier@ontario.ca with the subject line, "Where's the evidence?". Have you reviewed this email before?

A. I have seen it, yes.

173. Q. He says,

"...Doug and team, first time I ever voted was for you. Strong Ontario! As an entrepreneur I was inspired by this message. I now own 3 restaurants and a cafe and employed over 50 people in February.

I'll be lucky if I employ 10 by the end of the year if this keeps up.

I'll happily comply with your orders for my three restaurants once you answer a few questions:

1) Where is the evidence that

viral transmission is happening at bars, restaurants, and gyms?

2) Why are we using case counts to determine the severity of COVID instead of real impact - hospitalizations and deaths?

3) Why hasn't the minister of health addressed the serious concerns related to false positives from PCR tests?

Thanks, you can get back to me here or..."

...and provides his number. Do you agree that these are reasonable questions for a business owner in the City of Toronto to be asking its government as of October of 2020?

A. I mean, I'm not a business owner, so I would defer to your client if they were reasonable to him, but...that's probably more important. I think that if I may say on question 2...

174. Q. I'm not...no, Dr. Hodge, I'm not asking for your opinion on his questions. I'm asking...

A. You asked me if they're

reasonable. So, I was going to say that I find question 1 very reasonable.

175. Q. Okay.

A. Two, meaning no disrespect, is not fleshed out in a way that seems reasonable to me. And question 3 is a question for the Minister of Health.

176. Q. All right. Is there anything unreasonable about these concerns of a business owner who's being impacted by community public health policies? Now, I'm talking about in your view as an expert on these matters, you would expect these sort of concerns to be raised from a business owner, right?

A. Yes.

177. Q. Okay. And I understand Mr. Skelly's evidence to be is that he never received an email...never received an answer to that email. Do you have anything that suggests otherwise?

A. I have no access to the Premier's email. You're saying he never received a response from Doug and team? Okay, I take that as a statement of fact.

178. Q. You had the ability in forming

your opinion to consult with members of the provincial government and ask whether or not an email was ever given...an answer was ever given to this.

A. You vastly overestimate my influence. I don't think Mr. Ford even knows I exist, so I'm not sure how you imagine I would consult with him. He's generally not available for consultation, in my experience.

179. Q. I didn't say Mr. Ford. I didn't say the Premier of Ontario. I said you have access to the Government of Ontario, as a public body, in forming your opinions and conclusions for this expert evidence you're offering today, right?

A. So, in my experience, the government is not a monolith. The government is made up of people, and there's an important distinction between elected officials to whom this email appears to have been directed, with whom I had no interaction, and civil servants, members of the public service, with whom I would interact in a professional manner but in many cases were not in a position to interact during this time because they were busy trying to save

lives and provide the best advice under uncertainty that they could to the Government of Ontario, to those elected officials to make these hard choices, which Mr. Ford speaks to in the CTV excerpt.

180. Q. Just help me out here. What is the correct department or terminology for the arm of the government in which Dr. David Williams worked for while he was employed as the Chief Medical Officer of Health?

A. So, I would defer to Dr. Williams, but my understanding is at that time, the structure was such that he was an employee of the Ontario Legislative Assembly, i.e. the Parliament, and that he also had an Assistant Deputy Minister role within the Ministry of Health whereby certain departments, if you will, within the Ministry of Health reported through him to the Deputy Minister, who, if I recall correctly, was Helen Angus at that time, or possibly Catherine Zahn. I don't...we can... that's a matter we can resolve.

181. Q. All right. And in forming your opinion, given in either your affidavit of May 2021 or November of 2024, you did not consult

with anyone from the Ontario Legislative Assembly, correct?

A. That is correct.

182. Q. And same question in terms of who you consulted with for both of those affidavits. You never consulted with anyone from the Ministry of Health, correct?

A. I was in contact with staff of the Ministry of the Attorney General who were assigned to the Ministry of Health. I can get you their names if necessary.

183. Q. Yes. Who...just help me out. They were part of the Ministry of Health, or you're talking about someone from Mr. Ryan's office?

MR. RYAN: Counsel, if I can answer on a point of bureaucracy?

184. MR. PERRY: Please.

MR. RYAN: There are lawyers at every ministry in the Ontario government who are part of the legal services branch for that ministry, so whether that's the Ministry of Health, the Ministry of the Solicitor General, and formally, they are MAG lawyers seconded to that

ministry. That's...you know, for legal reasons, that is the formality. So, I believe that's what Dr. Hodge is referring to. They're lawyers who work in the Ministry of Health. Their email address would show up as from the Ministry of Health.

BY MR. PERRY:

185. Q. So, you consulted with lawyers from the Ministry of Health informing your opinions, Dr. Hodge?

A. Yes, because when I wanted to clarify questions or request data, requests flowed through that person.

186. Q. Okay, who was that person?

A. Mr. Ryan, do you have it handy? I can look up her name.

MR. RYAN: I don't.

THE DEPONENT: It'll just take me a couple of minutes to find it if you want.

187. MR. PERRY: That's all right. We can get an undertaking in that regard. Mr. Ryan, can we have an undertaking to

confirm the name or names of the counsel from the Ministry of Health that Dr. Hodge corresponded with in forming his opinions?

MR. RYAN: Under advisement. U/A

BY MR. PERRY:

188. Q. Okay. And what sort of things did you talk about with them, Dr. Hodge, or exchange with them?

A. Well...so, for example, in the... sorry, I have lost my page. In the May 2021 affidavit, the information in table 2...I made a request for that information. They passed it to Public Health Ontario. Public Health Ontario summarized the data, and I was provided that for my affidavit.

189. Q. Okay. You're talking about the table here at the conclusion of your report or near the conclusion at paragraph 28?

A. Yes, it's titled "Outbreaks in Bars, Nightclubs and Restaurants". You have it on the screen there.

190. Q. Okay. So, this was based upon information that you received from counsel for

the Ministry of Health?

A. Well, they were the delivery vehicle, as I recall, because the...Public Health Ontario was quite busy at this time. And so, I made a series of data requests, and the lawyer navigated those and produced the results for me...

191. Q. Okay.

A. ...or provided the results. The work was done by staff at Public Health Ontario.

192. Q. What did you do to verify the independence of those findings?

A. Independence from, or with respect to?

193. Q. From fudging the numbers, right? The government may be motivated to state its best evidence to you in support of its restrictions. Did you do anything to verify the accuracy of the data that you were provided?

A. I have to kind of take it on faith that government agencies generally represent the data accurately. I can't...in response to your question, I can't identify a way I could have "independently verified" this. Much of this information was publicly available

through various channels, whether it was the science table or reports from Public Health Ontario. So, the table 2 data were summarized by Public Health Ontario in their report on outbreaks. I, as a public health physician, accept that Public Health Ontario makes its best efforts to be accurate, similar to Statistics Canada, as we were discussing earlier.

194. Q. You know that Adamson Barbecue, the restaurant that was closed and restricted to indoor dining as a result of these restrictions...you know that it wasn't a bar, right?

A. I don't know the specifics of it. I understood that in the past there had been a licence to serve alcohol there.

195. Q. You know that it wasn't a nightclub, right?

A. So, the...

196. Q. Do you, or do you not know that Adamson...

MR. RYAN: Let the witness answer, Mr. Perry.

197. MR. PERRY: ...Barbecue was not a nightclub? It's a yes or no question.

MR. RYAN: Mr. Perry, you cannot tell the witness it's a yes or no question. Ask him the question and wait to hear his answer.

BY MR. PERRY:

198. Q. Are you aware that Adamson Barbecue is not a nightclub?

A. Yes, that is true. That is accurate. I'm aware of that.

199. Q. All right. You didn't think...in conducting your independent expert opinion on whether or not the restrictions on restaurants were justified, you did not think it was worthwhile to ask for a further breakdown between how many cases or outbreaks were the cause of bars, were the cause of nightclubs and were the cause of restaurants? You never thought to get that data as an individual location?

A. I think you're mistaken, sir. I actually would say that the distinctions between those establishments are difficult to establish with any clarity, and they all shared the characteristics of being places where people congregate in close quarters. There may be live

music or big crowds, which increases the risk of transmission as people raise their voice volume, as people consume alcohol or not if it's a licensed establishment, and it all goes back to breaking the chains of transmission. So, this group of establishments shared in common that they are places where transmission chains could be broken to reduce deaths and protect Ontario's population.

200. Q. So, you see no distinction between a bar, a nightclub and a restaurant? Is that your evidence?

A. From a COVID transmission perspective, there is no meaningful distinction in 2020 because we lacked the resources to go in and supervise every interaction in every one of those establishments. Province of Alberta actually attempted to establish music... background music volume levels in part to mitigate the adverse consequences of closing these businesses, and it was completely...it was unsuccessful. So, all of these establishments share in common from a public health or an epidemiologic point of view, heightened risks of COVID-19 transmission because of the activities

that take place in those establishments. People speak, they speak with their mouth full, they raise the volume of their voice over background music or over crowds. They're often in close quarters. In order to eat and drink, you have to remove a mask or face covering, which increases risk of transmission.

201. Q. So, a packed nightclub on King West has the same risk profile as a quaint steak restaurant that only serves indoor dining as of November 2020? That's your evidence?

A. It's not the same. It is similar. There are behaviours that people engage in in both established...types of establishment that increase the risks of transmission. And you...I think you said the word "stayed restaurant"?

202. Q. Steak.

A. Steak, my mistake. So, resources were not available to inspect or supervise every establishment within this grouping. What we know is that from a public health perspective, all of these types of establishments are associated with higher risks of transmission. And I would add that all of these establishments were eligible

for financial support programs that were put in place by government, recognizing the adverse consequences of the public health measures and seeking to mitigate those measures.

203. Q. You're not an expert on what sort of measures or grants or economic relief was suitable for these restaurants and bars and nightclubs, right?

A. I simply said they were eligible.

204. Q. Right. You have no evidence in your report as to what sort of financial compensation was offered to these restaurants?

A. I believe it's a matter of public record, so it's not in the affidavit.

205. Q. Now, these numbers, the data were provided to you in or around May 10th, 2021, correct?

A. That is correct.

206. Q. That is time travel, is it not? You are using data that was available to you post-incident to justify something that occurred in November of 2020. That's that time travel we spoke about previously, correct?

A. No, you're mistaken, sir. Let's...could you put the table on the screen so

we can all see all the table? And we'll go through it together. There are three time periods represented by the three rows. They represent different levels of restrictions. The first row, one outbreak in the period from March 19th to June 20...sorry, March 13th to June 22nd, when there was no on-premise dining permitted. The second row, June 23rd to November 22nd, there was outdoor with some indoor dining restricted with capacity limits. The number of outbreaks, and more important the number of outbreaks per 100 days, and the average number of cases goes up. November 23rd, the government implemented more strict restrictions on restaurants. The number of outbreaks goes down, the number of outbreaks per 100 days declines and the average number of cases declines as well.

So, this is not time travel. This is what's called time series, which is a basic tool in public health science. I'm happy to spend more time explaining it to you if that would be helpful to you.

207. Q. I know how to read the table. I'm asking you, you don't have anything in your report that suggests that, as of November of

2020, the provincial government knew that restaurants were a source of spread?

A. I cannot speak to what the provincial government knew or didn't know at any time.

208. Q. Okay, and you didn't think to ask your counsel or the counsel from the Ministry of Health for that information in forming your report?

A. Well, the data that are summarized in this table are actually a summary of a near real-time outbreak accounting or outbreak listing. So, at any moment in any of these three time periods, people in the government would have had access to this information, likely through the Ontario Science Table, which was created in July 2020 and continued until September 2022. So, the science table was in place at this time, and I believe their website is archived and this information was actually also available to the public.

209. Q. Are you able to ask your contacts from the Ministry of Health as to whether or not they could find out whether or not this email was ever responded to?

MR. RYAN: Counsel, why don't you ask me for that undertaking as opposed to directing Dr. Hodge to do inquiries elsewhere?

210. MR. PERRY: Does he have the ability to do that?

THE DEPONENT: If that's a question to me, that's a categorical no. I don't have access to the Premier's email.

BY MR. PERRY:

211. Q. Okay, thank you. Do they provide you with any training...in your post-doctorate program, in your post-doctorate education, is there anything that's part of that curriculum that addresses how to balance the enshrined rights of Canadians against public health measures, those enshrined rights being those in the Charter and our Constitution?

A. So, I think that there's probably two types of...two elements of the training that may speak to your question.

The first is at the level of principles. So, if you have a physician in your personal capacity who's a family doctor, there are certain

principles that we would hope they would follow: informed consent, first do no harm. In public health, there are similar principles, and one of those would be to be mindful at all times where restrictions are being put in place on people's liberties or where public health interventions have adverse consequences. How can those be the least restrictive for the shortest time possible? And that, in practice, means...in the same way as informed consent, some doctors do it some way, some do it another. In practice, there will be some...there's interpretation. There's ways in which people use that, but that is a core fundamental principle of public health practice.

I think the second thing that I would say is that public health is an input to a broader societal conversation. So, a colleague of mine recently retired after 20 years in Barrie as the Medical Officer of Health. He spent most of his time, most of his energy trying to get the City of Barrie to stop sprawling and build denser neighbourhoods because they're better for public health. And I think he would say, without putting words in his mouth, he was singularly unsuccessful because public health is...

212. Q. I'm sorry. I just didn't hear you. He would say...what would he say?

A. He was singularly unsuccessful, so...because public health is one input to a broader decision-making process. So, when I worked for the City of Hamilton, we would make recommendations, ECDEV would make recommendations, police and fire would make recommendations. And it was the job of elected officials to kind of make sausages out of all of that, and that becomes the policy or programmatic framework under which we live in any community. So, you know, that participation piece as a stakeholder in that process is also an important part of the training and recognizing that one has to play well with others, but also that, mercifully, we don't get to practise emergency response very often. The COVID pandemic was a, as you noted, once-in-a-generational, unprecedented event.

213. Q. Well, I said the restrictions were unprecedented, certainly. The public health aspect, though...that does require that balance, those competing interests, the rights of individuals specifically. Just so I have an

understanding of what your background is, you would say you have that expertise? You have that understanding how to find that balance?

A. I have expertise in acknowledging that balance is important. That balance is struck typically by elected officials because they receive inputs from people who are more expert in rights...Charter matters than I am as a public health professional. I do not hold myself to be an expert in the matter of the Charter of Rights and Freedoms. I think the important thing is that in that process, public health people are providing inputs that acknowledge that this is not a slam dunk. This is not just, "Do what we say". This is a balancing.

214. Q. In rendering your report, either affidavit...in swearing to either of your affidavits, you were never asked by the provincial government to comment on whether a balance between public health and some of these rights that we have been discussing just now was met? You weren't asked to do that?

A. That is correct.

215. Q. Okay. I just want to ask you a few things that I understand Mr. Skelly will be

saying was being undertaken at the restaurant, and it has found some support from the affidavit that we have received from the City of Toronto's witness. I just want to ask you if these things that we say were being undertaken at the restaurant...if they were being undertaken, would they have mitigated or increased the risk of COVID-19 transmission amongst patrons? The restaurant had big bay doors, garage-style type doors that opened and allowed free-flowing air to be passed through the restaurant. Does that architectural feature contribute to the spread of COVID-19 or mitigate the spread of COVID-19, in your opinion?

A. So, I can't speak to the specifics of your client's restaurant. In general, increasing the frequency of air exchange, which I understand a bay door would do over a closed box, should reduce the risks of COVID-19 transmission.

216. Q. Okay. And contact tracing, does that mitigate or increase the risk of COVID-19 transmission?

A. You know, I think that's a harder question to answer because we have the

theoretical contact tracing, or what we might call the practice, where we have a person who gets diarrhea at a restaurant and we follow up with 50 or 60 other diners. And then we had COVID-19, where the infrastructure required to do contact tracing in any effective way simply didn't exist. So, I think that we can say contact tracing in the abstract could potentially be a mitigating factor if people are willing to follow the directions from public health, and there's a body of learned experience that adherence was variable. The reality was during November 2020, there simply weren't enough people to work the phones.

And I would add, because I think we had a reasonable sense of this by November 2020, COVID-19 could be spread by a person who is infected but not yet symptomatic. So, they pick up the virus, they are able to transmit it to others, they're part of that chain of transmission, but they would have no reason to be tested and no reason to call in and say, "I'm concerned I have COVID", because they have no symptoms.

A number of consulting groups proposed

mandatory testing in the entire population every week in early COVID, and I think governments found that abhorrent in terms of the restrictions it would place on people's rights and freedoms. So, yes, in the abstract, contact tracing might have helped, but for COVID-19 in November 2020, it was ineffective.

217. Q. Social distancing, effective at mitigating the spread of COVID-19, or neutral, or increases the risk of COVID-19 transmission?

A. I think we can be reasonably confident it didn't increase the risk of COVID-19 transmission. I think we...the jury is out. In the affidavit from 2024, you'll note there are a couple of papers that highlight the degree to which the acceptance of how COVID-19 was transmitted was a slow process. So, initially, it was thought to be respiratory droplets. Perspectives from disciplines other than infectious disease said, "You're not understanding the physics here". And by, you know, fall 2020, I believe even Dr. Williams acknowledged that maybe the transmission was different than had been initially thought, and much more aggressive transmission, smaller

aerosols that can persist for longer time periods. So, I think with social distancing at the time it was implemented, it represented a best-efforts understanding of the virus transmission. Whether it was effective or not, hard to say.

218. Q. Masking?

A. Controversial, to be sure. Masking with medical-quality masks reduces transmission. I think the evidence for that is reasonably robust. They have to be worn properly, changed frequently enough. I think one of the things that can be very frustrating for us as public health people, and I appreciate was exceedingly frustrating for the public, was in that first phase of COVID, there was a certain amount of building the boat as we sailed it because...

219. Q. Sorry to interrupt, Dr. Hodge. When you say "first phase of COVID", can you just define that time period? What do you define the first phase of COVID...

A. The pre-vaccination era. So, essentially, let's say 2020. I'm fortunate I got my vaccine in December 2020, but population

access was spring 2021. But let's just focus on 2020, because that was where we had...new virus appears, not sure what to do. Italy and New York are getting crushed. Those were the frames that people brought to the table in the spring of 2020. We didn't want to have people dying on the steps of hospitals like happened in New York City.

Summer 2020 didn't seem to have been as bad as we expected. Fall of 2020, test positivity ramps up, hospitals are overwhelmed and the restrictions that affected your client come into force.

220. Q. So...sorry. Masking, effective or ineffective at stopping the spread?

A. Well, again, I think the point I was trying to make is that we really didn't have clear...like, nobody did a trial where they masked half the people and didn't mask the others. There was a reasonable basis of physics, fluid dynamics, public health practice that it would mitigate the risk of transmission.

221. Q. Hand washing?

A. Probably oversold, but generally a good public health measure, sort of like,

"Don't crap where you drink". You know, basic kind of sanitation.

222. Q. Okay, so, if it's correct that there was evidence of contact tracing, social distancing, masking, free airflow...if there are evidence of those four things being undertaken at the restaurant, would you agree that those things minimize the risks posed by the transmission of COVID-19?

A. I would say they diminish the risk compared to what it would be without those things but that risk may still be excessive in terms of...there's enough people getting infected. They're going to work. They're going home. They're making others sick. The hospitals are getting crushed. So, it's not "minimize", "eliminate". It's more a matter of "diminish". And I think in the context of October/November 2020, the restrictions were put in place because they reflected a consensus that the resources needed to supervise what we might think of as mitigating measures to ensure that people adhered were simply not available. There was also simply not enough people to do contact tracing, and we had come to understand that the virus resisted

contact tracing because of this asymptomatic infectious period.

223. Q. It's not documented that somebody who was asymptomatic could transmit a severe case of COVID-19 to an individual, correct?

A. COVID-19 is not transmitted as a case. So, if I can share with you the medical model...

224. Q. Can you...okay.

A. ...COVID-19 is an infectious agent. The severity of the clinical presentation is determined largely by the characteristics of the host, the human who receives that infectious agent.

225. Q. Can you please provide me with evidence or the support for a conclusion that somebody with asymptomatic COVID-19 could transmit...I don't know how else to describe it than as case. You'll have to forgive. I'm not a medical expert. I have no evidence in your report...none that I'm aware of...that an asymptomatic individual, somebody who is presenting with no symptoms of COVID-19...well, let's start with just being able to transmit a case of COVID-19. Do you have evidence for that,

an asymptomatic individual being a transmission point for another person to be infected with COVID-19?

A. So, you...maybe I can start with some vocabulary, because I want to make sure I'm understanding. So, asymptomatic can't present with COVID-19 because they don't know they have it unless we have forced testing of the entire population, and that was unacceptable. So, an asymptomatic person with the passage of...so, I'm asymptomatic today. In three days' time, if I have a cough and a runny nose, it's like, "Okay, now I have become symptomatic". Some people, three days from now, 10 days from now, two weeks from now...they're never going to have symptoms. Both of those people can transmit the COVID-19 virus to other humans.

226. Q. All right. Now, that latter portion...and, I mean, I think even the first portion is worthy of challenge, but that's a very...to a layperson, that's quite a surprising fact that I don't see supported in the record, that somebody could acquire COVID, the illness, and be asymptomatic for the entire duration of their infection and spread it to another

individual. Where is your support for that?

A. So, your...perhaps your "layness" is getting in the way of your question. Let me try again. An infectious agent is in a human host. That...the only way we know about that is one of two ways. We test everybody in the population, or we wait for symptoms to appear. So, an infection in a human evolves over time. Some humans who are infected will have symptoms. We then say, "You are symptomatic as of today". If we could know...all-knowing, some higher force...when they were exposed to the infectious agent, we would say they had an asymptomatic phase, no symptoms, but agent present, and a symptomatic phase, symptoms, agent present.

So, let me see if I can give you an example. If I develop a cold sore, it's typically a herpes virus that's been just chilling in my body asymptomatically. I get stressed, I get another illness, boom, herpes replicates. I get a cold sore on my face. I'm symptomatic when I have the cold sore. I shouldn't kiss anybody because I could give it to them. But I was asymptomatic because that virus is just chilling in a nerve cell, which is where

herpes lives. You're younger than me, but I had chickenpox. Perhaps you did too.

227. Q. I did.

A. If you get shingles...right now, if you had chickenpox, you're asymptomatic with respect to shingles. The varicella virus is almost certainly in your body. And maybe 10, 15, 30 years from now, if you get an episode of shingles, we'll say, "Now you're symptomatic". So, there's a period when the infectious agent is present, the host has no symptoms. So, when you use the word "illness", I'm going to understand that as symptomatic. So, people can transmit the infectious agent whether they have symptoms or not, and that has been established.

It was a challenge in the early days of COVID because we...the state of the science was such that it wasn't clear when does transmission actually occur. I think the patterns of transmission in households, in workplaces suggested that people without symptoms were able to transmit the virus because the number of people getting sick was too high compared...like, the arithmetic of infectious disease, if you will, highlighted for us, and that led to the

recognition...in part that led to the recognition that there was aerosol transmission, not just big chunky gobs of spit transmission. And those aerosols can persist in indoor spaces for hours to...rather than just seconds to minutes, which is the large chunks of snot, respiratory droplets.

228. Q. The concern for transmission was in...if the concern for restaurants was the increased transmission rates and then the sort of cascading effect that might have on health care professionals who work in long-term-care facilities or those who visit their loved ones in long-term-care facilities might bring in the virus...that was one of the primary drivers of restrictions on indoor dining, to ease the burden on the healthcare system, right?

A. I think the goal...like, the sequence of thinking was reduce transmission risk to reduce the number of people who get infected, and that has the effect of sparing the health care system. It also spares families from... like, everybody in the house being sick. It enables other sectors of the economy to function such as they could during COVID-19.

229. Q. Did...in your dealings with the counsel for the Ministry of Health, you don't know...or maybe you do, but you don't know whether or not they considered restrictions on long-term-care facilities, do you?

A. I'm aware that restrictions were put in place because my father was actually in a long-term-care facility, so there was a complete prohibition on visitors.

230. Q. My grandmother as well at the time. There was a restriction on visitors, correct, in the long-term-care facilities?

A. Yes.

231. Q. It was not unusual for the Chief Medical Officer of Health to give directives to hospitals and long-term-care facilities over the course of the pandemic, was it?

A. There were a series of directives that came out, yes.

232. Q. Right. And did you ask the Ministry of Health or its counsel why they did not feel that the restrictions on long-term-care facilities, its visitors and its healthcare workers were sufficient to minimize that concern of spread amongst the hospitals or long-term-care

facilities? Did you ask that question?

A. The question about, "Did they think their measures were adequate?"

233. Q. Yes, about with respect to what they were doing in long-term-care facilities on a location basis. So, the restrictions within that facility, restrictions on visitors and potentially restrictions on the workers that work there. They could have done that. Did you ask them about that?

A. No. What restrictions on workers do you envision would have been...

234. Q. Well, it was on...was it not part of directive 6 that the Chief Medical Officer of Health imposed on all hospitals a requirement that they have a vaccination policy in place, that sort of restriction on workers?

A. There weren't vaccines in...

235. Q. Before you go down there, just let me finish my question. Before you go down the path of, "We didn't have the vaccine in November of 2020", I'm not saying they could have done that in November of 2020. I'm saying they could have imposed restrictions on workers, where they may be able to go on their off hours, who

they should be encouraged to visit or not visit, while they're working in those long-term-care facilities. Your investigation into whether or not restrictions on indoor dining were reasonable, did it include any investigation on the effectiveness or use of measures such as that?

A. No, but if your concern is restrictions on people's Charter rights...you're proposing to lock the staff in the facility?

236. Q. No, that's not what I said.

A. I can't see how...I would be interested to understand what you're proposing, because I wasn't aware of this discussion, and I think it was largely because it was completely impractical, to say nothing of an incredible infringement on people's rights.

237. Q. Okay. You work at a hospital, correct?

A. Yes, I do.

238. Q. And you worked at Scarborough during the pandemic, right?

A. Yes, I did.

239. Q. Did Scarborough close the cafeteria at all?

A. Yes, they did.

240. Q. Did Scarborough close any of the health facilities within the hospital, not permitting people to use a gym facility or communal spaces, anything like that?

A. I don't know if we have a gym, but, yes, there were certain...they opened up corporate offices for people to have...to eat in so that there could be fewer people eating. So that was...

241. Q. So, you're well aware of the sort of restrictions that a hospital might place on employees, and you're well aware that I'm not saying they need to lock people in the hospital. I'm saying there's things that long-term-care facilities could have done, could have imposed upon their employees that would have mitigated a concern for the risk of transmission in its hallways amongst its patients.

A. So, I actually disagree with that assertion unless you can provide me a specific measure to which I can respond. Because let's say, for example, my spouse works in long-term care. I go to a bar. I bring home COVID-19. I give it to her. She goes to work, and she's

trying to help an elderly person, and the elderly person pulls her mask off her face. She coughs, the elderly person gets COVID, and they're dead three days later. At a practical level, which is where praxis happens and public health practice is practical, I think you would need to provide me an example to which I can respond if this is a matter of expertise. I'm happy to hear your examples. Please proceed.

242. Q. I have just given you some.

A. What are the specific measures you would have recommended for long-term care that would have been effective in reducing transmission in those locations that weren't in fact already in place?

243. Q. Well, first, it's my examination for you, but I'll run by some of those examples again. Okay? And you tell me whether that would have increased or minimized the risk of COVID-19 spread amongst the hospital. You have already told me visitors would have done that, right?

A. So, you're now switching to hospital. You started with long-term care. Can you clarify which one you want to discuss?

244. Q. Hospitals and long-term care.

Would you not have been concerned about the risk of transmission and spread amongst hospitals, or was it just long-term care?

A. They're different environments with respect to transmission dynamics.

245. Q. Okay. On your evidence, then, and your expertise, what were the restrictions most concerned about eliminating the transmission within, hospitals or long-term-care facilities?

A. So, restrictions placed in those locations that were to restrict transmission in those locations are too late because the goal... and this was the province's stated objective... policy objective...was to break transmission chains and reduce transmission. By the time it's inside the building, yes, you can do the measures you recommended, people eating apart, people wearing masks, people washing their hands. From a prevention perspective, which is what the goal is...stated in the *Reopening Ontario Act*, I believe. That was the goal, reduce transmission. So, none of those...like, once it's inside the building, it's kind of too late for that. So, the only...the one piece that was raised in conversations was, "What about restricting the

workers?" And the only restriction that would have been effective from a transmission reduction perspective would have been limiting...requiring them to remain on site for weeks to months at a time, and that was deemed, I think...I hope you would agree with me...to be unacceptable.

246. Q. So, rather than restrict in any way the employees that worked within the long-term facilities, it was better to close the entirety of an entire sector of businesses across the City of Toronto. Is that what I'm understanding correctly?

A. I don't think...I don't know what you're understanding. That's not what I said. So, maybe I'll try again if that would be helpful.

247. Q. You said there were...there was no realistic restrictions that we could have placed on long-term-care facilities, on the employees of those facilities. You're refusing, seemingly, to recognize anything other than a world in which we locked and threw away the key to the long-term-care facility and kept them there. So, is it your evidence, then, that the next best option to mitigate the transmission and

spread of COVID-19 of those living in long-term-care homes was to close restaurants and restrict them to takeout only?

A. No, that's illogical. Let me... so, the government had a number of objectives that it needed to balance. It wished to reduce transmission with the intended effect of reducing deaths in long-term care. It wished to reduce transmission with the intended effect of avoiding the health care system going off a cliff because there was no staff to take care of people. It wished to reduce transmission to avoid the situation where society could not function because so many people were sick. So, we have been through a number of...and I think we agree, if I'm not mistaken, that there was substantial numbers of deaths in long-term care. I don't recall your words...perhaps the reporter can get to them...but I believe you said that the deaths were largely confined or are happening in long-term care.

248. Q. I said I agree with you...sorry, just so you're...I said I agree with you that deaths happened in long-term-care facilities. We have a mutual understanding there. The cause of

COVID-19 being...or, excuse me, the cause of those deaths being COVID-19, I don't think we have a consensus on that, or we didn't really discuss one, but we are...

A. So, we have some agreement.

249. Q. Yes.

A. So, the measures that we have run through, eating apart, wearing masks, they were in place. There is no design solution that makes them 100 percent effective. And so, the province in the fall of 2020, faced with rising ICU occupancy, rising hospital admissions, rising test positivity, took additional steps, including restricting in-person dining, in an effort to achieve its objective of reducing transmission.

250. Q. Just give me one moment. I just want to find an excerpt that I have got in my notes here, and I just want to make sure I bring you to it in your materials. So, if you could turn to paragraph 20 of your affidavit...your November 2024 affidavit, just let me know when you're there.

A. Red number 57? Page 57?

251. Q. No, I have it at page 8.

A. Okay.

252. Q. I can share my screen with you if you would like.

A. Yes, that had be great if you could. Just saves me a lot of scrolling.

253. Q. Sure. Okay, so this is at paragraph 19 and 20 of your affidavit sworn in November of 2024. What begins this is...you're reviewing your transcript conducted in the other proceeding...your transcript from the examination conducted in the other proceeding, and it says,

> "...In an exchange with counsel at paras 184-195 & 208-212, counsel appeared to propose that locations where deaths occur are where NPI measures should be put in place, citing the opinion of an academic expert retained by the Applicant in that matter. Pursuing this approach led to the proposition that restaurant restrictions were excessive or of no relevance because few deaths could be attributed to restaurant outbreaks. Reviewing this exchange highlights the importance of the public health perspective - societies may opt to implement measures, such as limits on

restaurant occupancy, to reduce the transmission of a communicable disease, such as COVID-19, because the most vulnerable (for example, people living in LTC homes) have no choice but to rely on others for their basic needs, including feeding and toileting and by extension their survival.

Thus, limits on restaurant occupancy are not implemented because people who eat in restaurants will die from COVID-19 illness from infections they contract in restaurants. These limits are proposed in no small part because the people at highest risk, such as the elderly living in LTC homes, are entirely dependent on people who can eat in restaurants, or who live with or who are otherwise in contact with people who eat in restaurants, for the basics of survival..."

Are you telling me that the province of Ontario has told you that they enacted these restrictions because of the risk to long-term-care homes, or are you surmising it based upon your independence

of the provincial government?

A. I'm stating it as a matter of public health expertise, that if we wish as a society to protect those who are most vulnerable, these are the measures we need to do in the face of an infectious agent like COVID-19.

254. Q. Because when I look to the evidence of Dr. de Villa and what she has gone on record as saying were the motivations behind the restrictions in October and November, she mentions transmission in and amongst the community at large. Who told you, from the provincial government, that these limits were being imposed..."proposed in no small part because the people at highest risk, such as the elderly living in LTC homes"? Who told you that from the provincial government?

A. No one did. That's a statement of expert opinion about how the rationale for NPIs, or non-pharmacologic interventions.

255. Q. So, you're assuming that this was...based on your expertise, you're making an educated assumption that that's why restaurants were restricted to indoor dining?

A. And the provincial government had

a stated objective of reducing transmission, and these measures would be a reasonable means to do that and would have the...we can argue about its desirability...would have the effect of protecting those who were vulnerable. And in general, governments have taken steps to protect those who are vulnerable, whether from a pandemic, or poverty or disability. So, each government strikes a balance in its own way, reflecting presumably the wishes of the citizenry and other factors.

The goal of reducing transmission...so, when Dr. de Villa speaks of community spread, if you go to the grocery store and your risk of getting COVID goes from one in 1,000 to one in 10 because there's so many people with COVID, even if they're not all in the hospital system, eventually, so many people will be unwell that some proportion of them will require hospital care, some proportion will require ICU care, and the healthcare system goes off a cliff.

So, I don't think there's a difference between what we're saying. There's just... it's...we have different pieces of the elephant that was how to respond in the pre-vaccine era to

rising transmission and a healthcare system increasingly challenged. And by "healthcare system", I would include by extension long-term-care homes. They are...it's a...all of us are vulnerable when we're unwell. People living in long-term care have heightened levels of vulnerability because they can't take care of the basic...their basic needs on their own. That's why they're living there.

256. MR. PERRY: Can we just take a 10-minute break, if we could? Just, I'll review my notes, and I think we may be out of here. Maybe just a couple more questions.

--- upon recessing at 12:26 p.m.

--- A BRIEF RECESS

--- upon resuming at 12:31 p.m.

MATTHEW HODGE, resumed

CONTINUED CROSS-EXAMINATION BY MR. PERRY:

257. Q. Dr. Hodge, in your education as a public health professional, what sort of consideration is given to autonomy of the individual...an individual's choice in how they mitigate the risks of a viral infection or a

pandemic in their own lives, using their own discernment, using their own discretion? Does that come into your training at all?

A. I think it's certainly an important consideration, and it's something that's discussed both with trainees and among people in practice, and I would say the sort of professional consensus is that a person's right to autonomy to swing their fist stops at the edge of my nose. So, there are...we have relationships and responsibilities in society, which means that autonomy cannot be absolute, or at least our public health perspective is that absolute autonomy would not produce good health outcomes for the population. Others will see it differently.

258. Q. What about the inversion of what you have just said? I like that analogy. You know, your right to swing your fist stops at the edge of my nose. What about the fact that the government's right to swing its fists ought to stop at the front door of someone's business?

A. That's a matter that I'm not expert in, so...

259. Q. You don't have any information

from the provincial government that would lead you to conclude that it considered individual autonomy in its assessment of imposing these restrictions, do you?

A. I mean, I can...I would refer you to Exhibit S from my affidavit of 2021, which describes...this is a Government of Ontario document that talks about their COVID-19 response framework, "Keeping Ontario Safe and Open", and they list six priorities. And there's a series of principles. And I think that from my perspective, the government's...the reason we have a government, in part, is to have a way to balance the tensions between these principles and objectives, because they cannot all be achieved in the context of the COVID-19 pandemic pre-vaccine.

And I think if we look at the arc or the timeline of restrictions...so, fall...December 2020, vaccine comes to Canada. Summer 2021, basically anybody who wants it has had access to it, and then Omicron comes. And, in fact, the government of Ontario moved to place restrictions on restaurants in early 2022 because the priority of avoiding closures had been trumped by the

priority of the need to limit the transmission of COVID-19. How they did that...I wasn't at that table, but I think it speaks to the dynamic tension between these priorities and the principles that underlie them.

260. Q. You talked a lot today about the vaccines and the phase one being before we had vaccines. You understand that despite rapid uptake of the vaccine throughout 2021 amongst Ontario, we still closed down restaurants in 2022?

A. Well, because the virus had changed. The virus changed faster than the vaccine. We were back on the edge of a precipice in terms of, "How does the health system continue to function?", and the government put in place more restrictive measures for the time that they felt was necessary and included an exit strategy, which played out over early 2022.

261. Q. When did you first...when were you first contacted by the provincial government to give opinion evidence on the first application that was issued in 2021...or the first hearing that was brought in 2021? When were you first retained for that?

A. The first hearing in relation to your client, or the first hearing in relation to COVID?

262. Q. The first hearing in relation to my client. So, let me ask you a different way. I'll withdraw. When were you first contacted by the provincial government to render the expert opinion that you did in May of 2021? When did that first contact happen?

A. I would ask Mr. Ryan to check the notes. Maybe by way of context, I was a contractor for Public Health Ontario, as indicated in the affidavit, from September to the spring of 2021, and in the course of that was assigned a task of preparing an affidavit for an unrelated matter. And following on that, when the contract of Public Health Ontario came to an end, I agreed to continue to provide, on a sort of per-episode basis, additional expert testimony if they felt it would be useful. And they navigated that with...I believe it was Legal Services Branch in the Ministry of Health. So, Legal Services Branch said, "We have a case. We would like your expert advice". We draw up a statement of work under the contract I have with

Public Health Ontario.

That came to an end after the first proceeding involving your client, but before the proceeding we're currently in. And Mr. Ryan's team reached out to me because I had participated in the 2021 process in September of 2024, and we agreed that I would be willing to participate in this as an expert.

263. Q. Okay. So, at some point in 2021, you were first contacted for this particular incident?

A. Yes, because this contract I had with Public Health Ontario was...essentially, Public Health Ontario wished to retain me as an expert. The ministry would ask Public Health Ontario. I would say yes, Public Health Ontario would send me a work order, I would agree to it, and then I would work with the relevant elements of the government to prepare the expert testimony, because as you're probably aware, there's been a number of cases related to COVID-19 restrictions.

264. Q. Yes. So, it was a work order that you received in terms of setting out what the request of the government was in relation to

this opinion?

A. It would have been covered by that contract. So, it was a...I can't remember. I'm not sure if they called it a purchase order or a work order, but we had an umbrella contract where they could call on me. I think it was a way to...similar to a vendor-of-record-type relationship.

265. Q. They could call on you on an as-needed basis when your expertise is needed to serve as an expert witness?

A. Yes, that's more succinct. Yes, exactly.

266. Q. And what's your compensation structure?

A. I'm paid by the hour.

267. Q. How much is your hourly fee?

THE DEPONENT: I don't have the contract in front of me. I'm not sure. I think it's...Mr. Ryan, can you help me with that?

MR. RYAN: It's up to Mr. Perry to ask for something from me if he wants it.

THE DEPONENT: Thank you.

BY MR. PERRY:

268. Q. Dr. Hodge, you don't...you're not aware of your hourly fee today that the government is...that you're paying...that you're being paid by the government?

A. I mean, I don't want to give you a misleading answer, and I don't have the contract with me. So I can look it up. It's in a file in another room, but...

269. Q. Is it more or less than 500 an hour?

A. A lot less. Maybe I should work for you if you're offering 500 an hour.

270. Q. It wouldn't be beyond the pale for an expert.

A. I understand, yes. No, I think that the compensation is substantially less than that.

271. Q. And the compensation that you're receiving from your role as an expert in the various proceedings for which you have been asked to give evidence, that is distinct from the salaries with the Solicitor General that are listed as part of the public sector salary

disclosure, correct?

A. Yes. So, I'm an incorporated physician...Matthew Hodge Medicine Professional Corporation. The contract exists between the corporation and the Crown for my services as an expert in relation to this matter, and so payment would be made to the corporation.

272. Q. Were you contacted by the government at all in or around November and December of 2020, when the government sought an injunctive order against Mr. Skelly's restaurant, an order that was ultimately granted in December of 2020?

A. No, I was not.

273. Q. So, you have a file in the other room that contains your hourly rate. Does it contain as well everything that's been relevant to the scope of services you have rendered in both the 2021 proceeding and this 2024 proceeding?

A. I'm not sure what you mean when you say "relevant". Like, the...

274. Q. Oh. So, I would...let me take you through some specifics I would be looking for. The instructions given to you?

A. Yes. I think that's actually covered in the affidavit. Like, that's the... lays out what I was directed to do.

275. Q. I have your evidence, but in terms of what the government asked you to do directly from the horse's mouth, so to speak. You have that document?

A. It's either an email or a document, yes.

276. Q. Okay. And what about all of the correspondence and communications you have exchanged, either with Mr. Ryan or with counsel from the Ministry of Health? Do you keep records of those?

A. Yes. Those have been emails.

277. Q. What other ways do you communicate in writing with these individuals?

A. I think emails pretty much covers it. Mr. Ryan and I have had a couple of conversations in preparation for today.

278. Q. Do you exchange text messages with anyone from the Ministry of Health or Mr. Ryan or his office?

A. Alas, I'm too old for that. No, I don't.

279. MR. PERRY: Fair enough, fair enough. Counsel, I would like an undertaking for Dr. Hodges's complete file as it relates to his retainer for his expertise that he has given both in this proceeding and the 2021 proceeding. That would include his letter of engagement, the...all correspondence and communications exchanged with your office as well as the representatives from the Ministry of Health that we spoke of, and any other thing that was relevant in terms of formulating his opinions and conclusions from today.

MR. RYAN: We'll take that under advisement. U/A

280. MR. PERRY: Thank you. Well, subject to any questions that may arise from the answers taken under advisement or answers undertaken, those are all my questions. Dr. Hodge, I want to thank you for all of your time that you gave me today and all the time that you gave us in 2021. I know it's valuable, and I appreciate you being here today and

answering these questions. Thank you.

THE DEPONENT: Thank you.

--- DISCUSSION OFF THE RECORD

281. MR. PERRY: Could we put that on the record, Mr. Ryan?

MR. RYAN: That's fine. No re-exam for Dr. Hodge from Ontario.

282. MR. PERRY: Thank you.

--- upon adjourning at 12:43 p.m.

INDEX OF EXHIBITS

INDEX OF UNDER ADVISEMENTS

REFERENCE NUMBER	PAGE NUMBER	QUESTION NUMBER
1	59	158
2	73	187
3	120	279

REPORTER'S NOTE:

Please be advised that any undertakings, objections, under advisements and refusals are provided as a service to all counsel, for their guidance only, and do not purport to be legally binding or necessarily accurate and are not binding upon Victory Verbatim Reporting Services Inc.

I hereby certify the foregoing to be a true and accurate transcription of the above-noted proceedings held before me on the **24th DAY OF NOVEMBER, 2025**, and taken to the best of my skill, ability and understanding.

Certified Correct:

Shophie Chhetri
Verbatim Reporter