Court File No. _____

ONTARIO
SUPERIOR COURT OF JUSTICE

B E T W E E N :

ONTARIO HEALTH COALITION AND ADVOCACY CENTRE FOR THE ELDERLY

Applicants

- and -

HIS MAJESTY THE KING IN RIGHT OF ONTARIO AS REPRESENTED BY THE ATTORNEY GENERAL OF ONTARIO, THE MINISTER OF HEALTH, and THE MINISTER OF LONG-TERM CARE

Respondents

AFFIDAVIT OF DR. MAURICE ST MARTIN
(Affirmed April 11, 2023)

A. QUALIFICATIONS AND EXPERIENCE

1. I am a physician based in Sudbury, Ontario. A copy of my *curriculum vitae* is attached hereto as **Exhibit A**.

2. I have been working as a physician since 1982. I have always and continue to operate a family practice in Sudbury, Ontario. During my career, I have equally worked in Emergency Medicine (1982-1986), as an attending M.D. at the Sudbury Regional Hospital (2002-2009), as the Initial Medical Director for the program that became Telehealth Ontario (1999-2003), as the Physician Co-Lead for the St. Joseph's Family Health Organization (2009-2018), and as an attending physician at the St. Joseph's Complex Continuing Care Hospital (2009-present).

3. I have acted as a Preceptor in courses at the Northern Ontario School of Medicine in Sudbury for medical students, residents, physician assistants and nurse practitioners, from 2009 to present. I have equally lectured at numerous medical and other conferences. My teaching focuses on dementia, chronic pain management, diabetes, osteoporosis, and medical issues arising in long-term care.

4. However, much of my medical career has been focussed in the long-term care (LTC) sector. I began working in the LTC sector in 1986, at the Pioneer Manor LTC home, where I continue to act as the Medical Director today. Pioneer Manor has 433 residents divided into 14 'zones'. Along with my daughter, Dr. Monique St. Martin, we act as Most Responsible Physicians for 11 of those 14 zones at Pioneer Manor.

5. I also currently act as the Medical Director at St. Joseph's Villa LTC home in Sudbury, since July 2017. St. Joseph's Villa is a not-for-profit LTC home run by the Sisters of St. Joseph, which has 128 beds. I am also the Most Responsible Physician for 64 of the beds there.

6. In the past, I have also acted as the Medical Director and the sole attending physician at the Elizabeth Centre LTC home, which has 128 beds, between 2003 and 2004.

7. In addition to the Medical Director positions noted above, I have served in many appointed and elected medical positions. These have included serving as Medical Director of the Sudbury Memorial Emergency Department (1986), Chief of General Practice at Laurentian Hospital (1983-1985), Deputy Chief of General Practice at Laurentian Hospital (1985-1986), Board Member for Ontario Medical Directors Long-Term Care (2002-2010), Geriatric Lead at Sudbury Regional Hospital (2002-2009), Chief of Staff at St. Joseph's Complex Continuing Care

Hospital (2009-2018), and on the Ontario Hospital Association's Physician Provincial Leadership Council (2013-2015). I have served on Medical Advisory Boards for Sanofi-Aventis, Novartis, GlaxoSmithKline, Purdue Pharma, Pfizer, Abbott Laboratories, Biovail Corporation, Boehringer Ingelheim, Jansen Ortho and Solvay.

8. In June 2020, I received the Ontario Long Term Care Association's Circle of Excellence Award, which recognizes significant contributions to long-term care homes in Ontario.

9. I have been retained by the Ontario Health Coalition and the Advocacy Centre for the Elderly to give evidence in the above-noted proceeding. In particular, I have been asked to address the following issues:

a. the process for admission of a patient to long-term care and the ability of long-term care facilities to assess whether they have the staffing and skillset to care for a patient; and

b. the nature of patients being admitted to long-term care homes.

B. PROCESS FOR ADMISSION OF PATIENTS TO LONG-TERM CARE

10. The partners I primarily work with when patients are referred to long-term care are the Health Sciences North (HSN) hospital in Sudbury, and Home and Community Care Support Services (HCCSS) which coordinates care for people in the community upon being discharged from hospital. HCCSS is responsible for overseeing the placement of persons in long-term care homes.

11. Most of the admissions to the St. Joseph's Villa and Pioneer Manor LTC homes come from the hospital. For instance, in 2022, 98 of 165 admissions to Pioneer Manor were from HSN, or Amberwood Suites, a site where ALC patients from HSN reside while waiting for a LTC bed, or from the Clarion Hotel, another site operated by St. Joseph's Complex Continuing Care to house ALC patients waiting for a LTC bed. Another 8 admissions to Pioneer Manor in 2022 were from other hospitals. In total, 64% of admissions to Pioneer Manor in 2022 were directly from an acute care hospital setting. Of the remaining admissions to Pioneer Manor in 2022, 42 were from the community, 6 were from retirement homes, and 10 were from St. Joseph's Complex Continuing Care.

12. This follows a trend where a significantly greater proportion of admissions to LTC are coming directly from acute care hospitals. Historically, the number of admissions from hospital were similar to those from the community. This new imbalance has occurred because hospitals have been increasingly over capacity and admissions to LTC from hospital are given priority over other community admissions.

13. In my observation, the process for referring patients to long-term care has become significantly less consultative, transparent and collegial in recent years. Often, information that would allow the LTC facility to make a proper assessment of the individual is not provided and, as a result, I am often asked to make clinical decisions with little or no information.

14. Unfortunately, in some cases pertinent information about a patient may not be provided to the LTC home, making it impossible for it to make a full assessment of a would-be resident's needs.

15. In fact, I have often found there to be a lack of transparency, consultation and information sharing during the process of admitting patients to LTC, from hospital or from HCCSS. For example:

a. Around April 8 or 9, 2020, when hospitals were concerned about creating additional capacity for a surge of patients, we were to receive an admission to Pioneer Manor from HSN, where there had been a COVID outbreak. This was early in the pandemic, and we were trying to stop COVID from entering the facility. We received no disclosure or communication about the potential COVID exposure, but it was clear that staff who had been exposed to the COVID case, as well as the COVID patient at HSN had circulated around the hospital, thus greatly increasing the risk that the COVID outbreak was not contained. I blocked this admission out of concern that the applicant had been exposed to COVID while in hospital, leading to tense communications with staff at HSN, who threatened to call the Ministry of Health or the Local Health Integration Network. I then spoke with my Member of Provincial Parliament, France Gélinas about the situation, which led to a promise that HSN would not transfer the patient through the coming Easter weekend. On the Tuesday after the Easter weekend, all LTC admissions from hospital were blocked across the province.

b. In the last two months, we were referred a 95-year-old patient with dementia from HSN to Pioneer Manor. That morning, the patient fell, and we received a call from the patient's daughter, who said that her mother had broken her neck. The daughter told us that she had been cleared by the emergency department for

> admission to our long-term care facility. The patient had a non-operable cervical spine fracture. Her care would have been well outside of our normal capacity. I blocked this admission from HSN on the basis of her new health status, which the hospital had not provided to us. The patient was returned to Amberwood Suites (an ALC site for patients from HSN) by the HSN Emergency Department, but that same day, the patient required to be referred back from Amberwood Suite to the HSN Emergency Department, and subsequently was admitted to the acute care setting at HSN. This transpired because her eyes were closed shut due to trauma from the fall and she couldn't see. In addition to this, the patient could not open her mouth to eat or drink. This patient should never have been cleared from the hospital to long-term care.

16. Unfortunately, these examples reflect a broader trend where the communication and documents associated with the process of admitting patients to LTC has become significantly less transparent and consultative. In my opinion, this trend stems from fundamental problems with the model of caring for older patients. There is a clear lack of resources for proper care in the community, which would allow older patients to remain in the community, enter LTC facilities when necessary and on the proper terms and/or to be transferred to palliative or hospice care when appropriate.

17. Instead, the health system prioritizes acute care. Too often, sufficient care for older patients is not provided in the community, which can result in incidents that require their admission to hospital for acute care. Once admitted, their care in hospital typically deals only with the immediate issue for which they are admitted, and efforts are quickly made to discharge

the patient to care in the community or, often, LTC even if this is not in the patients' best interest.

18. While HCCSS practices also lack transparency during the admissions process, as an intermediary between the hospital and the LTC home, it may often not be fully informed of the patient's condition or made aware of red flags that are prohibitive to providing appropriate care in the LTC setting.

19. In my opinion, the increased trend away from collaboration and consultation, and towards the admission of patients who are inappropriate for LTC is a result of the long-term under-resourcing of chronic health care needs and the long-term care system. In the last few months, I have received admissions from HCCSS with information on a patient that is often 6 months old, and therefore of limited use in assessing the current state of frail older patients. We have been asked by HCCSS why we cannot process applications faster. When we ask for updated information, HCCSS responds that it does not have the resources to provide that for each file, clearly reflecting a lack of sufficient resources. Yet we are not able to make proper decisions on admitting residents to LTC without accurate information.

20. Importantly, once a patient sets foot in the LTC facility, they become our responsibility. At that point, it is very difficult to have them re-admitted to an acute care facility or to another more appropriate setting. It is for this reason that we have to be careful and vigilant during the admissions process to ensure that the needs of the individual correspond with the level of care that LTC can provide. Inappropriate admissions may also put current residents of the home at risk, as well as the LTC facility itself. The administrative burden of admitting residents is made

heavier by the erosion in transparency and consultation in the admission process and by regularly having to follow-up in order to obtain necessary information.

21. Moreover, once an individual is admitted to LTC, in my experience, they are no longer given priority in transferring to another LTC home. Once admitted, that resident would be lower priority than anyone in hospital in seeking a transfer to another LTC home. In my professional experience, it would be very unlikely for an individual admitted to an LTC home to be transferred to another LTC home before their death.

C. INCREASING UNSUITABLE PLACEMENT OF PATIENTS IN LONG-TERM CARE

22. Relatedly, there has been a general and increasing trend towards admission of patients to LTC who have much greater medical needs than LTC homes can actually manage or whose care needs would be much better served in other settings. Generally-speaking, LTC has clearly and increasingly become a 'dumping ground' for patients who are discharged from acute care but cannot receive the care necessary to remain in the community. They are often sent for admission to a LTC with little regard to the ability of the home to provide appropriate or proper care and whether it is the most appropriate type of facility to meet their needs. Given the limited ability of LTC homes to refuse patients, they often must be admitted despite them being more suited to other types of care.

23. This trend of patients being referred to LTC that cannot properly care for them has been growing over the past 5-10 years, but has become much frequent recently. The following paragraphs detail some of the specific issues I have seen.

24. Many LTC admissions are older and frailer than was previously the case. Many of these patients are sent to LTC essentially as a ‘default’ when discharged from hospital, when in many cases they should have been considered for or transferred to palliative care or hospice.

25. In the worst cases, individuals who have been admitted to LTC are only then found to be palliative after they arrive at the home, including on the very day of their admission. I have had this happen in two cases in the past 9 months. It is crucial that we know in advance that an individual will be arriving who has been designated as palliative, so that staff are alerted that the individual care needs will be significantly increased and they will take an approach that treats the person with dignity in the final stage of their life. It also demands much more time and attention from the staff, who are already tired and burnt out, because of additional demands in recent years, due to COVID. The time and energy invested to get to know the patient’s medical and personal needs, as well as the time needed to create a trusting and caring relationship with the family is truly immense. Additional demands are placed on the staff in order to provide the necessary care that the patient deserves and requires. These palliative patients often need more on call services and care during the night, when staffing ratios are at their minimum. Staffing shortages and concerns in LTC are well known to us all.

26. Where an individual is designated as palliative immediately on admission, without this having been identified earlier during the admission process, it raises questions. First, why was this not flagged earlier in the process? Second, if the person’s condition was this serious, why was a transfer to hospice not explored earlier in the process?

27. It has become ever more common to receive admissions of patients who require a level of care that is much higher than the capacity in LTC. When these individuals are being transferred from hospital or from hospice, they have been cared for at much higher staffing levels than now exist in LTC:

a. In LTC, a 32-bed pod will typically have a Registered Practical Nurse (RPN) and 3 Personal Service Workers (PSWs) during the day, but this is reduced to 1 RPN and 2 PSWs in the evening and then, on the night shift, one RPN will cover several pods with 2 PSWs assigned to each unit.

b. A hospice will have 1 RPN and 1.5 PSWs for 10 beds.

c. A rehabilitation unit in hospital or complex continuing care will not staff with PSWs and will instead only be staffed by Registered Nurses and RPNs. These registered staff receive more advanced training. The staffing for a 32-bed unit at St Joseph's Complex Continuing Care is 7 RPNs during the day shift and 3 RPNs at night.

28. Moreover, the individuals admitted to LTC may not be properly medicated or may have the proper medication for the environment they are coming from, which has higher staffing levels, but not for a context like long-term care with lower levels of staffing.

29. There is also a much greater number of psychiatric admissions to long-term care of younger, more physically able residents, who I believe would be better suited to an assisted living setting. These admissions cause a number of issues within the LTC settings. First, these patients are often much younger, stronger, and more mobile than other LTC patients, who are

generally frailer, more elderly and often have dementia. Combining these patient populations creates a real risk. In particular, some of the psychiatric admissions are less tolerant of dementia patients that may wander around the facility or into rooms of other residents. In some cases, these younger psychiatric patients can get very upset at this behaviour, causing a significant risk of conflict and harm. Second, while LTC staff are very experienced in dealing with dementia patients, they are not typically trained or experienced in handling serious psychiatric issues, such as acute schizophrenia. Most LTC homes equally do not have the specialized treatments and services to deal with these psychiatric patients. The home's ability to provide care to these residents, especially if they go into crisis, is limited, and they often require admission to an acute care hospital that can provide the necessary expertise. At Pioneer Manor, we will frequently have residents who require an admission into the acute care system on an urgent basis, through a 'Form 1' under the *Mental Health Act*, who are then returned to LTC, only to have the cycle continue. These residents would be far better served in supportive housing in the community geared towards persons with mental health issues, where the staff would have the specific expertise and the facility the appropriate services to enable them to lead a full life. Finally, admissions of these much younger psychiatric residents, who will occupy a long-term care bed for many years despite the unsuitability of the home to provide needed care, will also exacerbate the shortage of available long-term care beds. A patient who is only 60 years of age may occupy a bed over the next 20 years that could have served up to 10 older, frailer patients.

30. Two examples illustrate the admission of psychiatric patients who are not appropriately placed in LTC:

a. One patient who is currently admitted to one of my LTC homes has Down's Syndrome with behaviours. Her plan of care on admission required 5-7 hours of hands-on care per day, well above the expected capacity of a LTC facility. While it is possible to receive one-on-one funding for a particular patient, this funding is not indefinite and is intended only to bridge the patient in their transition to LTC. When admitted, this individual would have been far better served in a group home setting. Given that many LTC residents are suffering from dementia or other forms of cognitive impairment, managing conflict is a day-to-day issue in providing for the care and safety of residents. As a result, this resident had to be admitted to our secure dementia unit for her security and well-being of other residents. Even in this unit, there is an ongoing concern of conflict, and even a physical altercation with other cognitively-impacted residents Fortunately, this resident's behaviour has de-escalated during the year since her admission, but she still requires care well above what is sustainable at staffing levels in a LTC setting.

b. In another case, a community psychiatric resident was going to be admitted to one of my LTC homes. He had been followed in the community by a Behavioural Supports Ontario staff and by the North-East Specialized Geriatric Team. However, believing that the individual would resist admission, they heavily pre-medicated him with a sedative and transferred him by ambulance for his admission to LTC. When the medication would wear off, this patient would come to in a completely unfamiliar environment, one lacking in the expertise or resources to deal with someone with a mental illness who likely would not want

> to be there. Once we became aware of this plan, I intervened as Medical Director of Care and blocked the transfer at the front door, insisting that the admission not happen until it was appropriate. That individual has since been admitted to a specific 16-bed behavioural support unit in the LTC home, which cares for some of the most challenging dementia and psychiatric patients in our community, but also has a specific procedure for admission.

31. Other categories of residents are being admitted to LTC, when it is questionable whether it is the most appropriate environment. In addition to younger psychiatric admissions, LTC homes now also regularly receive admissions whose primary issue is addiction, as well as individuals with criminal records or currently serving criminal sentences and who pose a reasonable security risk to other residents, who are discharged from the acute care system. Despite my long history in LTC and my role in the process of admitting new residents, it is unclear to me why individuals in these categories are sent to LTC. My view is that with the closure of institutions such as psychiatric hospitals or publicly-funded addictions programs, which provided specialized support and care for these individuals in a more appropriate setting, and in the absence of appropriate supports in the community, LTC is simply the 'dumping' ground for those discharged from acute care and needing somewhere to go, because of the absence of better and more appropriate options.

32. These inappropriate admissions to long-term care are avoidable, if there was greater consultation and collaboration between levels of care and a greater understanding of the capacity of LTC. Of course, there would also need to be suitable alternative care facilities to meet their health care needs.

33. Because these inappropriate admissions are being sent to long-term care, we are required to reject many potential residents each year. Between 2018 and 2022, we had to reject 193 clients applying for admission to Pioneer Manor, or approximately 40 each year. Most commonly, the reason for the rejection is the need for psychiatric care that is not available in long-term care. There are also rejections due to:

a. lack of physical facilities or expertise to manage complex medical conditions;

b. lack of nursing and other expertise to deal with serious responsive behaviours such as verbal and physical aggression or sexual responsive behaviors; and

c. because of a lack of expertise and staffing to provide services for those with drug addiction or alcohol addiction problems.

34. The increased incidence of inappropriate admissions causes a significant burden on our operations in long-term care. There is a significant amount of manpower involved in admitting a person into long-term care. There is a great deal of clerical work that precedes the actual arrival of the resident which is then followed by the interdisciplinary team members individual assessments. A comprehensive physical examination is conducted by the physician following their admission. The physician also has discussions with the family to establish trust and develop a relationship with them. Moreover, following the death of a patient, a significant amount of medical, nursing, and administrative staff time is required. As a result, when patients are increasingly admitted to the long-term care home near the end of their lives, it draws more on the limited resources of the LTC home.

35. Finally, we see the effect of the strained process for admitting individuals to LTC and the under-resourcing of the chronic care and long-term care systems in the families of patients. It is increasingly common that families demand and expect the same level of care provided in the acute care setting from the LTC doctors and staff. Families are faced with an unclear process of navigating a health system that prioritizes acute care, and therefore often gives them unrealistic expectations of what can be achieved in the long-term care environment. Rather than planning for an appropriate and dignified approach to the final years or months of life for their loved one, families are not provided with guidance and direction as to what to expect and what should be happening.

D. EFFECT OF BILL 7

36. I have not had any direct experience with the new powers accorded to the hospitals and HCCSS under Bill 7, but my understanding is that they are intended to expedite the process of placing ALC patients in LTC homes. By doing so, it can only exacerbate the problems that I have described, while doing nothing to address the lack of suitable care options for ALC patients, many of whom cannot properly or appropriately be cared in most LTC homes. Moreover, in my opinion, any measure that reduces the participation of an ALC patient, or their substitute decision maker, in the process of the patient transitioning from the hospital to a LTC home can only add to the issues of a lack of consultation and transparency in respect of ALC admissions to LTC homes.

37. I make this affidavit for the purpose of providing evidence in the above noted proceeding having been apprised of and understanding my obligation as an expert witness. I have signed and attached hereto an acknowledgment of my duty in this respect.

AFFIRMED REMOTELY BY **Dr. Maurice St. Martin** of the City of Sudbury, in the Province of Ontario, before me in the City of Ottawa, in the Province of Ontario on April 11, 2023 in accordance with O. Reg. 431/20 Administering Oath or Declaration Remotely.

Maurice St Martin

DR. MAURICE ST MARTIN

Commissioner for taking affidavits

Amanda Marie O'Brien, a Commissioner etc.
Province of Ontario, for Goldblatt Partners
LLP, Barristers & Solicitors
Expires November 15, 2024

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Respondents

ACKNOWLEDGMENT OF EXPERT'S DUTY

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1. My name is Dr. Maurice St Martin. I live at Sudbury, in the Province of Ontario.

2. I have been engaged by or on behalf of the Lawyers for the Applicants to provide evidence in relation to the above-noted court proceeding.

3. I acknowledge that it is my duty to provide evidence in relation to this proceeding as follows:

   a. to provide opinion evidence that is fair, objective and non-partisan;

   b. to provide opinion evidence that is related only to matters that are within my area of expertise; and

   c. to provide such additional assistance as the court may reasonably require, to determine a matter in issue.

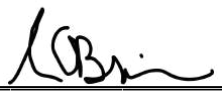
4. I acknowledge that the duty referred to above prevails over any obligation which I may owe to any party by whom or on whose behalf I am engaged.

April 11, 2023

Maurice St Martin

DR. MAURICE ST MARTIN

This is **Exhibit "A"** referred to in the Affidavit of **Dr. Maurice St Martin**, affirmed this 11 day of April 2023, in accordance with O. Reg 431/20, Administering Oath or Declaration Remotely.



A Commissioner for taking Affidavits etc.(*or as may be*) (pursuant to O. Reg 431/20)

Amanda Marie O'Brien, a Commissioner etc.
Province of Ontario, for Goldblatt Partners
LLP, Barristers & Solicitors
Expires November 15, 2024

CURRICULUM VITAE
DR. M.E. ST MARTIN

960 Notre Dame Ave, Unit E
Sudbury, ON, P3A 2T4
Office Telephone: 705-524-5911

DOB:
December 22, 1952
Sudbury, Ontario

Family Data:
May 12, 1973 married to Lucie St Martin (Gervais)
Father to Léane 1977, Monique 1978, and Luc 1981
Proud Grandfather to 6 grandchildren

Education:
- Elementary- St. Dominque School, Sudbury, ON
- Secondary- Lasalle Secondary School, Sudbury, ON
- B.Sc. - Queen's University, Kingston, ON 1976 (Hon Biology)
- M.D. - Queen's University, Kingston, ON 1980

Post Graduate Training:
- C.C.F.P.- Queens University, Kingston, ON 1982

Practice History:
- Family Practice – 1982 to present
- Emergency Department- shared full-time position with Dr. Deacon at Sudbury Memorial Hospital (1982 to 1986)
- Pioneer Manor - (433 bed Long Term Care Facility) Attending Physician 1986 to present
- Elizabeth Centre - (128 bed Long Term Care Facility) only attending physician 2003-2004
- Sudbury Regional Hospital –attending M.D. January 2002 to November 2009
- St. Joseph's Complex Continuing Care Hospital- Attending Physician 2009-present
- Telehealth Ontario – Initial Medical Director, outreach team member of Pilot Project, Direct Health, which evolved into the Province wide program that is used for THAS support to primary care (June 1999- June 2003)
- St Joseph's Family Health Organization– Physician Co-Lead- May 2009 to April 2018
- LTC Co- Lead- Uniting 6 Long Term Care Facilities in the Sudbury area to provide city wide coverage to 1250 LTC and common pathways for care (2000 to 2009)
- Preceptor for NOSM Medical Students and Residents 2009 to present
- Preceptor for Physician Assistant and Nurse Practitioners Program 2011 to present
- St Joseph's Villa- (128 bed Long Term Care Facility) Attending Physician 2017-present

Appointments and Elected Posts:

- Medical Director of Sudbury Memorial Emergency Department 1986
- Chief of General Practice, Laurentian Hospital 1983 to 1985
- Deputy Chief of General Practice, Laurentian Hospital 1985 to 1986
- Medical Director of Pioneer Manor 1987 to present
- Ontario Long Term Care Board Member 2002 to 2010
- Sudbury Regional Hospital – Geriatric lead Jan 2002-Nov 2009
- Medical Director, Elizabeth Centre 2003 to 2004
- Associate Professor- NOSM (Northern Ontario School of Medicine) 2015 to present
- Chief of Staff St Joseph's Complex Continuing Care March 2009 to June 2018
- Ontario Hospital Association's Physician Provincial Leadership Council 2013- 2015
- Medical Director St Joseph's Villa July 2017 to present

Teaching Opportunities:

A love for teaching colleagues and allied professionals in the field of Dementia, Behavioral and Psychological Symptoms of Dementia(BPSD), Chronic Pain Management, Diabetes, Osteoporosis and LTC issues. These have done at Medical Conferences, the Pan Geriatric Northern Conferences, Dementia Symposium for the Alzheimer Society in Sudbury, Timmins and North Bay. Multiple CME to small group of physicians and allied professionals.

Medical Advisory Boards (in past):

- Sanofi-Aventis
- Novartis
- GSK (Glaxo-Smith Klein)
- Purdue
- Pfizer
- Abbott
- Biovail
- Boehringer Ingelheim
- Jansen Ortho
- Solvay

Awards & Achievements

- 30 Years of Recognition- Pioneer Manor Long Term Care Facility 2016
- Circle Of Excellence- Ontario Long Term Care Association 2020

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Respondent

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Proceeding commenced in Toronto

AFFIDAVIT OF
DR. MAURICE ST MARTIN
(Sworn April 11, 2023)

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Counsel for the Applicants

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(Sworn April 11, 2023)

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