CANADA

PROVINCE OF NOVA SCOTIA

IN THE MATTER OF THE

FATALITY INVESTIGATIONS ACT

S.N.S. 2001, c. 31

THE DESMOND FATALITY INQUIRY

TRANSCRIPT

HEARD BEFORE: The Honourable Judge Warren K. Zimmer

PLACE HEARD: Guysborough, Nova Scotia

DATE HEARD: February 3, 2020

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1 **February 3, 2020**
2 **COURT OPENED (13:36 HRS)**
3
4 **THE COURT:** Mr. Russell.
5 **MR. RUSSELL:** Yes, Your Honour. This afternoon we'll call
6 Dr. Justin Clark.
7 **THE COURT:** Okay. Dr. Clark.
8
9 **DR. JUSTIN CLARK, affirmed, testified:**
10
11 **DIRECT EXAMINATION**
12
13 **MR. RUSSELL:** Good afternoon, Dr. Clark.
14 **A.** Hi.
15 **Q.** Thanks for coming. In front of you as discussed,
16 you're going to see, we'll look at, I guess we'll just pull up
17 exhibit number 66.
18 **EXHIBIT P-000066 - *CURRICULUM VITAE* OF DR. JUSTIN CLARK**
19 **Q.** So Dr. Clark, there will be a binder in front of you
20 as discussed, on the desk, that will have exhibit 66. You can
21 either look on on paper format or on the screen, whatever you
22 prefer.

1 **A**. Okay.
2 **Q**. And if at any point you need time to sort of get
3 caught up with where I'm looking, just let me know.
4 **A**. Okay.
5 **Q**. So, Dr. Clark, I guess what is your full name and
6 occupation?
7 **A**. Justin Dale Clark, I'm an emergency room physician.
8 **Q**. And how long have you been a physician in general?
9 **A**. Since 2016. Sorry, since 2013.
10 **Q**. All right. And, Doctor, if you could look at exhibit
11 66 which appears to be your *CV* outlining your qualifications, I
12 just want to take you through that and I'll have a few
13 questions. I guess starting first with your education, I'm
14 wondering if you could outline for the Court what your education
15 is, starting I guess in 2007 through 2016.
16 **A**. Okay. So I went to St. FX, I did a Science degree
17 there for four years. Then I went to medical school at Saba
18 University and that's another four years. I did two years of
19 family medicine residency after that and then I did an
20 additional year in emergency medicine training. The family
21 medicine residency was in Ottawa at the University of Ottawa and
22 the emergency medicine training was at Dalhousie.

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1 **Q.** So I note that there's a family medicine residency and
2 an emergency medicine residency, how do they differ and what are
3 the reasons that you had to do both, I guess?
4 **A.** Well, you don't have to do both. To practice as an
5 emergency physician, you first do family medicine and then you
6 can get additional training in emergency medicine. It's not
7 required *per se*. There are family physicians who work in
8 emergency departments but there is the opportunity to get
9 additional training.
10 **Q.** So I guess that was going to be my next question and
11 I'll get you maybe to elaborate. So could a family physician, a
12 family doctor in Nova Scotia, sort of immediately go to,
13 presumably qualified as a family doctor, immediately go to
14 covering shifts in an ER hospital, ERs throughout the province?
15 **A.** Yes, they can. Generally speaking, they would be in
16 smaller community hospitals. The regional hospitals such as St.
17 Martha's or Truro or Kentville, the majority of emergency
18 physicians who work there have emergency medicine training. The
19 ones that work there that don't have specific training have
20 usually been working there a long time so they would have
21 started working there maybe 15 years ago as a family doctor.
22 But today, if you're going to start working in a regional

1 hospital, generally you have emergency medicine training
2 specifically.
3 **Q.** I'm wondering if you could tell us just generally what
4 does an emergency residency involve that's different above and
5 beyond sort of a residency for family practice.
6 **A.** So there's a lot of overlap but you sort of focus on
7 things that are specific to the emergency room that you might
8 not get as much of in your family medicine training. So some
9 examples would be orthopedic, an orthopedic rotation, a plastic
10 surgery rotation, a specific trauma rotation, things like that
11 that you might not be exposed to in the family medicine
12 training.
13 **Q.** So could you outline your work experience as a
14 physician on your *CV*?
15 **A.** So I guess my main place of work is in Truro, I work
16 in the emergency room there, that would be the majority of my
17 shifts but I also do some shifts at Dartmouth General Hospital
18 and at St. Martha's Hospital and I've been working in all three
19 of these places since I started working in 2016.
20 **Q.** So since, I guess, 2016 your role as a physician, I
21 guess, hasn't been in private practice, in a family practice?
22 **A.** I've never worked as a family physician since I

DR. JUSTIN CLARK, Direct Examination

1 finished residency.

2 **Q.** So it's always been in an ER setting?

3 **A.** Yes.

4 **Q.** In terms of you outlined that you worked at St.

5 Martha's, Dartmouth, and Truro primarily in 2016, would that

6 apply to early 2017 as well?

7 **A.** Yes.

8 **Q.** My question, I guess, is are you able to estimate, and

9 I know it probably varies, how many days a week would you work

10 at each different location?

11 **A.** So I would do about 14 shifts a month so eight of them

12 will be in Truro, two to four at St. Martha's, and two to three

13 at the Dartmouth General Hospital.

14 **Q.** And your shifts would normally, I guess ... your ER

15 doctor shifts would typically be between what hours?

16 **A.** They could be any hours, so it's basically shift work,

17 so they could be morning, evening or overnights. I currently

18 work more evenings and overnight shifts. In 2016/2017 I

19 probably had an equal distribution.

20 **Q.** So typically when would be the starting hour and sort

21 of completion hour?

22 **A.** So it's different by hospital ...

1 **Q.** Okay.
2 **A.** ... so at St. Martha's?
3 **Q.** Yes, I guess.
4 **A.** So their shifts generally, there have been some
5 changes, but generally they run from 8 a.m. to 2 p.m., 2 p.m. to
6 8 p.m., and then 8 p.m. all the way till 8 a.m. so two six-hour
7 shifts and a 12-hour shift.
8 **Q.** So without telling us your exact address, your home
9 residence is sort of based, in 2016 and '17, based out of where?
10 **A.** In the Halifax area.
11 **Q.** Halifax area? And so I take it there's obviously some
12 traveling involved in what you do, would you say that that
13 creates sort of some additional workload, I guess, and adds to
14 the pressures of an ER doctor, the traveling?
15 **A.** I don't, myself, I don't find it does. Getting from
16 where I live to Truro is not much different than driving into
17 Dartmouth or Halifax in traffic in terms of time. Also I use it
18 as an opportunity, while I'm driving, to listen to podcasts
19 about medical education rather than have to study in my free
20 time, I kind of use it as that.
21 **Q.** Sounds exciting. So, I guess, in terms of
22 professional organizations, on the second page of your *CV* you've

1 listed a couple but one in particular that I'm interested in is
2 a membership with the S.R.P.C. which indicates Society of Rural
3 Physicians of Canada. So what is that organization and what
4 sort of topics, I guess, do they get into?
5 **A.** So basically when you sign up you get a medical
6 journal that comes out, I believe four a year, and it's just
7 looking at things specific to rural physicians. So looking at
8 specific skills, learning new skills, looking at issues that
9 they may face in a smaller community department.
10 **Q.** So in your experience, are there actual differences of
11 being sort of a ER doctor in a rural region as opposed to a
12 central region such as, say, Dartmouth or Halifax?
13 **A.** For sure, there's a lot less resources. In rural
14 areas you may not have an ophthalmologist or a plastic surgeon
15 or an orthopedic surgeon to help you deal with things so it's
16 important to be proficient in dealing with some things like
17 that.
18 **Q.** And are there sort of limitations as it relates to
19 resources or access to, say, a psychiatrist for mental health
20 consults for an ER physician?
21 **A.** In rural areas, most rural areas don't have a
22 psychiatrist on call in that hospital. There's always a

1 psychiatrist on call somewhere but they may be in a regional
2 hospital, you know, an hour or more away.
3 **Q.** I'm just going to ask you a few questions sort of as
4 life as an ER physician. I wonder if you could tell us a little
5 bit about the process of someone presents themselves at the ER
6 for any sort of ailment and ultimately how do they get to you in
7 the end for treatment?
8 **A.** So when people walk in on their own, they generally
9 present to the triage nurse in the triage area. The nurse will
10 assess them there and based on their assessment, they may come
11 into an examination room or go back to the waiting room. Also
12 people come in by ambulance from time to time and they generally
13 go directly either into the hallway for an assessment or
14 directly into an examination room and the triage process can
15 sort of happen at the same time as an initial assessment.
16 **Q.** So, Doctor, you indicated primarily in the timeframe
17 of 2016 and 2017 and what we're really interested here, you
18 spent your time mostly between three hospitals, I believe you
19 said St. Martha's, Dartmouth and?
20 **A.** Truro, Colchester
21 **Q.** Truro, Colchester. Did you notice any sort of
22 differences in that general process between the hospitals?

1 **A.** No, the process is generally the same.
2 **Q.** And compared to maybe other ERs you worked in, is
3 there any difference that you noticed?
4 **A.** With respect to the triage process, no.
5 **Q.** Okay. I'm going to ask you a bit about charts and
6 history as an ER physician. What are you, I guess, provided
7 with? I mean, a patient is eventually presented to you in the
8 ER for assessment and treatment, is there anything that
9 accompanies a patient that an ER doctor is provided?
10 **A.** So the chart which would include information such as
11 the vital signs. Also included is usually a nursing page which
12 has their triage assessment as well but those would be the two
13 components of the chart I would get.
14 **Q.** Do you have sort of ... so you're provided with that
15 chart which has the triage notes and the basic information, a
16 number of things I'm wondering. If a patient had previously
17 seen a family practitioner, someone for example in Lionel
18 Desmond's case, if he had seen a family doctor, would you have
19 access to that record when you're in the ER?
20 **A.** No.
21 **Q.** In terms of if, for example, Lionel Desmond had
22 visited the ER in Guysborough, would you have had access, and he

1 presents to you in St. Martha's, would you have had access to
2 the Guysborough ER visits, the charts?
3 **A.** Yes, generally there's an electronic medical record
4 called MEDITECH which is used in most of the province where an
5 emergency room visit would be uploaded into there.
6 **Q.** We'll get into MEDITECH a bit later and what's sort of
7 in that system. So you indicated as of now the prior ER visits
8 at different hospitals would be in MEDITECH but sort of family
9 physician records wouldn't be?
10 **A.** Correct.
11 **Q.** If a patient, such as Lionel Desmond, had consulted
12 with sort of a private practitioner whether it be a social
13 worker, psychologist, or a psychiatrist in private practice and
14 he presents to you in the ER like he did and we'll get into
15 that, do you have access to those records?
16 **A.** Generally no. If a specialist saw a patient in the
17 emergency room, those records would be in the EMR but if a
18 patient in the community goes to a private practice, has an
19 assessment, then that documentation is generally not in
20 MEDITECH.
21 **Q.** And say if a patient such as Lionel Desmond had
22 consulted various health care professionals during his time in

1 the military or spent time in a OSI clinic, would you as an ER
2 doctor when he presents to you, have access to those records?
3 **A.** No.
4 **Q.** And if a patient, such as Lionel Desmond, attends an
5 ER in another province such as New Brunswick and then he
6 ultimately presents to you in Nova Scotia, would you have access
7 to those New Brunswick ER records?
8 **A.** No. I should say I wouldn't have electronic access or
9 immediate access. I mean, we can always try to get faxes from
10 medical records anywhere in the world really but in terms of
11 immediate access, no.
12 **Q.** So I understand, sir, the life of an ER physician is
13 fairly busy I understand and do you think it would be helpful to
14 know as much as possible about a patient's history, in
15 particular in a mental health context?
16 **A.** Certainly.
17 **Q.** So if there were sort of records from private clinics,
18 consults with psychologists, would that be important when you're
19 assessing a patient in a moment of crisis in the ER?
20 **A.** Yes.
21 **Q.** And why is that?
22 **A.** I mean the more information you have, especially

1 recent information, it's much better in terms of giving an
2 overall assessment.
3 **Q.** Okay. And we'll get into the details and I'm not for
4 a second suggesting that Lionel Desmond had not been sort of
5 upfront and honest and candid with you during the time you spent
6 with him, but can you always count on patients, and in
7 particular patients that present in a mental health sort of
8 crisis whether it's anxiety, depression, whether they're manic,
9 can you always just sort of take it at face value and count on
10 their word on everything?
11 **A.** No, I don't think so. I think it's part of my job to
12 have some degree of skepticism with anything that someone says.
13 **Q.** And do you think, do you have any sort of way as an ER
14 physician of validating what it is they're telling you, their
15 account?
16 **A.** So sometimes if you have collateral information it can
17 be very helpful, various family members or friends present.
18 Other than that, I guess you can have, during the interview and
19 assessment, you can get a sense of if someone is being truthful.
20 You know, for example, if you ask someone if they're feeling
21 suicidal and they hesitate to answer or seem withdrawn or start
22 to cry, you might think that they're hiding something but, I

1 mean, you have no way to know for sure.

2 **Q.** Would having access to those other medical records
3 that we've referred to, private clinics, family practitioners,
4 other ER visits perhaps recent in other provinces, would that
5 information be helpful in sort of testing sort of the honesty or
6 validity, I guess, of what the patient is telling you in the
7 moment?

8 **A.** It could be beneficial for sure.

9 **Q.** And in what way, do you have sort of an example?

10 **A.** Well, if a patient's telling you certain details of
11 their life and events that have happened and you see the same
12 information from multiple sources, then that kind of helps you
13 when you're assessing whether or not you think the person's
14 being truthful.

15 **Q.** In terms of, again, hospital charts and records that
16 an ER physician has access to, do you know typically what format
17 they come in? Do they come in paper format, digital format,
18 does it vary?

19 **A.** The record I would document on as a physician?

20 **Q.** No, the records you might review if you had to have
21 access to sort of previous visits in different hospitals.

22 **A.** So I would use again MEDITECH, it's an electronic

1 medical record that you can sign in on on a computer and go
2 through the documents. The documents, they're for the most part
3 handwritten documents that are uploaded or they're dictated
4 notes from various places.
5 **Q.** And in addition to sort of looking, if you're looking
6 for sort of history or background as it relates to a patient
7 from different sources, is MEDITECH the only place an ER
8 physician has to look or are there other places you have to
9 start looking around?
10 **A.** So MEDITECH is the electronic record for most of the
11 province outside of the Central Zone. So in the Halifax area
12 there's a completely different electronic system. As an ER
13 physician working in St. Martha's, I have access to information
14 in Halifax through something called SHARE, so that's a separate
15 sign-in from MEDITECH. So if a patient is seen at Dartmouth
16 General, they would be in that SHARE system and I have access to
17 that from anywhere in the province.
18 **Q.** And in your experience in the various ERs you've been
19 in, have there been any sort of limitations on your access to
20 MEDITECH? Do some hospital not have it or in your experience do
21 they all have it?
22 **A.** So every hospital I work in outside the Central Zone

1 has MEDITECH. I've never been working in the Central Zone, for
2 example in Dartmouth, and tried to sign into MEDITECH so I don't
3 know, I would assume it's on the computer there.
4 **Q.** And say a patient such as Lionel Desmond, we know and
5 we'll get into later, that he had a consult with Dr. Slayter in
6 the clinic, not in an ER, presumably that record is held
7 somewhere. As an ER doctor, would you be made aware of where to
8 look to see that yes, okay, Lionel Desmond attended a clinic
9 that was operated by and assessed by Dr. Slayter? Do you know
10 where to look for that as an ER doctor?
11 **A.** I would look in MEDITECH or SHARE and if it's not
12 present there, I'm not aware of anywhere else to look. We would
13 have to contact the specific office to get the records.
14 **Q.** Okay. Have there been any other occurrences where, as
15 an ER physician, you had to look other places other than
16 MEDITECH for information when you're assessing a patient?
17 **A.** In terms of health records?
18 **Q.** Yes.
19 **A.** I have had records faxed from various places in the
20 past.
21 **Q.** So what's an example of a place you would have had a
22 record faxed from?

1 **A.** So the most common thing would be if someone, for
2 example, someone comes in with chest pain and they have a
3 history of having heart attacks but they're coming from a
4 different province. I would want to know some details about
5 their diagnosis and management that they had in the other
6 hospital and we could have the patient sign a form and the form
7 faxed to that specific hospital and then they could fax back
8 those records.
9 **Q.** And in your experience, in times where you feel the
10 need to access information from another source when sort of, I
11 guess, looking at ER records throughout the province just isn't
12 enough, you're looking for other information, I realize your
13 time is valuable in the ER, that's a correct comment, I believe?
14 **A.** Correct.
15 **Q.** And in your experience, in times where you feel the
16 need to access information from another source when sort of, I
17 guess, looking at ER records throughout the province just isn't
18 enough, you're looking for other information ... I realize your
19 time is valuable in ER. That's a fair comment, I believe?
20 **A.** Sure.
21 **Q.** And have there been any sort of difficulties that
22 you've run into when you're trying to process a form in the ER

1 to get that information from another source?
2 **A.** So I wouldn't typically do it myself. It would be
3 like a clerk who would send the fax and get the information and
4 then give me the information. I think the limiting factor is
5 it's just not practical most of the time. Like in the middle of
6 the night it's not practical to be sending faxes to get
7 information.
8 **Q.** So in, I guess, your opinion from an ER doctor
9 perspective, would it be more practical and helpful if there was
10 a way that, say, MEDITECH would allow access to family health
11 records, clinic records, private practice records?
12 **A.** Yes. That would be helpful.
13 **Q.** We've heard Dr. Bowes earlier. Obviously, you
14 wouldn't have had the benefit of it. He talked about the
15 advantages, in general, of one ... he called it ... I'm going to
16 paraphrase a
17 little bit, but he called it one patient/one chart system. So,
18 basically, the concept is as best you can, is that a patient
19 presents themself to whatever physician and that physician has
20 as much of the background and history as possible from all
21 sources. Would you share a similar view that that would be
22 beneficial?

1 **A.** Yes.
2 **Q.** And why, from an ER doctor perspective, would it be
3 beneficial?
4 **A.** Knowing more information about a patient's medical
5 history is necessary to manage them. The more you know, the
6 better essentially.
7 **Q.** And when you say "the more you know the better", would
8 that apply to diagnosis?
9 **A.** It would apply to all aspects. Some people are ... a
10 lot of people will not know specific details about their medical
11 history, so it's hard to just base decisions off of what someone
12 is telling you. So, for example, if someone has a heart attack
13 and they have a cardiac catheter done where they have dye shot
14 through their vessels in their heart, people come in and they're
15 not going to know the results of that test. That specific test
16 is helpful to know what that test showed. So having immediate
17 access to that will change the way that I may manage someone.
18 So that goes in all areas of medicine. The more information you
19 have, the better you are able to make decisions about diagnosis
20 and management.
21 **Q.** And, in particular, I guess you ... obviously, in your
22 time as an ER physician, you had time to diagnose and treat

1 people showing up with various mental illnesses.
2 **A.** (No audible response.)
3 **Q.** And have you run into examples where there has been
4 some difficulty in trying to get their narrative of the history
5 of their depression or anxiety or bipolar? Have you run into
6 some difficulties trying to draw that information out of a
7 patient?
8 **A.** For sure.
9 **Q.** And what sort of barriers are sometimes there in
10 trying to get that information from the patient?
11 **A.** Sometimes people won't give you any information. You
12 can ask them questions and they just refuse to answer you.
13 **Q.** And in cases such as that or, in general, would it be
14 helpful at that point to have access to, Oh, they were treated
15 by their family doctor for this.
16 **A.** Yes. Potentially, it could be very helpful.
17 **Q.** And perhaps information sharing across provinces in
18 terms of different ER/past ER visits?
19 **A.** That would be beneficial, as well.
20 **Q.** So, for example, someone such as Lionel Desmond who we
21 ultimately know presented to you with a form of situational
22 crisis, we know that he had, previous to that, been taken to an

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1 ER, you may not be aware, in New Brunswick, for example. Having
2 access to that information, would it have been helpful to you as
3 an ER physician to have access to that information?
4 **A.** Yeah.
5 **Q.** And why?
6 **A.** Again, more information is always better. It gives
7 you a better picture of the patient and their history and it can
8 help you to determine again if they're being truthful or it can
9 help you decide on which way to go with management.
10 **Q.** And we'll get into it in a bit of detail, the concepts
11 of suicidal ideation and homicidal ideation. I guess probably
12 now is sort of the best time to sort of define those. So what
13 is "suicidal ideation"?
14 **A.** So it's sort of a general term that encompasses ... so
15 I would ask a patient specific direct questions. Have you
16 thought about killing yourself? Have you considered killing
17 yourself? Do you have a plan to kill yourself? And suicidal
18 ideation encompasses all those aspects.
19 **Q.** And "homicidal ideation"?
20 **A.** So similarly, Have you thought about harming or
21 killing anyone? Have you considered harming or killing anyone?
22 Do you have any plans to harm or kill anyone?

1 **Q.** So when someone is showing up in a form of ... if I'm
2 using the wrong terminology, definitely correct me. If they're
3 showing up in a state of sort of mental health distress or
4 situational crisis are you, as a rule, as an ER doctor, trying
5 to follow up to assess whether there's any suicidal ideation or
6 homicidal ideation?
7 **A.** That's always part of the assessment.
8 **Q.** And, again, when you're driving at that information,
9 you're dealing with patients that often, as you said, have
10 challenges in terms of conveying a narrative to you that's
11 accurate, do you think access to that previous information would
12 be helpful ... medical history?
13 **A.** It would be helpful.
14 **Q.** And just as an example, different people present to
15 the ER and ultimately to you for different reasons. I'll use an
16 example of someone may attend for a cut finger and someone may
17 attend, like Lionel Desmond, in a form of a situational crisis,
18 post-traumatic stress disorder, other symptoms and history. The
19 access to the prior history, does it take on a different
20 significance depending on what it is you're assessing at the
21 time?
22 **A.** Yeah.

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1 **Q.** And why is that?
2 **A.** Well, some things would be pertinent for how you
3 diagnose and manage. Using a cut finger as an example, an
4 otherwise healthy person with a cut finger, their past medical
5 history means little to nothing. But someone with a cut finger
6 who is getting chemotherapy and is prone to infection, that
7 would be a relevant part of their history in that specific case.
8 So you always have to consider other issues that ... medical
9 problems that a person has when you're treating the current one.
10 **Q.** I'm going to ask you a little bit about the
11 particulars of January 1st of 2017, basically the reason ... one
12 of the main reasons why you're here. So you were working at St.
13 Martha's Hospital in Antigonish on that date?
14 **A.** Yes.
15 **Q.** Do you remember what hours your shift was that
16 particular day?
17 **A.** My shift was 2 p.m to 8 p.m.
18 **Q.** In terms of the flow of the ER that night, workload,
19 was there anything significant or notable or different on that
20 particular evening?
21 **A.** I don't recall. It's typically busy during those
22 hours but ...

1 **Q.** But nothing ...
2 **A.** ... I don't recall that specific day.
3 **Q.** So is it fair to say nothing stands out to you to make
4 it sort of abnormal in any way?
5 **A.** That's correct.
6 **Q.** I'm sure you can probably recall ... if I took you to
7 a certain time, you may recall if that was an abnormal day or
8 different in its operation?
9 **A.** Yes.
10 **Q.** Okay. But there was ... so there was nothing notable
11 or different with this one.
12 **A.** That's correct.
13 **Q.** And at that point, January 1st, how long, as an ER
14 doctor, had you been covering shifts at St. Martha's?
15 **A.** Approximately six months.
16 **Q.** And how long had you been an ER physician at that
17 point?
18 **A.** So approximately six months.
19 **Q.** And do you recall the names of any sort of nurses that
20 might have been ... I realize you probably work with a lot of
21 staff in a lot of different hospitals, obviously, but do you
22 recall the names of any particular nurses you might have worked

1 with that evening?

2 **A.** No.

3 **Q.** Going to ask you about ... before going back to that

4 date, something called "triage screening". Are you familiar

5 with triage screening?

6 **A.** (No audible response.)

7 **Q.** I notice you're nodding. We'll have to get you saying

8 ...

9 **A.** Yes.

10 **Q.** Yes. Okay.

11 **A.** ... I'm familiar.

12 **Q.** What is triage screening, I guess? I'm not going to

13 hold you to a detailed, I guess, account, but your understanding

14 as an ER doctor what it is.

15 **A.** So it's a scoring system from one to five. So,

16 basically, a one would be a patient that is a true emergency and

17 needs assessment immediately, something like a cardiac arrest or

18 a seizure. And then it's sort of a spectrum all the way to

19 five, which may be something that is very minor, a twisted ankle

20 or something.

21 **Q.** And what sort of effect does it have ... and so, I

22 guess, before we get into that, who does the triage screening

1 and scoring?

2 **A.** That's done by a nurse in the triage area.

3 **Q.** And what's the purpose behind giving each patient a

4 triage number, I guess?

5 **A.** So the lower the number would be the higher severity

6 of the medical problem. And it's basically to get them seen

7 sooner.

8 **Q.** And so from an ER perspective ... an ER doctor's

9 perspective, you're given a chart with a description of the

10 details. And we'll go through what a triage nurse provides you

11 in those details. And on that same form, you're giving a triage

12 score. From an ER doctor's perspective, are you looking at the

13 score ... the triage number of any significance? What are you

14 interested in?

15 **A.** So I do look at the score. In St. Martha's, in

16 particular, the charts are organized in bins. There will be a

17 bin for the scores of three and a bin for the scores of four and

18 five. So I am aware of the score. For me, it's the vital signs

19 and the actual details of the triage notes are more important

20 than the score itself.

21 **Q.** When you say vital signs, what do you mean by "vital

22 signs"?

DR. JUSTIN CLARK, Direct Examination

1 **A.** So when the patient presents, they always take their
2 heart rate, blood pressure, oxygen saturation, those sort of
3 things.
4 **EXHIBIT P-000067 - ST. MARTHA'S REGIONAL HOSPITAL EMERGENCY**
5 **CHART - JANUARY 1, 2017**
6 **Q.** I'm wondering if you could look at Exhibit 67. It may
7 even be open for you on the binder, but we'll pull it up on the
8 screen just in case. And, in particular, I guess we'll start by
9 looking at page 32 ... maybe 33. Sorry. Okay.
10 So, Doctor, do you recognize ... maybe we'll get a more
11 wide shot so we can see the whole thing. Do you recognize what
12 that document is?
13 **A.** Yes.
14 **Q.** What is it?
15 **A.** That's the emergency chart from January 1st.
16 **Q.** And which hospital is it from?
17 **A.** St. Martha's Regional Hospital.
18 **Q.** And the chart relates to which patient?
19 **A.** Lionel Desmond.
20 **Q.** And when you talked about being provided with a chart
21 when you see a patient, is this ... I appreciate there's
22 information in the chart that certainly may have gotten added

1 later, but this chart, was that provided to you when you saw
2 Lionel Desmond on January 1st, 2017?
3 **A.** Yes.
4 **Q.** If you could turn to the following pages, which would
5 be 34, 35, 36, 37, 38 and all the way to 40 ... now again
6 appreciating that some of that information may not have been in
7 there when it was provided to you, what sort of details were
8 provided to you when you saw Lionel Desmond initially?
9 **A.** So, initially, page 33 and page 35 would be on a
10 clipboard and that clipboard would be sitting on a desk. And
11 then I would take that and go see the patient.
12 **Q.** Okay. And page 33 is titled "Emergency Care Record".
13 And page ... 35, did you say?
14 **A.** So 34 and 35 would likely be on the chart, as well.
15 But, of course, some of the documentation ... like, for example,
16 page 34 would likely be blank at the time I pick up the chart.
17 **Q.** Okay. And page 35, what's that document titled?
18 **A.** "St. Martha's Hospital Triage Record".
19 **Q.** And you were provided with that?
20 **A.** Yes. That would be on the chart, as well.
21 **Q.** In terms of this emergency care record, are you able
22 to comment whether or not this document is the same throughout

1 all of the ERs that you've worked in throughout the province?
2 **A.** It's not the exact same form but all the components of
3 the form are the same.
4 **Q.** So when you say "the components of the form", what do
5 you mean?
6 **A.** So a section for the patient's information, a section
7 for vital signs, a section for medical history, allergies,
8 discharge instructions, those sorts of things.
9 **Q.** So is the content blocks the same? Is that what
10 you're saying?
11 **A.** (No audible response.)
12 **Q.** And it's just the format is a little different?
13 **A.** Exactly.
14 **Q.** When you were working at St. Martha's that particular
15 date, January 1st, 2017, do you recall how many separate ER
16 rooms were available for patients or how it was sort of divided
17 up?
18 **A.** So St. Martha's has approximately 10 to 12 rooms where
19 we assess patients in the Emergency Room and then two additional
20 rooms, which we call interview rooms, which don't have an
21 examination table. They have more of like a couch, a
22 comfortable place to sit. Sometimes they're called a "family

1 room". Family members may be waiting in one of those rooms or
2 we may use it for a mental health interview as well.
3 **Q.** Are you able to recall how many or approximately how
4 many actual beds there were in the ER Department around that
5 time?
6 **A.** So 10 to 12 beds in the ER Department. There is an
7 area called the "observation area" which is in the same area as
8 the emergency room with five or six beds with curtains between
9 them. It's where patients are kept for observation or if
10 they're admitted to the hospital waiting for a bed to go
11 upstairs, they would be in that area. It's not an area where
12 patients are initially assessed by the emergency room physician.
13 **Q.** So this area of five to six beds, is this over and
14 above the 10 to 12 you indicated or ...
15 **A.** Yes.
16 **Q.** It is over and above.
17 **A.** Yes.
18 **Q.** And if a patient is sort of either formally admitted
19 overnight or just kept overnight for observation, do they
20 typically stay in a bed in the ER?
21 **A.** Sorry. Could you clarify what you mean?
22 **Q.** So I guess if a patient ... I'll use an example. If a

1 patient presents with significant burns at the ER, and they're
2 admitted to the hospital or kept in the hospital, do they stay
3 in a bed in the ER overnight or are they moved elsewhere, as a
4 rule?
5 **A.** If there is a bed available elsewhere, they will be
6 moved. The goal is to have the emergency beds open so that we
7 can see emergency patients coming in. In reality, sometimes we
8 call it "bed block" where there's no bed on the ward to send
9 someone to, so they may be held in a room overnight. But that's
10 ... generally, they're moved from the emergency bed into the
11 hospital.
12 **Q.** And this is sort of consistent between St. Martha's,
13 Dartmouth, Truro, that ...
14 **A.** Yes.
15 **Q.** ... you work? So someone, for example, like Lionel
16 Desmond, and we'll get into the details, but presenting with a
17 mental health-related issue and they're I wouldn't say I guess
18 "admitted", but are allowed to stay overnight, let's say, at the
19 hospital, do they typically stay in the ER in an ER bed or do
20 they normally go elsewhere?
21 **A.** No. They would normally go elsewhere.
22 **Q.** And where in St. Martha's would they normally go?

DR. JUSTIN CLARK, Direct Examination

1 **A.** There's a psychiatric ward that they would go to.
2 **Q.** Do you often see, in your experience, patients that
3 are either admitted overnight or kept overnight for mental
4 health- related reasons in St. Martha's? In your experience, do
5 you typically see whether or not they are kept in an ER bed? Is
6 that usual, unusual, frequent, unfrequent?
7 **A.** So they would usually not be kept in an ER bed. And
8 so I guess what I would call an ER bed is the 10 to 12 beds
9 where, as an Emergency physician, I'm seeing patients.
10 **Q.** Okay.
11 **A.** Like I said before, there's another area called the
12 observation area, that five to six rooms with curtains. So I'm
13 not sure if you're referring to the ...
14 **Q.** I guess either/or.
15 **A.** So I wouldn't call those emergency room beds. That's
16 an observation area. Physically, it's very close to the
17 emergency room. It's right beside it. And then there's the
18 wards in the hospital which would be on, usually, different
19 floors. So, typically, a patient with a mental health issue
20 that was staying overnight for any reason, whether it just be to
21 stay overnight or if they're admitted, they would typically go
22 to the psychiatric floor.

DR. JUSTIN CLARK, Direct Examination

1 **Q.** Which is separate and apart from those additional beds
2 off to the ...
3 **A.** Yeah. Apart from ...
4 **Q.** The observation ...
5 **A.** ... the observation area.
6 **Q.** ... beds, you call them?
7 **A.** Yes.
8 **Q.** And when you first examined Lionel Desmond on January
9 1st, where did that examination occur? Which of those ER rooms,
10 I guess.
11 **A.** So it took place in one of the interview rooms, which
12 is sort of down the hall, in a more quiet area. And there's a
13 room that has a couch in it.
14 **Q.** Was there a particular reason why that room might have
15 been used for Lionel Desmond as compared to one of the rooms
16 with the beds in it?
17 **A.** That would be a typical room that we would assess
18 someone in a situational crisis in the absence of physical
19 symptoms.
20 **Q.** So we're going to look to Exhibit 67, page 33. We're
21 going to go into some details. So at the top, Doctor, as we
22 identified as the emergency care record, we see a date of

1 January 1st, 2017. And do you see that in a registered time of
2 18:51?
3 **A.** Yes.
4 **Q.** And mode of arrival, it says "Walk-In".
5 **A.** Yes.
6 **Q.** So that information, is that completed by you?
7 **A.** No.
8 **Q.** Do you know who, as a rule, that's completed by?
9 **A.** I would say likely either the triage nurse or the
10 clerk at the front desk.
11 **Q.** And we see where it says, "R-E-G.time." What's the
12 significance of that?
13 **A.** That's the registration time. So during daytime
14 hours, there's a clerk that sits at a desk and they would
15 initiate this process and that would be the time they would
16 input when the person first presents.
17 **Q.** And this is pretty self-explanatory. Mode of arrival,
18 walk-in. I guess had somebody been brought in by the police or
19 if somebody was brought in by ambulance, would it typically say
20 otherwise?
21 **A.** Yes.
22 **Q.** And down below it, it says, "Family Physician". Do

1 you recall who Lionel Desmond's family physician was noted as?
2 The last name would be sufficient if ...
3 **A.** I don't know who this physician is.
4 **Q.** Okay. But that information would have been entered?
5 **A.** It would be present. Yes.
6 **Q.** So it says Dr. Ranjini. So that information was
7 available to you at the time you ... or entered ...
8 **A.** Yes.
9 **Q.** ... at the time you assessed Lionel Desmond?
10 **A.** Yes.
11 **Q.** To the right, we see some background information where
12 it has Lionel Desmond's name, full name, his address, date of
13 birth, et cetera. Is that information that's entered by someone
14 else, as well?
15 **A.** Yes.
16 **Q.** And who's that typically entered by?
17 **A.** The registration clerk, as far as I know.
18 **Q.** So by the time a chart gets to you with a patient,
19 it's already filled in.
20 **A.** Yes.
21 **Q.** And it says ... if you look back to the left, you see
22 "Complaint" listed there.

1 **A.** Yes.
2 **Q.** And what does it say?
3 **A.** It says "PTSD".
4 **Q.** What is ... I guess before I ask you what that is;
5 again, who would have entered this information? Do you know?
6 **A.** As far as I know, it would be the clerk. At certain
7 hours of the day, there's no clerk. So, at that point, it may
8 be the triage nurse entering it. I'm not sure.
9 **Q.** And, again, that's information that's completed on the
10 chart before it's provided ...
11 **A.** Prior to ...
12 **Q.** ... to you with the patient?
13 **A.** Yes.
14 **Q.** So what is "PTSD", I guess? And I recognize you're
15 not a psychiatrist, but you're a doctor obviously. What is
16 "PTSD"?
17 **A.** Post-traumatic stress disorder.
18 **Q.** Okay. And below that, we see a CEDIS code and it has
19 MH.F41.9. And, there, it says, "Anxiety/situational cri".
20 What's that?
21 **A.** So that would be anxiety/situational crisis. It must
22 just be cut off.

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1 **Q.** And that information was entered by someone else as
2 well?
3 **A.** Someone else as well.
4 **Q.** And provided to you at the time with the chart with
5 the patient.
6 **A.** Yes.
7 **Q.** So what is, I guess, "anxiety"? We all have a general
8 sense but is there a special clinical ...
9 **A.** I mean, generally, it's someone experiencing symptoms,
10 feeling worried. Some people can get physical symptoms like
11 their heart racing, palms sweaty. It's sort of a constellation
12 of symptoms that ...
13 **Q.** And what is "situational crisis"?
14 **A.** So that's sort of a non-specific term to describe when
15 someone presents in crisis in some way that's not a specific
16 physical symptom. So it's sort of a catch-all term.
17 **Q.** So a catch-all ... what does it capture, "situational
18 crisis", in your experience as an ER doctor? When you see that
19 entered, your mind goes to what?
20 **A.** To someone may have been in an altercation, they may
21 be brought in by police, they may have had ... you know, it may
22 be alcohol or drugs involved, just generally ... again, it could

1 be anything that's not a physical symptom. So people will
2 present for all sorts of different reasons; anxiety, depression,
3 fight with someone, altercation, arguments ...
4 **Q.** So it's a mixture of mental health-related matters.
5 **A.** Yes.
6 **Q.** And circumstance, I guess, related matters.
7 **A.** Right.
8 **Q.** So below that, we see triage date again, 18:51. And
9 then we see a number of things, "Lvi". What is that? It says
10 "LVI 2".
11 **A.** So that's a triage score, level two.
12 **Q.** And you indicated level one was cardiac arrest.
13 **A.** Uh-huh.
14 **Q.** Level two, in terms of the hierarchy, seems to be next
15 in terms of level of significance?
16 **A.** Yes. Two would be next.
17 **Q.** And realizing that you haven't ... you didn't score
18 Lionel Desmond as a level two, but as an ER physician, when you
19 looked at that what, if anything, was that telling you?
20 **A.** So level two is, generally, you want to try to see
21 them as soon as possible.
22 **Q.** Does it suggest some sort of maybe urgency or ...

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1 **A.** Yes, it does suggest urgency.
2 **Q.** And then you see ... it looks like temperature; HR,
3 heart rate. AA?
4 **A.** RR, respiratory rate.
5 **Q.** And BP, blood pressure. And O2, oxygen?
6 **A.** Yeah.
7 **Q.** So these are the vitals you had referred to?
8 **A.** Correct.
9 **Q.** And what were his vitals?
10 **A.** I would call those normal vital signs.
11 **Q.** So temperature, heart rate, respiratory, blood
12 pressure, oxygen.
13 **A.** They're all within the normal range.
14 **Q.** So those numbers, did they cause you any ... warrant
15 any sort of concern or ...
16 **A.** No. None.
17 **Q.** Below that it says ... under "Allergies" ...
18 **A.** Uh-huh.
19 **Q.** See that where it says "Medical History"? What does
20 it say there?
21 **A.** "PTSD. Post-concussion disorder."
22 **Q.** So that information, as well, was that entered by you?

1 **A.** No.
2 **Q.** So someone else. And you indicated ... would it be
3 the same person, presumably the triage nurse?
4 **A.** Yes.
5 **Q.** And that's information that's entered and provided to
6 you prior to or just as you see Lionel Desmond.
7 **A.** Yes.
8 **Q.** And below that it says, "Triage Assessment". I wonder
9 if you could indicate whether that triage assessment was entered
10 by you or someone else.
11 **A.** It was entered by someone else.
12 **Q.** And again a similar person?
13 **A.** The triage nurse.
14 **Q.** Okay. And entered in advance of you seeing Lionel
15 Desmond?
16 **A.** Yes.
17 **Q.** So I wonder if you could indicate what the triage
18 assessment was for Lionel Desmond.
19 **A.** To read it?
20 **Q.** Yeah.
21 **A.** "Patient dealing with PTSD since before 2011.
22 Patient had a bad day today. Argued with partner. Walked a lot

1 to try to calm down. Feels he's not coping well and is looking
2 for admission. Calm and speaking quietly."
3 **Q.** So you would have reviewed that, I guess, prior to
4 seeing Lionel Desmond?
5 **A.** Yes.
6 **Q.** So I guess we have that information or you have,
7 you're equipped with that information going into this. So is
8 there any sort of particular process that's happening in your
9 mind as an ER doctor being presented with this information?
10 What is your plan, I guess, if any?
11 **A.** So, initially, I would, I would look in MEDITECH to
12 get some background information prior to going to see the
13 patient and then after that I would go have a conversation, a
14 medical interview with the patient.
15 **Q.** Okay. So I guess step one would be looking at that
16 chart?
17 **A.** This chart, correct, yes.
18 **Q.** Okay. And step two, you would go to MEDITECH?
19 **A.** Yes.
20 **Q.** And step three, patient?
21 **A.** Yes.
22 **Q.** I'm just curious about step two. Why the look to

1 MEDITECH from an ER perspective?
2 **A.** It's helpful to have a sense of the patient before
3 you go in to talk to them. I mean it can be a lot more
4 efficient. Rather than asking them certain details about their
5 medical history, if you can, you can get it and you can confirm
6 it, that's much quicker. And also it may prompt you to ask or
7 go into certain things during the interview.
8 **Q.** So, again, would you say the more information
9 available to you as an ER doctor on MEDITECH, the more helpful
10 it is for you as an ER doctor to assess, diagnose, treat?
11 **A.** Correct.
12 **Q.** Is it relevant, as well, to sort of ... in that
13 assessment of suicidal ideation and homicide ideation?
14 **A.** It could be relevant.
15 **Q.** So if, for example, if there had been a chart, again,
16 Lionel Desmond attended an ER in New Brunswick and it had have
17 talked about that he had made suicidal comments to his wife,
18 would that information have been relevant to you in assessing
19 Lionel Desmond that particular night?
20 **A.** Yes.
21 **Q.** If there had have been details about consults with
22 various health care professionals such as psychologists and

1 psychiatrists, would that have been helpful to you as an ER
2 doctor in your plan to assess Lionel Desmond that night? And
3 I'm keeping in mind, Doctor, that ultimately we're going to get
4 to the fact that you did ultimately consult a psychiatrist. So
5 the description in the triage assessment that described him
6 having a bad day, trying to calm down, not coping well, looking
7 for admission, "calm, speaking quietly, bad day, argued with
8 partner", is that consistent with this term of "anxiety
9 situational crisis"?
10 **A.** Yes.
11 **Q.** Do you recall when you looked at MEDITECH, do you
12 recall what, if any, documents you ... I know it's been a while,
13 obviously. Do you recall what, if any, documents you'd seen on
14 MEDITECH?
15 **A.** I don't recall.
16 **Q.** If we could look at page 3 ... Maybe it's page 2. My
17 numbering might be a little off. At page 2, this appears to be
18 a St. Martha's Regional Hospital Emergency Care record. Do you
19 see that?
20 **A.** Yes.
21 **Q.** And it's in the same format as the one from January
22 1st, 2017. There it talks October 24th, 2016, again related to

1 Lionel Desmond. Complaint: situational crisis. Do you see
2 that? I think we're on the wrong page here.
3 **A.** I don't think ...
4 **Q.** If we could ...
5 **A.** This looks like it says 1995.
6 **Q.** If we could look at page 3, maybe 4. Yes, we will
7 leave it on page 4, sorry. My numbering is one page off. So on
8 page 4, do you see that there, October 24, 2016?
9 **A.** Yes.
10 **Q.** "Lionel Desmond, situational crisis."
11 **A.** Yeah.
12 **Q.** So there's a chart there completed by ... There's a
13 signature down at the bottom, "attending physician", do you
14 recognize that signature?
15 **A.** I don't recognize the signature. I recognize the
16 handwriting, but I can't say which physician for sure.
17 **Q.** Okay. And you recognize the handwriting. Who do you
18 believe that was? You can scroll up a little bit.
19 **A.** I can scroll up. Actually, I'm not sure.
20 **Q.** Okay.
21 **A.** I recognize the writing but I don't know specifically
22 which physician.

1 **Q.** Sure. But you would agree that this appears to be a
2 previous ER chart?
3 **A.** Yes.
4 **Q.** St. Martha's, predating January 1st when you had seen
5 him, outlining a situational crisis of Lionel Desmond?
6 **A.** Yes.
7 **Q.** And do you recall if you looked at that record on
8 that particular night through MEDITECH?
9 **A.** I don't recall if I looked at it.
10 **Q.** But, normally, would this document have been part of
11 MEDITECH on that date?
12 **A.** Yes.
13 **Q.** And I appreciate you can't recall if you looked at it
14 but is it typically something ... You seem very diligent in
15 wanting to go to MEDITECH to look up the history.
16 **A.** A recent ... I certainly would have. This would be
17 the first document I would open. A recent ER visit would be
18 very relevant and I would, typically, I would certainly look at
19 it.
20 **Q.** Okay.
21 **THE COURT**: In the normal course of events you would
22 expect to have read it even though you might not specifically

1 recall that today?
2 **A.** Exactly, exactly.
3 **MR. RUSSELL:** If we could turn to page 29, and, Doctor, I
4 just want you to take a quick look at that document. There are
5 three pages in total to it. And it appears as though, on the
6 first page, on page 29, it's a psychiatric consultation dated
7 December 2nd, 2016. He talks to clinician Catherine Chambers
8 and, ultimately, it appears to be signed, the detailed report,
9 by a Dr. Ian Slayter.
10 **A.** Um-hmm.
11 **Q.** Now this document, it says St. Martha's Regional
12 Hospital up at the top. Do you know if that document is
13 something that's uploaded and entered into MEDITECH?
14 **A.** I'm not sure.
15 **Q.** Okay. Do you recall if you had access to that
16 document on January 1st, 2017?
17 **A.** I don't recall.
18 **Q.** So in the report, on the first page, Dr. Slayter is
19 indicating, do you see where it says, just above that, go up a
20 little bit. "I saw Lionel Desmond in consultation today at St.
21 Martha's Mental Health Clinic on referral."
22 **A.** Right.

1 **Q.** So were Mental Health Clinic documents accessible to
2 you as an ER physician on January 1st, 2017?
3 **A.** As far as I know, no. I don't recall ever seeing a
4 document from the Mental Health Clinic in the Emergency Room.
5 **Q.** Okay.
6 **A.** If a psychiatrist sees a patient in the Emergency
7 Room and does a consult, those documents are available.
8 **Q.** Much like the chart you had indicated earlier from
9 October?
10 **A.** Yes.
11 **Q.** Do you think such a detailed report from a
12 psychiatrist that occurred prior to your assessment and initial
13 encounter with Lionel Desmond on January 1st may have been
14 helpful to some degree?
15 **A.** Yes.
16 **Q.** And in what way?
17 **A.** Again, the more information that you get about a
18 person, the better.
19 **Q.** If we could turn to page 37, we're back to the chart
20 of, just to orientate you, the chart of Lionel Desmond from the
21 night you had seen him, January 1st, 2017. This is one of the
22 documents you sort of identified. It says "Medication

1 Reconciliation"?

2 **A.** Yes.

3 **Q.** Is this a typical sort of form that goes with a

4 patient's chart in the ER?

5 **A.** Yes.

6 **Q.** And what's the significance of this particular form?

7 **A.** So it's a list of the patient's current medications.

8 **Q.** Okay. And the information of the patient's current

9 medications, do you know how that's typically gathered? Is that

10 gathered by you or ...

11 **A.** It's not gathered by myself. Usually, the nurses

12 will gather that information. It may be from the pharmacy, it

13 may be the patient may present with a bag of their medications

14 or they may present with a list of their medications.

15 **Q.** And you're provided with this information along with,

16 I guess, the first page of the chart, the Emergency Care Record?

17 **A.** Yes. It would not always be completed prior to me

18 seeing the patient, but at some point this is completed.

19 **Q.** So at some point during your evaluation and

20 assessment of a patient in ER you would have seen what

21 medications they'd been on?

22 **A.** Yes.

1 **Q.** And realizing that a period of time has passed and
2 it's doubtful you'll be able to recall exactly what medications,
3 but is it fair to say that particular page 37, the Medication
4 Reconciliation, is a proper reflection of medications as
5 reported to you that were being taken by Lionel Desmond on
6 January 1st, 2017, or up to that point?
7 **A.** Yes. I think it's reflective of his current
8 prescriptions. I guess, whether or not he's taking those is an
9 entirely other, different thing.
10 **Q.** Fair. Fair point.
11 **A.** Yes, his current prescribed medication.
12 **Q.** So I'm wondering, Doctor, if you could just briefly
13 walk me through what these medications are. I see, I believe
14 it's Tylenol ES.
15 **A.** Yeah, extra strength.
16 **Q.** Okay. What's the second medication?
17 **A.** It's called trazodone.
18 **Q.** And what is trazodone?
19 **A.** It's a medication, it's generally used to help with
20 sleep.
21 **Q.** Prazosin?
22 **A.** Prazosin is also a medication used to treat sleep

1 disturbance.
2 **Q.** What's the next medication?
3 **A.** Quetiapine.
4 **Q.** What's quetiapine?
5 **A.** So quetiapine is an anti-psychotic medication that
6 can be used as ... I guess it's classified as an anti-psychotic,
7 but it can be used for various things, including sleep.
8 **Q.** And below that is another medication. What's that?
9 **A.** Quetiapine XR.
10 **Q.** And what is that and how is it different from
11 straight quetiapine, do you know?
12 **A.** So it would be a longer acting formulation of the
13 drug.
14 **Q.** And you normally would have reviewed that sort of
15 currently prescribed medication list?
16 **A.** Yes.
17 **Q.** Did anything sort of cause you any concerns ... or
18 notable about that when you assessed Lionel Desmond on January
19 1st?
20 **A.** No. Those would be medications I would expect to see
21 from someone with his diagnosis.
22 **Q.** So in terms of your, I guess, approach as an ER

1 physician and, in particular, your approach to treating and
2 assessing Lionel Desmond on January 1st for mental illness, you
3 have him ... you're provided with information that it's
4 situational crisis, it's noted PTSD, it's also noted post-
5 concussion. What is your sort of approach ... what was your
6 approach to assessing Lionel Desmond, after you looked at
7 MEDITECH, you reviewed the chart, presumably you reviewed the
8 prior ER visit or what was available on MEDITECH, ...
9 **A.** Yes.
10 **Q.** You were diligent. What was your approach at that
11 point?
12 **A.** So I would go to the room where the patient is and
13 sit and have an interview. Typically, in the beginning, I would
14 allow the patient to describe why they're there in their own
15 words. So I would start with something like, What brought you
16 in tonight and I would let them describe their symptoms,
17 concerns, their story kind of in their own way.
18 **Q.** And do you have a recollection of interacting with
19 Lionel Desmond?
20 **A.** I do.
21 **Q.** And are you sort of assessing, in that initial
22 encounter, anything about body language or eye contact?

1 **A.** Yes, those would be included.
2 **Q.** And why are you sort of looking to those things?
3 **A.** So the goal of the interview is to get an overall
4 picture of what is going on. So there's a number of different
5 components that you'd look at when you're getting that sense,
6 and body language, eye contact, those would be a couple of those
7 components, for sure.
8 **Q.** And how would you describe Lionel Desmond's body
9 language or eye contact during the time that you had met with
10 him in the ER?
11 **A.** So I recall that he was calm and polite and
12 cooperative with the interview.
13 **Q.** A little bit about your history, Doctor. And we're
14 going to go back to the details of your interaction with Lionel
15 Desmond. Up to January 1st had you had much experience in
16 dealing with patients in the ER setting related to mental
17 health- related concerns or issues?
18 **A.** Mental health related concerns, yes. It would be a
19 common presentation in the Emergency Department.
20 **Q.** And what about your experience directly with military
21 veterans presenting in some sort of mental duress or concerns?
22 **A.** I would say I don't have a lot of experience with

1 military veterans. The areas I practice don't have a big
2 military population. In my family medicine residency in
3 Renfrew, Ontario, there is a military base near there, so I do
4 recall seeing patients, young veterans there ...
5 **Q.** Okay.
6 **A.** ... from time to time in the Emergency Room but I
7 would say I don't have a lot of experience.
8 **Q.** And is there any difference or was there any
9 difference in your approach to your assessment of Lionel
10 Desmond, knowing that he was a military veteran with those
11 symptoms ...
12 **A.** Yeah.
13 **Q.** ... versus a civilian with the same symptoms? Is
14 there any difference in your approach, from an ER physician's
15 perspective, in the treatment, diagnosis, assessment?
16 **A.** No. I would go through the same process.
17 **Q.** Is there anything different in terms of flags or
18 concerns that you might be sort of keeping in the back of your
19 mind due to the fact that he was a military veteran with those
20 symptoms as opposed to a civilian with those symptoms?
21 **A.** Yes. Because it's a specific patient demographic I
22 don't have a lot of experience with, that was one of the reasons

1 I chose to involve Psychiatry when treating him.

2 **Q.** And you indicated you consulted Psychiatry. Do you

3 remember which psychiatrist you had consulted that evening?

4 **A.** Dr. Rahman.

5 **Q.** And my understanding is Dr. Rahman may be the Chief

6 of Psychiatry for that region?

7 **A.** I'm not sure.

8 **Q.** We'll find out. Perhaps I'm giving him a title he

9 doesn't have but I think he is or was. In your experience as an

10 ER physician at the St. Martha's Hospital, in particular, during

11 the shifts, whether it's day or afternoon or night, is there

12 always a psychiatrist present in the hospital that's available

13 directly?

14 **A.** They're not always present in the hospital, no.

15 **Q.** And ...

16 **A.** There's always a psychiatrist on call. They may be

17 at home.

18 **Q.** So if you're working a shift at 3 o'clock in the

19 morning in Truro or St. Martha's in Antigonish and you need a

20 psychiatrist to consult, is there one available to you by way of

21 call?

22 **A.** Yes.

1 **Q.** That was the case in January 1st, 2017?
2 **A.** Yes.
3 **Q.** And does that continue to be the case today?
4 **A.** Yes.
5 **Q.** In your entire time, I guess, 2016 to today, and I
6 know this is putting you on the spot a little bit, and I
7 apologize, and I know you haven't been tracking data, but just
8 to get a sense from your perspective as an ER doctor, are you
9 able to estimate how many patients as a rule present to the ER
10 with a mental health-related medical issue or concern versus a
11 physically ... purely physiological concern, whether it's a sore
12 back, sore neck, cut, or a combination of both, in your
13 experience, and I won't hold you directly to hard and fast
14 numbers, but I'm just trying to get a sense.
15 **A.** I would estimate around 10 to 15 percent of
16 presentations would be primarily mental health-related concerns.
17 And then there would be a significant number of people who
18 present with physical symptoms where there's some component of
19 their mental health that's involved but not the primary reason
20 they're there. But the majority would be physical, purely
21 physical components.
22 **Q.** So I understand that as part of your ongoing

1 professional experience as a physician, I guess the College of
2 Physicians ... Is that the right term?
3 **A.** Um-hmm.
4 **Q.** Requires you probably to keep so many continuing
5 education hours?
6 **A.** Yes.
7 **Q.** And are there set areas in which each physician and,
8 in particular, an ER physician has to complete so many hours in
9 mental health crisis-related illnesses, physiological, or a
10 combination of both?
11 **A.** There's a set number of hours or credits that we need
12 to get of CME, continuing medical education credits, but it's
13 not specified in which areas. It's largely up to the physician
14 to be working on areas where they may not be as strong.
15 **Q.** So I guess you, it's left to the physician's
16 judgment, to determine where they want to spend their continuing
17 education hours?
18 **A.** Correct.
19 **Q.** Which could mean going to conferences, I guess, or
20 reading sort of literature, that sort of thing?
21 **A.** Correct.
22 **Q.** So is it conceivable that as an ER physician who may

1 routinely deal with someone presenting in a mental health
2 crisis, you could decide I'm not going to do any continuing
3 legal education in that area - legal education? I'm thinking
4 from where I am, continuing education in terms of medicine, you
5 could decide I'm not going to do anything as it relates to
6 mental health, I want to do everything as it relates to burns, I
7 guess?
8 **A.** Yes, you could decide that. There are ways that in
9 your everyday treating patients and looking up diagnoses and
10 management of conditions, you can use that as your CME.
11 **Q.** Okay.
12 **A.** For example, if you're working in the Emergency Room
13 and you look, there's an app where we can look up diagnoses and
14 management. You get CME credits for using that.
15 **Q.** In your time as, as a physician could you, do you see
16 more of an emphasis, I guess, and concern or an awareness of
17 mental health related medical conditions or concerns compared
18 to, say, earlier on? Has there been a rise in the awareness of
19 that from a doctor's perspective?
20 **A.** I mean I have, I've only been practicing a few years.
21 I haven't seen ... I guess, do you mean with respect to
22 presentation to the Emergency Room or just ...

1 **Q.** Yes, specifically as it relates to presentation to
2 the Emergency Room.
3 **A.** To the Emergency Room. I have not seen a rise in the
4 number of people presenting, no.
5 **Q.** And in your ...
6 **A.** But again I have no data. I guess, in my experience,
7 I haven't found that to be true.
8 **Q.** And in your experience as an ER physician, would you
9 say it's of a high or low level degree of importance to be sort
10 of well-rounded in terms of - I realize you can't know
11 everything, and we presume that you do - but well-rounded in
12 terms of knowing mental health issues, signs, symptoms, as well
13 as the physiological aspects of things?
14 **A.** I would say they're equally as important, they're all
15 very important.
16 **THE COURT**: I'm going to suggest we take a short break.
17 So let's try for 15 minutes or thereabout. Thank you.
18 **COURT RECESSED (14:54 HRS.)**
19 **COURT RESUMED (15:07 HRS.)**
20 **THE COURT:** Thank you.
21 **MR. RUSSELL:** So, Dr. Clark, we're now going to turn to
22 the details of the chart as it relates to the visit with Lionel

1 Desmond which is Exhibit 67, page 33.
2 So, Doctor, if we could go down to the page where I guess
3 the handwriting starts where it says "time seen".
4 **A.** Yes.
5 **Q.** We're looking at the chart of Lionel Desmond from
6 January 1st, 2017. I'm wondering if you could ... and that's
7 your handwriting, I presume?
8 **A.** Correct.
9 **Q.** I'm wondering if you could read that into the record.
10 I wouldn't dare try.
11 **A.** Okay. So "Time seen - 19:09. 33-year old. Ex-
12 military. History of PTSD. Diagnosed in 2011. Followed by Dr.
13 Slayter and Veterans Affairs. Issues at home. Has a wife and a
14 nine-year old child. Outburst tonight. Breaking furniture. No
15 harm to family per patient. Wife told him, 'Don't come back
16 until tomorrow.'"
17 **Q.** Okay. I guess we'll stop right there. So the time
18 you would have actually seen Lionel Desmond would've been when?
19 **A.** 19:09. I would put the time ... write the time seen
20 immediately before going into the room.
21 **Q.** Okay. So this note here that you made, there's quite
22 a few details in that small amount of note. Would you have made

1 these notes at the time you're doing your assessment with Lionel
2 Desmond or would you have made them after or a combination of
3 both, I guess?
4 **A.** Yeah. Sometimes during and sometimes after and
5 sometimes during and after. I don't recall in this case. I
6 would say that most of the time I see patients with mental
7 health concerns, I wouldn't be writing while talking to them.
8 **Q.** And why is that?
9 **A.** So I would want to be observing them closely and the
10 details of our interaction. I guess non-verbal details are a
11 lot more important in that case than if someone had a twisted
12 ankle, for example.
13 **Q.** So we're going to talk about sort of the outward
14 demeanour, I guess, of Lionel Desmond. Are you able to recall
15 sort of the tone or inflection of his voice?
16 **A.** I recall that he was calm and polite and cooperative
17 answering questions.
18 **Q.** Was he able to sort of engage in a conversation? And
19 what I mean by that is sort of question-answer dialogue with
20 you?
21 **A.** Yes.
22 **Q.** Were there any sort of stumbling blocks or concerns in

1 trying to get a narrative from him?
2 **A.** Not that I recall.
3 **Q.** And you described how his eye contact was. How was
4 that?
5 **A.** I recall that he had good eye contact during the
6 interview.
7 **Q.** Did he appear, say, nervous or restless at all when he
8 met with you?
9 **A.** Not that I recall.
10 **Q.** What's that?
11 **A.** Not that I recall, no.
12 **Q.** Did he appear excitable?
13 **A.** No.
14 **Q.** Did he appear to have any sort of, I guess, what's
15 referred to as "flat affect"? Very basic ...
16 **A.** I don't recall.
17 **Q.** Did you note anything from his body language?
18 **A.** Like I mentioned to you, he was calm, seated on the
19 couch in the interview room. That's all that I recall really.
20 **Q.** Do you recall if he was forthcoming with you in
21 providing information as to why he was there, why he was seeking
22 assistance?

1 **A.** I don't recall.
2 **Q.** Was he forthcoming in describing his symptoms or
3 concerns?
4 **A.** I guess what do you mean by "forthcoming"?
5 **Q.** I mean willing to sort of engage you. Was he holding
6 back information from you that you had to pull out of him?
7 **A.** No. I would say no.
8 **Q.** Did he seem willing to you to talk about his symptoms,
9 what he was experiencing and why he was there?
10 **A.** Yes.
11 **Q.** Was there anything in your interaction, I guess, with
12 Lionel Desmond that he appeared to be guarded or resistant to
13 sharing information with you?
14 **A.** No.
15 **Q.** There were a number of times you said you didn't
16 recall in terms of appearing sort of in different states. If
17 there was anything of significance that you noted about his
18 outward demeanour, would you normally have noted that in your
19 chart?
20 **A.** Yes.
21 **Q.** So, for example, if Lionel Desmond had been in what's
22 referred to a "manic state" ...

1 **A.** Yes.
2 **Q.** ... would you have noted that?
3 **A.** Yes.
4 **Q.** If he was agitated or irritable, would you have noted
5 that?
6 **A.** Yes.
7 **Q.** If he was aggressive, would you have noted that?
8 **A.** Yes.
9 **Q.** In that note you say, "Ex-military, PTSD", and you
10 have "2011", I believe?
11 **A.** Yes. "Dx 2011." Diagnosed in 2011, yes.
12 **Q.** So "Military, Dx PTSD, Dx 2011"?
13 **A.** Yes.
14 **Q.** So do you recall where the topic of him being
15 diagnosed with PTSD in 2011, where did that information come
16 from? Did it come from Desmond? Did it come from the charts?
17 **A.** I don't recall.
18 **Q.** You just recall having that information.
19 **A.** Yes. I documented it so I suspect it was from the
20 medical record, MEDITECH, the online EMR.
21 **Q.** Do you recall any discussion with Lionel Desmond about
22 the particulars of his post-traumatic stress disorder, when that

1 might've first occurred, how long it's been there?

2 **A.** I don't recall that conversation.

3 **Q.** Did you get into any sort of discussion or details

4 about his military service?

5 **A.** I don't recall.

6 **Q.** You just it noted "military" and you don't remember

7 where you got that information from?

8 **A.** No.

9 **Q.** Did you ever discuss with him, I note in the chart, as

10 it was provided to you by the triage nurse, it said "post-

11 concussion disorder". Did you do any sort of analysis or

12 follow-up with Lionel Desmond about post-concussion disorder

13 symptoms, if he was experiencing any, do you recall?

14 **A.** I don't recall but that is something I would typically

15 do. Ask the patient about their medical history. In that

16 section, I would confirm the details that are already written

17 and I would either add to it or cross out things that he didn't

18 endorse to me. So the fact that I made no changes, I most

19 likely confirmed that those details were there.

20 **Q.** And at one point in your note, you indicated, "No harm

21 to family per patient."

22 **A.** Yes.

DR. JUSTIN CLARK, Direct Examination

1 **Q.** So that note, do you recall the circumstances
2 surrounding what information you gathered enough to make that
3 assessment of "no harm to family per patient". Or what does it
4 mean? Is it him telling you that?
5 **A.** So it means, according to the patient, there was no
6 harm done to his family.
7 **Q.** So that's information directly from him.
8 **A.** Yes.
9 **Q.** And do you recall how that information came out in the
10 dialogue with him?
11 **A.** I guess I don't recall our specific conversation, but
12 based on reading my own note, he told me about being in an
13 altercation or an argument and breaking some furniture so,
14 certainly, I would probe into the details of that. And one of
15 the most important pieces of information would be that, did he
16 harm any of his family members or did he have any thoughts or
17 considerations of plans to do so.
18 **Q.** Because you indicated that one of the things you
19 would've been looking for is this concept of not only suicidal
20 ideation but also homicidal ideation.
21 **A.** Correct.
22 **Q.** Do you recall specifically what you asked him

1 surrounding that when you learned the information of the
2 distress, I guess, that was happening between him and his wife?
3 **A.** Again, I don't recall the specific conversation but I
4 typically ask in the same way every time. It's something I do
5 every day, multiple times a day. So I would ask, Have you had
6 any thoughts of harming anyone? Any thoughts of killing anyone?
7 Have you considered harming anyone or killing anyone? And do
8 you have any plans to harm anyone or kill anyone?
9 **Q.** Do you recall what his answers were to those?
10 **A.** His answers were "no".
11 **Q.** And I didn't see ... Normally, do you document that
12 you had asked those questions in your chart?
13 **A.** Yes. So where I document, down towards the bottom,
14 "No SI/no HI".
15 **Q.** Yes.
16 **A.** So "HI" is referring to those questions. Homicidal
17 ideation refers to those specific questions. Any thoughts,
18 considerations or plans of harming anyone or killing anyone.
19 **Q.** And this is flowing, as well, there's a comment,
20 "Issues with wife. Breaking table."
21 **A.** "Furniture", yes.
22 **Q.** "Furniture", sorry. Is that information you gathered

1 from him directly?
2 **A.** Yes.
3 **Q.** And did you understand that to be recent? Occurring
4 recently?
5 **A.** Based on my note, I believe it happened recently, yes.
6 I don't recall the details surrounding that, but based on my
7 note, I would suspect that's something I would write if it
8 occurred recently.
9 **Q.** Back to your note, you say, "No harm to family per
10 patient". Was there a particular importance or reason why you
11 wanted to document it that it was per his narrative?
12 **A.** Yes. I had no collateral information at the time. He
13 was alone, so there was no other family members or friends or
14 police or anyone else.
15 **Q.** So it's fair to say it wasn't your definitive view,
16 that "no harm to family", but that's according to him.
17 **A.** Correct. On my assessment, that's what he told me.
18 **Q.** When you're having this interaction with Lionel
19 Desmond and there's talk about sort of recent issues at home,
20 breaking furniture, his wife told him, Don't come back until
21 tomorrow, and you're assessing, trying to get a full picture,
22 did you, in this case, ask Lionel Desmond about whether he had

1 access to firearms or does the topic of firearms ever come up,
2 or weapons?
3 **A.** That would be a typical question I would ask. I don't
4 recall a conversation we had about that but that's a typical
5 question during this type of interview.
6 **Q.** And why would you ask that sort of question?
7 **A.** So, at some point, you do an assessment for risk, so
8 you look at risk factors and protective factors and you kind of
9 go through those things.
10 **Q.** So the question you typically ask around firearms, in
11 your practice, what would it normally be?
12 **A.** I guess, Do you have any guns at home, or, Do you have
13 any access to guns, I guess, more importantly.
14 **Q.** Do you ever ask, and this may be getting into too much
15 detail, whether you have a license or a means to access
16 firearms? Is that something you would ever ask or is that too
17 detailed?
18 **A.** I wouldn't ask about a license routinely, but I guess
19 "do you have access" is the question I would usually ask, and I
20 guess that would include if they have means to.
21 **Q.** That's fair.
22 **A.** Yeah.

1 **Q.** I was going to have a separate section on it but I
2 think it's more relevant here. In terms of those questions,
3 when you're asking and assessing homicidal ideation, suicidal
4 ideation, and assessing risk, I guess, to himself and others ...
5 **A.** Mm-hmm.
6 **Q.** ... those questions that you say you typically ask,
7 are they outlined anywhere in a guideline for sort of an ER
8 physician? Is there a set series of questions? Perhaps like a
9 "best practices" manual or guide?
10 **A.** I'm not aware of any specific guideline, but it would
11 be a list. Risk factors and protective factors are in every
12 textbook and we're tested on it multiple times throughout
13 medical school and residency. So any physician or medical
14 student, if you ask them to list a few risk factors for suicide
15 completion, they would be able to list those, and those are
16 generally the same questions we ask during the interview.
17 **Q.** And you say this is sort of medical school, you learn
18 this?
19 **A.** Yes.
20 **Q.** So post-medical school but in terms of day-to-day
21 practice for ER physicians across Nova Scotia.
22 **A.** Mm-hmm.

DR. JUSTIN CLARK, Direct Examination

1 **Q.** And I got the sense from you that it's a very active
2 thing that you're assessing risk to harm himself or others.
3 **A.** Yes.
4 **Q.** Is there anywhere that an ER doctor can sort of take a
5 quick look and say, Okay, I think I went through this here. I
6 checked off what I should be looking for. Is there a resource
7 that you can consult?
8 **A.** Yeah, and like I said, any textbook would have those
9 in it. A lot of us use online apps and things like that.
10 **Q.** Okay. Are you aware of any sort of ... If I could
11 have one moment, Your Honour.
12 My understanding is that there's sort of a suicidal risk
13 protocol or list of factors ...
14 **A.** Okay.
15 **Q.** ... that have been prepared by various psychiatrists.
16 Are you familiar with the document?
17 **A.** I'm familiar with that concept. I don't know of a
18 specific document that you're talking about but lists such as
19 that would be, like I said, they would be in any textbook, any
20 ...
21 **Q.** Yeah.
22 **A.** Yeah.

DR. JUSTIN CLARK, Direct Examination

1 **Q.** But if there had been something sort of worked on in
2 Nova Scotia that identified risk factors for suicide, risk
3 factors for homicidal ideation, as an ER doctor, are you aware
4 of any such document?
5 **A.** I'm not aware of a specific document.
6 **Q.** Okay. I don't want to get too hypothetical, but do
7 you think it would have any particular value to ER doctors to be
8 privy to that information if there is one?
9 **A.** I think it would be valuable. It's something that we
10 all do sort of every day, multiple times a day. So I guess it
11 depends what you mean by "valuable". I suppose you could have a
12 checklist as part of the chart. That would save a lot of time
13 rather than writing out specific things but those risk factors
14 are something that we're expected to know.
15 **Q.** Okay. So I guess my question is, if there was a part
16 of psychiatry in Nova Scotia that had worked on devising a
17 series of risk factors for suicide, for example, and they were
18 confident in saying, These are the main sort of areas to assess
19 for suicide risk, do you think it would be valuable for an ER
20 doctor to be aware of that document?
21 **A.** Yes.
22 **Q.** And perhaps learn a bit about that?

DR. JUSTIN CLARK, Direct Examination

1 **A.** Yes, but I mean we would already know a lot about that
2 but ...
3 **Q.** That's fair.
4 **A.** Yes.
5 **Q.** For sure. Some of it obviously may be routine
6 information.
7 **A.** Yes.
8 **Q.** In terms of the living situation of Lionel Desmond,
9 you have in quotes, "Don't come back until tomorrow." So I take
10 it that's a direct answer from him.
11 **A.** Yes.
12 **Q.** Or words from him? And so was there any sense from
13 you, in your conversation with Lionel Desmond, how long he
14 might've been out of the home? Had he just been kicked out of
15 the home? What was your understanding of that situation?
16 **A.** I don't recall having a conversation specifically
17 about that. Again, the sense I get from reading my chart was
18 that it was very recent that he left his home and immediately
19 came to the emergency room but I don't recall him telling me
20 that specifically.
21 **Q.** Was there any discussion that you can recall whether
22 Lionel Desmond had somewhere to stay? Whether there was a

1 discussion about staying with relatives or anything? Do you
2 recall anything?
3 **A.** Again, that's something I would ask but I don't recall
4 having that conversation.
5 **Q.** And do you recall any sort of specific requests from
6 Lionel Desmond about wanting to stay overnight in the hospital?
7 **A.** Yes. I believe he wanted to stay overnight in the
8 hospital because he didn't want to go home until the morning
9 because he wanted to follow what his wife had asked him.
10 **Q.** In this situation when you're dealing with Lionel
11 Desmond, does he come to the ER with anyone that you're aware of
12 that particular date?
13 **A.** No.
14 **Q.** To your knowledge, he was alone?
15 **A.** Yes.
16 **Q.** Now did that cause you to sort of evaluate things or
17 did you start to draw any inferences or any additional questions
18 as a result of him showing up alone?
19 **A.** I guess having collateral information is very helpful
20 in a situation like this. So I guess that contributed to my
21 decision of whether or not to manage him on my own or to involve
22 one of my colleagues in Psychiatry. So if I don't have any

1 collateral information as an emergency physician, someone's
2 alone, I'm much less likely to manage it on my own.
3 **Q.** So I understand that there's rules on patient-doctor
4 confidentiality. Would there ever be any sort of discussion
5 with, say, Lionel Desmond in this situation of saying, Are there
6 any supports of people you can talk to? Would you ever have
7 that conversation with him?
8 **A.** Oh certainly. And often I will specifically ask
9 someone if I can call their friend or family member to speak
10 with them. I don't recall, in this particular case, if I did or
11 not, but that's something I would routinely do because sometimes
12 they'll be just fine with that.
13 **Q.** And is there a reason why you would sort of ask the
14 patient, in Lionel Desmond's situation, Look, is there somebody
15 I can call? Speak to?
16 **A.** To get collateral information. Just to ... more
17 details to verify what he's saying like that. But if he says no
18 to me doing that, I can't.
19 **Q.** Obviously.
20 **A.** I can't call someone for confidentiality reasons.
21 Yeah.
22 **Q.** Clearly. But in a circumstance where, if somebody had

1 said to you, I am going to go home and I'm going to do this to
2 my wife, threaten violence, does that lift your veil of
3 confidentiality?

4 **A.** Yes, in that situation, yes.

5 **Q.** Okay. But there was no indication of that here.

6 **A.** No.

7 **Q.** There's a reference in these notes, as well, by you.
8 It says, "Followed by Dr. Slayter/Veterans Affairs." Do you
9 know, the reference to Dr. Slayter, do you know where that comes
10 from? Does that come from Lionel Desmond or does it come from
11 your exploration of MEDITECH?

12 **A.** I don't know for sure. I suspect it is from
13 MEDITECH.

14 **Q.** In terms of drugs or alcohol, just if I look at the
15 right side of your report, you see the line that says "Time
16 Seen"?

17 **A.** Yes.

18 **Q.** "Time Seen" and then all the way over to the right of
19 the page there is two, looks like zeros with lines drawn through
20 them.

21 **A.** Yes.

22 **Q.** What is that?

1 **A.** That mean no. So no ETOH, no alcohol.
2 **Q.** Yeah.
3 **A.** And no illicit drugs.
4 **Q.** So you would have specifically asked ...
5 **A.** Yes.
6 **Q.** ... Lionel Desmond? And would you have also sort of,
7 there was that self-reporting aspect, but would you have also
8 sort of, as a trained physician, look to see if there was any
9 sort of visible impairment?
10 **A.** Yes, certainly.
11 **Q.** And to your recollection, was there any sort of
12 visible impairment?
13 **A.** No.
14 **Q.** If we look down below the note that said, "Wife told
15 him don't come back until morning ../ until tomorrow," we see,
16 it looks like an O/E and what appears to be an NAD. What's
17 that?
18 **A.** So O/E is objective slash ... like I guess it means
19 what you're seeing, what you're observing, that section.
20 **Q.** Okay. And what is, is it "NAD"?
21 **A.** NAD. No acute distress.
22 **Q.** So what's the significance there, I guess, what are

1 you ...

2 **A.** So I guess the goal of the Emergency chart, in
3 general, it's a limited space, of course, is to paint an overall
4 picture of the patient. So that's a common phrase used to
5 describe someone who is sitting appropriately and answering
6 questions. They're not in any apparent distress.

7 **Q.** Okay. You went over, below that 0SI/HI, which is no
8 homicidal ideation or suicidal ideation?

9 **A.** Correct. And the, and, sorry, the "E",
10 objective/examination would be what the E stands for. Like the
11 whole O/E generally means what you're seeing.

12 **Q.** Okay. Below that appears to be the word speech and
13 something by it. What is that?

14 **A.** So that's speech with an N and a circle around it, so
15 that means normal. So his speech was normal.

16 **Q.** And what is below that?

17 **A.** No evidence of psychosis.

18 **Q.** So I guess Dr. Rahman is definitely the person that
19 speaks to psychosis but your understanding of ... What is
20 psychosis, what you are looking for as an ER doctor?

21 **A.** So I guess it's when someone is disconnected from
22 reality in some way, so it's sort of a spectrum. There are a

1 number ... So when you're trying to look for any evidence of
2 psychosis. During the interview you observe the patient, listen
3 to their answers to questions, observe the behaviour, to try to
4 get an overall sense if there's features of psychosis. So
5 there's different components, I guess, what they look like: for
6 example, are they taking care of themselves; what's the
7 behaviour, are they disorganized or erratic, aggressive;
8 something called thought content. Is there any suggestion of
9 hallucinations or delusions? Something called thought process -
10 are they, you know ... do the details of what they're telling
11 you make sense? Is it all logical? Does the story make sense?
12 So you're looking at all these different components during the
13 interview in order to come up with a final assessment of whether
14 there's any evidence of psychosis.
15 **Q.** And was there any suggestion of any of those present
16 with Lionel Desmond?
17 **A.** No. So when I document no evidence of psychosis, all
18 those components in the entire interview sort of goes into that
19 conclusion.
20 **Q.** Okay. You talk about, in your global assessment, of
21 no suicidal ideation, no homicidal ideation. When you look at
22 previous records, would that be something you would be looking

1 for in those past records, if there were?

2 **A.** Yes.

3 **Q.** Yes. And I realize and appreciate you're limited to

4 the information that's provided to you. Had you been aware that

5 there was any suggestion of past comments or threats of suicide

6 or even concerns in obsessions or delusions regarding his wife

7 ...

8 **A.** Um-hmm.

9 **Q.** Is that information that would have assisted you in

10 your assessment of Lionel Desmond in the ER?

11 **A.** Yes.

12 **Q.** And in what way?

13 **A.** So, I mean, if you go through the risk factors for

14 suicide, a previous attempt or ... That's one of the risk

15 factors. So generally on my ... Typically, I would, at the end

16 of seeing a patient, if I were to manage the patient on my own

17 and discharge them from the Emergency Room, for example, I would

18 have a lot of things on this chart that aren't present. So that

19 portion is where I would typically list specific risk factors

20 and protective factors. So I may have been aware ... I don't

21 recall what I found from those charts, but that's something that

22 I would typically include in if I were the one coming up with a

1 management plan.

2 **Q.** Okay.

3 **A.** In this particular case I had consulted Dr. Rahman,
4 and there's a transfer of care there, and I wasn't present
5 during the final management plan.

6 **Q.** That's fine.

7 **A.** I guess those details would be something I would
8 typically include when I document the plan.

9 **Q.** And when you're asking the questions, assessing those
10 two concepts, you know, Do you have any thoughts of harming
11 yourself, Do you have any thoughts of harming others, is there a
12 question that, Did you recently threaten to harm yourself or Did
13 you recently in the past threaten to harm others, is that a
14 series of questions you ask?

15 **A.** Yes, it would be part of the interview, asking about,
16 I guess, at any time.

17 **Q.** And you would have asked those of Lionel Desmond, I'm
18 presuming?

19 **A.** Yes, yes.

20 **Q.** So back to sort of testing the validity of the
21 caution, I guess, with patients and what they're telling you, if
22 you were aware of a document that had said in the recent past he

1 had threatened to harm himself and the specifics of what he said
2 he would do ... And his answer in this case was no, I'm
3 presuming?
4 **A.** Yes.
5 **Q.** And so they, on its face, would appear to contradict
6 each other?
7 **A.** Yes.
8 **Q.** So he says no to you, that he hasn't threatened harm
9 to himself, but there's a chart out there that says he did and
10 you weren't aware, I presume, at the time, how would your
11 approach differ if you were aware of a chart that contradicted
12 your patient?
13 **A.** That would make me more concerned and it would make
14 me more likely to consult a colleague in Psychiatry.
15 **Q.** And convey that information?
16 **A.** Yes.
17 **Q.** And that, certainly, if you came across that
18 information, is that, and when you did your consult to
19 Psychiatry is that information that you would have conveyed and
20 said, look, he told, I guess this scenario, He told me that he
21 didn't threaten harm to himself in the recent past, but there is
22 a chart out there that we know that he did?

DR. JUSTIN CLARK, Direct Examination

1 **A.** I don't know for sure; possibly.
2 **Q.** Okay.
3 **A.** Yeah.
4 **Q.** And did you ever get a sense - I just want to be
5 clear. During your interview with Lionel Desmond or assessment
6 of Lionel Desmond on January 1st, at any point did you get any
7 sort of indication that he was being misleading or untruthful
8 with you?
9 **A.** No.
10 **Q.** And turning now to your consult, Doctor, if we look
11 below your note about psychosis, we see, above Diagnosis, what
12 is that? It's a little squiggly ...
13 **A.** So A/P, so that's assessment and plan.
14 **Q.** Okay. That is your assessment and plan?
15 **A.** So that, if I were the one who came up with his final
16 management plan and disposition, that's where I would write it.
17 So I guess my plan from that point on was to consult the
18 psychiatrist.
19 **Q.** And ...
20 **A.** So that's ... So the next line with the Psy symbol is
21 sort of short form for Psychiatry. So that just means Psych to
22 see, so Psychiatry is going to come assess the patient.

DR. JUSTIN CLARK, Direct Examination

1 **Q.** So I guess based on the totality of the information
2 you had received from Lionel Desmond and the totality of the
3 circumstances, you made the determination that you felt it
4 necessary to consult ...
5 **A.** Yes.
6 **Q.** Psychiatry. I'm wondering if you could indicate ...
7 Obviously, you were the one that made that judgment call.
8 **A.** Um-hmm.
9 **Q.** What led you to say, Okay, I've assessed him, I
10 gathered the information, I've looked at everything, Psychiatry
11 needs to be consulted? From your ER doctor perspective, what
12 were the reasons for that in Lionel Desmond's case?
13 **A.** So as an Emergency physician I see a lot of mental
14 health complaints. I'm obviously not an expert, so I have a low
15 threshold to involve my colleagues to begin with. In this case,
16 like I said previously, there was no collateral information, so
17 that was one of the factors going into not feeling comfortable
18 managing it on my own. Also, I don't have a lot of experience
19 treating young veterans with PTSD. Like I said before, it's not
20 a common complaint that we deal with. So for those reasons I
21 wanted to call Dr. Rahman.
22 **Q.** Okay. And looking to the right of that last thing

1 you identified, the Psy symbol, "To See" ... Consultation
2 appears to be checked off?
3 **A.** Correct.
4 **Q.** And again is that the same symbol?
5 **A.** Yes.
6 **Q.** Psychiatry. So what time was the consult requested?
7 **A.** So at 7:30, 19:30.
8 **Q.** So just sort of doing some math here, I guess, to get
9 a sense of the time you're ... It's ... 19:10 is when you enter
10 the room with Lionel Desmond?
11 **A.** Correct, 19:09.
12 **Q.** 19:09, sorry. And 19:30 is the consult requested?
13 **A.** Yes.
14 **Q.** So is 19:30 ... does that denote sort of your end of
15 contact with Lionel Desmond?
16 **A.** Yes.
17 **Q.** So you see Lionel Desmond for 21 minutes, I believe?
18 **A.** Correct.
19 **Q.** So Dr. Rahman, do you recall if he was readily
20 available for the consult?
21 **A.** He's always readily available by phone.
22 **Q.** Do you recall if he was by phone or in person, what's

1 your recollection?

2 **A.** I called him, initially. I believe, I can't remember

3 for sure, but I believe I called him.

4 **Q.** Do you remember speaking to him in person or ...

5 **A.** I did speak to him in person, as well.

6 **Q.** All right.

7 **A.** Yeah.

8 **Q.** And do you recall what sort of information you might

9 have provided to Dr. Rahman about Lionel Desmond and the reason

10 for your consult?

11 **A.** I don't recall the conversation we had over the phone

12 or prior to him seeing him.

13 **Q.** But you did ...

14 **A.** But I would have communicated ... I suspect I would

15 have communicated the details of my note here and told him I was

16 uncomfortable managing it on my own.

17 **Q.** And did he sort of agree to assist?

18 **A.** Oh, yeah.

19 **Q.** So once it's sort of turned over, I guess, to Dr.

20 Rahman, the consult at 19:30, we see a time on the left, just

21 below ...

22 **A.** 19:32.

1 **Q.** Yeah. So what's the significance of 19:32?
2 **A.** So 19:32 was probably the time I signed the bottom of
3 the chart and it was so the chart was complete. So it was
4 shortly after I called Dr. Rahman.
5 **Q.** And do you have any further contact with Lionel
6 Desmond past 19:32?
7 **A.** No.
8 **Q.** And at that point it's, I guess, turned over to Dr.
9 Rahman?
10 **A.** Yes.
11 **Q.** I'm going to show you, for the sake of completeness,
12 a piece of legislation - you may have it in front of you -
13 called the **Involuntary Psychiatric Treatment Act**, and on the top
14 left-hand corner you'll see the page numbers.
15 **A.** Yeah.
16 **Q.** So, in particular, I want to look at page 6, section
17 8 of the **Act**. It says "Medical Examination and Involuntary
18 Psychiatric Treatment", you see that?
19 **A.** Yes.
20 **Q.** And it says certificate for involuntary assessment.
21 **A.** Yes.
22 **Q.** Section 8.

1 **A.** Yeah.

2 **Q.** So, Doctor, you're somewhat familiar with that **Act**?

3 **A.** Yes.

4 **Q.** I guess ... I understand you might not know it front
5 to back, but the concepts that are conveyed in that particular
6 **Act**?

7 **A.** Yes, and this particular paragraph is on a form that
8 I have routinely completed at times.

9 **Q.** Okay. So that form, it's in relation to what? I
10 understand patients can be voluntary or involuntary and just
11 generally what are those concepts?

12 **A.** So if someone presents and they have certain symptoms
13 or they're telling me certain things and then they want to
14 leave, you have the ability to hold them in the hospital, I
15 guess, against their will, if they meet these certain criteria.

16 **Q.** And ER doctors, I guess, play a role in, could I say
17 initiating that process, where it's relevant?

18 **A.** Yes. It wouldn't be uncommon for someone to want to
19 leave and to need to fill out a form in order to have them stay.

20 **Q.** And in the particular case of Lionel Desmond, in your
21 ... This form, I guess, before we get to that, so this form you
22 complete, which is under section 8 of the **Act**, what generally is

1 that form and what's its purpose?
2 **A.** So the purpose is once the form is filled out the
3 patient's not allowed to leave until they're assessed by a
4 psychiatrist. So you have the ability to physically keep them
5 there. Now sometimes people leave because you can't physically
6 keep them and, if that's the case, we call the police and they
7 bring them back. So it forces the person to have an assessment.
8 **Q.** By a psychiatrist?
9 **A.** By a psychiatrist.
10 **Q.** Okay. So in this particular case, if we look at
11 section 8, it says, "Where a physician has completed a medical
12 examination of a person and is of the opinion that the person
13 apparently has a mental disorder ..." So was that the case in
14 Lionel Desmond's circumstances, that first little bit?
15 **A.** Yes, the patient had known mental health disorders.
16 **Q.** And then it says, " ...the person, as a result of the
17 mental disorder, (I) is threatening or attempting to cause
18 serious harm to himself or herself or has recently done so, has
19 recently caused serious harm to himself or herself, is seriously
20 harming or is threatening serious harm towards another person or
21 has recently done so ..." So in Lionel Desmond's case was there
22 a suggestion that that was present?

DR. JUSTIN CLARK, Direct Examination

1 **A.** No, there was no suggestion.
2 **Q.** And below it it says, Or, so there's another
3 scenario, "As the result of the mental disorder, the person is
4 likely to suffer serious physical impairment or serious mental
5 deterioration, or both." Was there a suggestion that that may
6 be the case here?
7 **A.** There was no suggestion of that.
8 **Q.** And then it says, "(b) the person would benefit from
9 psychiatric inpatient treatment in a psychiatric facility and is
10 not suitable for inpatient admission as a voluntary patient."
11 So in the case with Lionel Desmond was he willing to see a
12 psychiatrist?
13 **A.** Yes.
14 **Q.** So was there any suggestion that you needed to hold
15 him there or force him there to undergo that assessment ...
16 **A.** No.
17 **Q.** ... with the psychiatrist?
18 **A.** No.
19 **Q.** And, again, so was there any suggestion that you ...
20 there was a need to fill out that form to hold him there, I
21 guess, involuntary?
22 **A.** No.

1 **Q.** And had certain circumstances existed as such, say,
2 if Lionel Desmond had not wanted ... he was, you know, in a
3 manic state, he was a threat to himself or others, not wanting
4 to undergo an assessment by a psychiatrist, in such a
5 circumstance, would you perhaps have considered, under this **Act**
6 and under that form, making, holding him for the purposes of a
7 psychiatric assessment?
8 **A.** Yes, in that circumstance, I would have.
9 **Q.** But there was no need here?
10 **A.** No.
11 **Q.** So were you present ... I know you indicated you
12 turned everything over to Dr. Rahman. At any point were you
13 present during Dr. Rahman's assessment or meetings with Lionel
14 Desmond?
15 **A.** In the room?
16 **Q.** Yes.
17 **A.** No.
18 **Q.** Do you recall, have any recollection as to where
19 Lionel Desmond stayed that particular night on January 1st?
20 **A.** I do recall a conversation with Dr. Rahman about
21 where he would spend the night.
22 **Q.** So if you could tell us a little bit about how that

1 conversation came about and what the conversation was about.
2 **A.** Okay. So like I said before, typically, a patient
3 with a mental health issue seen by a psychiatrist or waiting to
4 be seen by a psychiatrist would go to the Psychiatry ward. In
5 this case, Dr. Rahman told me that the patient didn't want to go
6 to the Psychiatry ward because his wife had friends who worked
7 there, so he felt uncomfortable. So Dr. Rahman asked if it was
8 appropriate or okay for him to stay in the observation area
9 overnight.
10 **Q.** And when you say his wife had friends that worked
11 there, was there any discussion about whether Shanna Desmond, in
12 fact, Lionel Desmond's wife, had, in fact, worked there, do you
13 remember?
14 **A.** I'm aware of that. I don't recall the conversation.
15 **Q.** Okay. So is that something you were willing to
16 accommodate, that request?
17 **A.** Certainly. I think it was more of a courtesy. To me
18 ... it wouldn't be up to me, I think, but it was a reasonable
19 thing.
20 **Q.** Okay.
21 **A.** Again, it wasn't in an Emergency Room bed, he wasn't
22 taking a bed that we would have been seeing patients in the

1 Emergency Room. There was an observation area and it was under
2 the care of him. So for me, there was no difference between the
3 observation area and the Psychiatry ward. So if it made the
4 patient more comfortable, then, then that was just fine.
5 **Q.** So he was separate and apart and away from sort of
6 the ER traffic?
7 **A.** Yes.
8 **Q.** Over in Observation?
9 **A.** Yes.
10 Q. And did you have any interactions with Lionel Desmond
11 or recall seeing him over in that observation area?
12 **A.** No.
13 **Q.** No. And in your experience, has that sort of
14 scenario ever happened before when you were working in the ER?
15 **A.** Not that I can recall. Do you mean just someone
16 being in the observation area waiting or the situation where
17 they don't want to go maybe to the ...
18 **Q.** A situation where normally they would go to another
19 area in the hospital but there's a request to keep them in an
20 ER?
21 **A.** No, no other request that I can recall. Sometimes
22 out of ... There's no bed available. That would be the only

1 other time.
2 **Q.** Do you recall when your shift, roughly, ended that
3 particular evening?
4 **A.** So my shift ended at 8 p.m. I don't recall when I
5 actually left. It wouldn't be uncommon to stay for half an hour
6 to an hour or more to finish up with patients.
7 **Q.** Were you involved to any degree in Lionel Desmond's
8 ultimate discharge from the hospital?
9 **A.** No.
10 **Q.** I'm just going to ask you briefly if you have an
11 understanding of the concepts of formal admission of a patient
12 and what's maybe loosely referred to as a social admission and
13 I'm wondering if you could discuss what they are and define
14 those concepts for us.
15 **A.** So a social admission refers to when someone is
16 either admitted or stays in the hospital but there's no
17 indication medically for them to be there.
18 **Q.** And in your experience had you, as an ER physician,
19 had someone there as not formally admitted but there as a social
20 admission?
21 **A.** It happens frequently. Probably the most common
22 example would be someone who's homeless who comes in at

1 nighttime and, for example, if they have chest pain, after
2 they're worked up for their chest pain and it's determined that
3 they're discharged, you know, it's night, it's winter, and they
4 have nowhere to go, no shelter, we'll often hold them overnight
5 to be discharged in the morning.
6 **Q.** And when they're held overnight is it your
7 understanding that they still receive sort of nurse observation,
8 medication ...
9 **A.** Yes.
10 **Q.** ... regular care?
11 **A.** Yes.
12 **Q.** Is there any, in practical terms, is there any
13 distinction between the two other than one is sort of
14 accommodating someone that doesn't have a place to go?
15 **A.** It really just means there's no ... there's some
16 other reason other than a medical or psychiatric reason to keep
17 them in the hospital. They would otherwise be discharged but
18 there's usually a social factor that you accommodate.
19 **Q.** Okay.
20 **A.** That's the distinction I would have between those two
21 terms.
22 **Q.** Okay. And finally, Doctor, I'm going to ask you

1 some broad questions, I think it really is a prime opportunity,
2 and certainly feel free to share. I recognize to some degree,
3 as best I can, the stressors on ER doctors in Nova Scotia, the
4 valuable service you provide and how busy ER doctors are and how
5 vital they are to Nova Scotia. In situations such as this, and
6 what I'm driving at is in situations where patients appear in
7 the ER in some form of mental crisis and they're seeking
8 treatment, do you see any sort of, and in particular, this sort
9 of scenario, improvements or elements that can be made to assist
10 ER doctors, from your practical experience?
11 **A.** I would say it would be beneficial to have access to
12 social workers or a crisis worker outside of daytime hours. I
13 think that would be of benefit.
14 In this particular case I think ... I believe the patient
15 presented at just before 7 p.m. and he saw a psychiatrist at 8
16 p.m. So that's very fast. I would say that's not typically
17 what would happen. Typically, patients will wait hours, and
18 usually they wouldn't be seen by a crisis worker or a
19 psychiatrist until the following day, if they presented in the
20 evening. But generally speaking, from the different emergency
21 rooms I've worked with, I think having more resources outside
22 daytime hours, with crisis teams and social workers, would be

1 would be beneficial.

2 **Q.** Okay. Anything else in terms of records and patient

3 history that may be helpful?

4 **A.** I mean any way that we can get more information

5 quickly is going to help.

6 **Q.** And anything in terms of ... It's a very difficult

7 task that you have when you're trying to evaluate risk of

8 suicide and homicide and it's a very pressured environment, it's

9 a very fast environment. Are there any sort of things you think

10 could help ER doctors to make their roles easier or more

11 complete?

12 **A.** I think resources or CME opportunities, those are

13 always a good thing for any area, especially if there's any

14 changes that are happening in the literature. So it's important

15 to stay up to date. So any opportunities that would allow us to

16 stay up to date would be good.

17 **Q.** What's CME?

18 **A.** Continuing Medical Education. So, I mean, it's a

19 broad term ...

20 **Q.** Yes.

21 **A.** But sometimes there'll be, for example, someone, an

22 internist in a hospital may do a talk on heart failure and

1 update all the physicians and you can get CME credit for that.
2 So those happen for all sorts of different topics. So a CME
3 talk from a psychiatrist on some of these issues - and they
4 certainly are happening now - but I think would be beneficial,
5 they're always beneficial.
6 **Q.** Okay. And just back to one of the topics you
7 brought up about having access to sort of a social worker, did
8 you say sort of an outreach?
9 **A.** So there's something called a crisis worker in every
10 hospital that I work in, and they will often come assess the
11 patient prior to the psychiatrist. But this usually happens
12 during daytime hours. So it may be beneficial to have ... and
13 the crisis worker is ... I don't know their specific
14 credentials, but they're often a social worker. And so it's
15 helpful to have them present because they will do their own
16 assessment of the patient.
17 **Q.** Just so ... maybe deal with the aspects of
18 homelessness or where they're going to go, sort of ...
19 **A.** Certainly.
20 **Q.** ... day-to-day life stressors.
21 **A.** Certainly. And then they also do a full comprehensive
22 assessment. And they're very experienced with that sort of

1 thing, assessing risk and other things, as well.

2 **Q.** And, in your experience, are they available after

3 hours, let's say, after ...

4 **A.** No.

5 **Q.** No. Okay.

6 **A.** They're not available after dinnertime.

7 **Q.** No further questions for Dr. Clark. Thank you, Dr.

8 Clark.

9 **MS. WARD:** No questions, Your Honour.

10 **THE COURT:** Ms. Ward? Mr. Anderson?

11 **MR. ANDERSON:** No questions, Your Honour.

12 **THE COURT:** Thank you. Mr. Macdonald?

13 **MR. MACDONALD:** Thank you, Your Honour.

14

15 **CROSS-EXAMINATION BY MR. MACDONALD**

16

17 **MR. MACDONALD:** Good afternoon, Dr. Clark. I'm Tom

18 Macdonald and I'm the lawyer for the Borden family, so the late

19 Mrs. Desmond and also co-counsel with Tara Miller for Aaliyah

20 Desmond. So I just have a few questions. I'm going to hop

21 around just a little bit. And if I ask you a question and you

22 think I've phrased it that you do not understand or unfairly to

1 you, please tell me and we'll move on from there.
2 So just a question about the access to medical records you
3 would have had, taking you back to January 1st and 2nd of 2017.
4 So we know about the electronic system that was available to you
5 at St. Martha's. When you choose to look at that then, or even
6 today, how long would it take you to actually call up records?
7 Not asking how long it would take you to read them but to bring
8 the file ... the electronic file up. How do you do it and how
9 long would it take to do it?
10 **A.** It would take maybe ten seconds to sign in.
11 **Q.** Okay.
12 **A.** You sign in on a computer.
13 **Q.** Yes.
14 **A.** It would take ten seconds. You click on a tab where
15 all the documents are and then you can start to look through
16 them.
17 **Q.** Okay. You mentioned in a question with Mr. Russell,
18 sometimes patients who are presenting with mental issues don't
19 answer questions. Did Lionel Desmond refuse to answer any
20 questions?
21 **A.** No.
22 **Q.** Just a clarification. At St. Martha's, Psychiatry, is

1 that on the third floor and sort of known colloquially as "the
2 third floor"? Is that where the psychiatric unit is?
3 **A.** I believe so. I've only been there one time, so I
4 don't know for sure.
5 **Q.** And so was the one time when you saw Lionel Desmond or
6 ...
7 **A.** No.
8 **Q.** No, with ... another time. Okay. Understood.
9 So back to the triage questions and the intake. And you
10 explained, at least for my benefit, the scoring system one to
11 five. One is a heart attack, a true emergency; five is a
12 sprained ankle. Lionel Desmond was a two. In the St. Martha's
13 scheme of things in terms of triaging, that's pretty serious,
14 isn't it? It's just below a full-blown emergency. Is that
15 fair?
16 **A.** So the triage system is the same ... my understanding,
17 it's the same everywhere in Canada.
18 **Q.** Okay.
19 **A.** Not just St. Martha's. And triage level two suggests
20 that the patient should be seen soon. That may be for various
21 reasons.
22 **Q.** The notes on the chart with respect to situational

1 crisis ... and I ... in response to Mr. Russell, you mentioned
2 some factors. And I think ... at least as I was taking down
3 that ... I don't pretend the list is exhaustive; police
4 involvement, alcohol and drugs, a fight, for example. But one
5 of those factors would be domestic violence, wouldn't it?
6 **A.** Certainly.
7 **Q.** And of ...
8 **A.** Yeah. Any ...
9 **Q.** Yes.
10 **A.** ... altercation or ... yes.
11 **Q.** And on the chart we see the notation, "argue with
12 partner". Right?
13 **A.** Correct.
14 **Q.** Yeah. Would that, for you, raise the level two at all
15 or the immediacy of seeing someone?
16 **A.** So I do not ... as part of my job, I do not triage ...
17 **Q.** Right.
18 **A.** ... patients. So it's hard for me to comment on how
19 ... I know that they have objective criteria that they use and
20 there's also some component that's subjective criteria they can
21 use to change the score.
22 **Q.** Okay.

1 **A.** But I don't do that as part of my job, so it's hard
2 for me to comment on the specific score.
3 **Q.** Understood. So I just wanted to be clear. And I know
4 Mr. Russell was taking you through the electronic records. And,
5 I'm sorry, what was the name again? MEDITECH?
6 **A.** MEDITECH.
7 **Q.** MEDITECH. So can you say today with any clarification
8 that ... and I don't need you to look at the records unless you
9 need to. But the chart that came up, we know there was an
10 October 2016 visit by Mr. Desmond. Dr. Slayter saw him. We
11 know there was a December 2nd or 3rd. The report is there.
12 Prepared an analysis, I guess, prepared by Dr. Slayter. Can you
13 say with any certainty today whether those two documents I refer
14 to would have been on the MEDITECH system the night you went to
15 the computer at St. Martha's?
16 **A.** So I don't recall ...
17 **Q.** Right.
18 **A.** ... the visit that was documented on an emergency room
19 chart.
20 **Q.** Yes.
21 **A.** I believe it would be present in MEDITECH. And,
22 sorry, what was the second ...

1 **Q.** And the second would have been this December 2016
2 assessment, that Dr. Slayter saw Mr. Desmond the second time and
3 completed a lengthy psychiatric assessment.
4 **A.** That one would be from his private clinic.
5 **Q.** Yes, but I think it was at ... the letterhead, as I
6 understand it, has St. Martha's Hospital on it so maybe the
7 clinic was at the hospital.
8 **A.** Right. I don't recall seeing that document.
9 **Q.** Okay.
10 **A.** And in my experience, I've never seen a psychiatric
11 clinic note present in MEDITECH.
12 **Q.** Okay. If it turns out ... and I don't know the answer
13 to give you today, but if it ... so I'm not trying to trick you.
14 But if it turns out that it was on the MEDITECH system, you'd
15 agree with me it would have been available for you to read if
16 you chose to do so ...
17 **A.** Oh, certainly.
18 **Q.** ... and if you'd seen it.
19 **A.** Yes.
20 **Q.** Thank you.
21 **A.** And that would have been a document I would certainly
22 read.

1 **Q.** Understood.
2 **A.** Yeah.
3 **Q.** And you called Dr. Rahman and spoke with him on the
4 telephone. Dr. Rahman is present here today, listening to your
5 evidence, isn't he?
6 **A.** Yes.
7 **Q.** He's seated in the gallery over here?
8 **A.** Yes.
9 **Q.** Yes. Okay. You mentioned about ... and I think Mr.
10 Russell put it, I guess, the way I would, weapons, firearms, and
11 then the word "guns" came into it or if not, I'll use it. Do
12 you have ... and you said, I believe, that that was normally
13 something you would ask about.
14 **A.** Yes. It would be a typical question.
15 **Q.** Exactly. Do you have a specific recollection that you
16 asked Mr. Desmond anything about guns on January 1st?
17 **A.** I don't have a specific recollection. No.
18 **Q.** And I know you said that it might have been a typical
19 question you would ask about access to guns.
20 **A.** Correct.
21 **Q.** Would you also ask if someone had possession of a gun?
22 **A.** Yes.

DR. JUSTIN CLARK, Cross-Examination by Mr. Macdonald

1 **Q.** And so you ...
2 **A.** The ...
3 **Q.** ... understand where I'm coming from, "access" means
4 ...
5 **A.** Correct.
6 **Q.** ... I can get my father's gun. "Possession" means
7 I've got my own gun or ...
8 **A.** I would start with asking if they have their own guns
9 in their home.
10 **Q.** Okay.
11 **A.** And then I would progress to ask do they have access
12 in any way ...
13 **Q.** Understand.
14 **A.** ... from a friend, from ...
15 **Q.** Okay.
16 **A.** ... another family member.
17 **Q.** Is there any reason ... if that's something you think
18 you would have done with Mr. Desmond, why wouldn't it be
19 somewhere noted on the chart?
20 **A.** Like I mentioned before, I would typically include
21 that ... a detailed risk assessment, risk factors, protective
22 factors. I would include those things with my management plan

1 ...

2 **Q.** Yes.

3 **A.** ... kind of at the bottom of my chart. So because I
4 wasn't ... I consulted the patient to see a psychiatrist, so I
5 wasn't present and didn't come up with any management plan. So
6 that's why that documentation isn't there. So that risk
7 assessment, plus a lot of other things like medication changes,
8 follow-up plan and return precautions, all of these things would
9 be included sort of in my management plan area.

10 **Q.** Okay.

11 **A.** But I didn't have a management plan.

12 **Q.** I ... okay. And I hear you. Thank you. If you had
13 asked ... and you say you did, so I don't mean anything by the
14 "if". But if you asked Mr. Desmond whether he had access to a
15 gun or possessed a gun and he said yes, would that be something
16 you would note even though you know you're going to refer it on
17 to a psychiatrist for management? Would you have noted that in
18 the chart if he said, Yes, I do.

19 **A.** I may have.

20 **Q.** Okay.

21 **A.** Yeah.

22 **Q.** Yeah.

1 **A.** Hard to say for sure.
2 **Q.** Those are my questions, Dr. Clark. Thank you very
3 much.
4 **THE COURT:** Mr. Rogers?
5
6 **CROSS-EXAMINATION BY MR. ROGERS**
7
8 **MR. ROGERS:** Dr. Clark, my name is Rory Rogers and I'm
9 one of the counsel for the Nova Scotia Health Authority. You
10 talk in your testimony about availability of psychiatrists in
11 various institutions. Can I focus your attention on St.
12 Martha's? St. Martha's does have psychiatry services available?
13 **A.** Correct.
14 **Q.** So when you're providing ER shifts at St. Martha's, if
15 you feel the need or benefit for a psychiatric consult, that's
16 something that's available to you.
17 **A.** Yes.
18 **Q.** And so that can be done by referring or consulting
19 with the psychiatrist who happened to be present in the hospital
20 when they are present. Correct?
21 **A.** Correct.
22 **Q.** And at other times there's a phone system, an on-call

1 system, so that 24/7 you have access to psychiatric services?
2 **A.** Correct.
3 **Q.** And in this case, the psychiatric services were
4 provided and were made available to you by and through Dr.
5 Rahman. Correct?
6 **A.** Correct.
7 **Q.** And what can you say about the timeliness of Dr.
8 Rahman's response and availability with respect to the consult
9 you sought for Mr. Desmond?
10 **A.** I could say it was very good. It wouldn't be typical.
11 Dr. Rahman is usually very willing to come assess patients
12 himself. Certainly not typical for a psychiatrist to assess a
13 patient at nighttime in any of the hospitals I work in.
14 **Q.** Okay. So when you say "not typical", this was gold
15 standard delivery of psychiatric services by ...
16 **A.** Uh-huh.
17 **Q.** ... Dr. Rahman in terms of timeliness and his
18 willingness to spend time with Dr. ... or with Mr. Desmond?
19 **A.** Yes.
20 **Q.** Thank you. You made reference to the triage record
21 that's part of the chart that's available to you when you have
22 time to assess a new patient who comes in to Emerg. Correct?

1 **A.** Correct.
2 **Q.** And I think that's found at page 33 of Exhibit 67?
3 **A.** (No audible response.)
4 **Q.** So this is the triage record that you typically have
5 as part of the chart together with the list of meds when you
6 determine you're able to see somebody who has been triaged.
7 Correct?
8 **A.** Correct.
9 **Q.** And you see here that the reference was to triage
10 level two. Correct?
11 **A.** Yes.
12 **Q.** Is it fair to characterize this triage assessment as
13 largely a means and a mechanism for the hospital to prioritize
14 those individuals who come into the hospital and who are in the
15 waiting area seeking treatment?
16 **A.** Correct.
17 **Q.** So that you know if you have somebody who comes in who
18 needs urgent treatment, they're going to be given a triage level
19 score higher so it gets them through the door to see you or one
20 of your colleagues faster. Correct?
21 **A.** Correct.
22 **Q.** Because the goal is to say who needs to see a

1 physician earliest among our group who's in the waiting room or
2 who has arrived. Fair?
3 **A.** Exactly.
4 **Q.** And the assessment note, that's the note that we see
5 under the heading that says "Triage Assessment"?
6 **A.** (No audible response.)
7 **Q.** And that's typically entered by the triage nurse who
8 does that quick three-, four-, five-minute triage assessment.
9 Fair?
10 **A.** Correct.
11 **Q.** In your evidence earlier, Dr. Clark, you said that the
12 triage scale affects the timing of your assessment.
13 **A.** Correct.
14 **Q.** So is it ultimately your assessment as an emergency
15 room physician that really is the determining factor as to what
16 the diagnosis will be or what the treatment will be? You're not
17 relying upon the triage assessment to supplant what you're doing
18 as the physician in treating ... an emergency room physician.
19 Is that fair?
20 **A.** Sorry. Could you phrase that again?
21 **Q.** Sure. So when someone comes in to see you, you're
22 doing your own assessment as a physician. Correct?

1 **A.** Correct.

2 **Q.** And you're not relying upon the triage assessment
3 solely as identifying the assessment for a patient. Correct?

4 **A.** Umm ...

5 **Q.** It's information available to you but it doesn't take
6 the place of your assessment. Fair?

7 **A.** No, it does not take the place of my assessment.

8 **Q.** Okay. You described briefly the number of beds in the
9 Emergency Department at St. Martha's and then the observation
10 area. I just want to go through that a little bit. You talked
11 about the fact that there are 10 to 12 beds in the Emergency
12 Department at St. Martha's. Correct?

13 **A.** Correct.

14 **Q.** But over and above that there are rooms available that
15 I think you described, in part, as the family room and I believe
16 now may have changed its term to an interview room ...

17 **A.** There's two such rooms at St. Martha's.

18 **Q.** Okay. So let's take it to the January 2017 period.
19 There was a family room that was less clinical in nature and had
20 solid walls and a couch and nice chairs. Correct?

21 **A.** Correct.

22 **Q.** And your understanding is that mental health patients

1 were often taken to that room because it's more private?
2 **A.** It's more private and more comfortable. Yeah.
3 **Q.** And more comfortable in what way?
4 **A.** Well, sitting on a couch rather than on an examination
5 bed.
6 **Q.** Okay. Fair enough. And so that's where you saw Mr.
7 Desmond on the night of January 2nd. Correct?
8 **A.** Correct.
9 **Q.** Okay. Then over and above ... and just to talk about
10 changes that have been put in place, I understand that that room
11 has now moved but there are two interview rooms or more-quiet,
12 more-personal, less-clinical rooms available in St. Martha's
13 Emergency?
14 **A.** So the room I saw Mr. Desmond in was an interview room
15 at that time and it is still, currently. That room hasn't
16 changed. I think you might be referring to they added a second
17 one.
18 **Q.** Okay.
19 **A.** I'm not sure when that took place.
20 **Q.** Fair enough. So there's now two of those rooms
21 available to deal with or interview folks presenting with any
22 mental health issues. Fair?

1 **A.** Correct.

2 **Q.** Okay. And over and above that, you talked about the
3 observation area. And is that area slightly separate and
4 distinct from the 10 to 12 emergency room beds ...

5 **A.** Yes.

6 **Q.** ... that you referred to?

7 **A.** Yes.

8 **Q.** And that area of the observation that I think you
9 described as five or six beds, is it fair to say it's an area
10 that's shared between what's referred to in St. Martha's as the
11 observation area as well as Clinical Decision Unit beds or CDU
12 beds?

13 **A.** Correct.

14 **Q.** So those two areas are really short-term beds for
15 people who have left the emergency room beds but are waiting for
16 determination as to whether they will be discharged or admitted
17 to the hospital on a floor.

18 **A.** Correct.

19 **Q.** Okay. And in the observation beds, that's your
20 understanding that Mr. Desmond was moved to one of those
21 observation beds.

22 **A.** That's my understanding. Yes.

DR. JUSTIN CLARK, Cross-Examination by Mr. Rogers

1 **Q.** And I think that the Inquiry may have heard evidence
2 earlier that suggested that there was second- or third-hand
3 information that Mr. Desmond was left on a stretcher somewhere
4 in the hospital. And we've all heard some press reports of that
5 example. But the beds in the observation area of the Clinical
6 Decision Unit area, those aren't stretchers. Those are normal
7 full hospital beds. Correct?
8 **A.** I'm not sure.
9 **Q.** Okay. You talked a bit, Dr. Clark, about the records
10 access and what you had available to you electronically to
11 review as part of your assessment of Mr. Desmond. You're aware
12 that the Nova Scotia Health Authority is looking at and aiming
13 at something called "one patient/one record"?
14 **A.** Yes.
15 **Q.** And what's your understanding as to what that would
16 then make available to physicians such as yourself in an
17 emergency department when a patient presents?
18 **A.** So my understanding is that it would be an electronic
19 medical record that would capture every interaction ... every
20 healthcare interaction in the province in one EMR.
21 **Q.** Okay. So that would cover ...
22 **A.** That's my understanding.

DR. JUSTIN CLARK, Cross-Examination by Mr. Rogers

1 **Q.** ... all the hospitals of the Nova Scotia Health
2 Authority as well as private family physicians, as well.
3 **A.** I would assume. I don't know for sure. I've just
4 read some about it and that's the only ...
5 **Q.** Okay.
6 **A.** ... place I got information.
7 **Q.** You indicated in addition to looking typically at what
8 information you'd have available in terms of a medical history
9 before you see a patient that there are examples and situations
10 where you have thought it beneficial to seek information of a
11 medical nature from another province. Correct?
12 **A.** Correct.
13 **Q.** And I assume ... and then you said that in those cases
14 you would have someone from the clerical side of the hospital
15 make the inquiry in an attempt to have those records faxed to
16 you. Correct?
17 **A.** Correct.
18 **Q.** And I think you said that, typically, there can be
19 restrictions on that through the evening hours but that that's
20 something that can be available through the day. Correct?
21 **A.** Correct.
22 **Q.** So would it be fair to say you make a judgement call

1 each time that you learn that there may be records in another
2 jurisdiction, in another province or another country? You make
3 a judgement call as to whether those records would be helpful
4 and necessary for you as part of your treatment?
5 **A.** Yes. I would determine if they were relevant for
6 treating the patient's acute issue. The example I gave of
7 someone having a history of cardiac disease, if you had no
8 information whatsoever, then some records would be important.
9 **Q.** Okay. But that's a judgement call you make all the
10 time. And you don't request those records from every other
11 provincial jurisdiction every time you see a patient, do you?
12 **A.** No, certainly not. It would be fairly uncommon.
13 Typically, it would be when I have no information at all.
14 **Q.** Okay. You talked a little bit earlier in response to
15 some questions Mr. Russell put to you as to what recommendations
16 or suggestions you might have for change. And you made
17 reference to potential benefit of increasing the hour
18 availability of what you called the "crisis team". At St.
19 Martha's, that's the Mental Health Crisis Team. That's a
20 service available to emergency room physicians. Correct?
21 **A.** Correct.
22 **Q.** So if you see a need for a mental health assessment to

1 be undertaken as part of the work you're going to be doing, you
2 have the ability to refer those patients to Mental Health Crisis
3 at St. Martha's. Correct?
4 **A.** Correct.
5 **Q.** And, to be fair, I think you indicated you weren't
6 sure exactly the background of the first line of the workers who
7 would assess. You believe there would be some social workers.
8 Are there, to your knowledge, also some nurses with some special
9 training in mental health issues that perform that service?
10 **A.** I mean that makes sense but I don't know of any,
11 personally, that I know that are nurses. I'm not aware of any.
12 **Q.** And then ... but to your knowledge when you again are
13 seeking to have a patient access that service at St. Martha's,
14 then there is also the availability of a psychiatrist through
15 that service as part of that referral. Correct?
16 **A.** Yes. So 24 hours a day there is a psychiatrist on
17 call. And then during the daytime hours, you can consult the
18 Crisis Team or Crisis person. In my experience, during the day
19 it is usually an initial assessment by the Crisis Team and then
20 there's a determination from them whether or not to get the
21 psychiatrist involved.
22 **Q.** Okay.

1 **A.** That's my understanding of how it works, but ...
2 **Q.** Okay. And turning next and speaking of psychiatrists,
3 you were taken to the emergency record you prepared. And that's
4 page 33 of the materials in front of you?
5 **A.** Yes.
6 **Q.** And take you to your handwritten note. And I see you
7 make reference to the fact that Mr. Desmond was followed by Dr.
8 Slayter. And Dr. Slayter is a psychiatrist at St. Martha's.
9 Correct?
10 **A.** Correct.
11 **Q.** So your note says, "He was followed by Dr. Slayter.
12 Veterans Affairs." Correct?
13 **A.** Correct.
14 **Q.** And I think in the question that Mr. Russell put to
15 you, he asked whether you could recall if that reference to Dr.
16 Slayter was information that was provided to you by Mr. Desmond
17 or it came from your review of the electronic records or
18 whatever records were available. And if I'm recalling
19 correctly, you thought it might have come from your review of
20 MEDITECH. But, certainly, the information about Veterans
21 Affairs, would it be fair to say that would have come directly
22 from the patient, from Mr. Desmond?

1 **A.** I don't recall. If Veterans Affairs was mentioned on
2 any of the notes in MEDITECH, that may have triggered me to
3 write that.
4 **Q.** Yeah.
5 **A.** I don't recall where I got that information.
6 **Q.** Okay. That's fair. Just a few additional questions,
7 Dr. Clark.
8 You referred to the concept of a social admission as
9 opposed to a formal admission. Based on the information you saw
10 and the information we were able to obtain from Mr. Desmond,
11 would you characterize his period of time in Observation as a
12 social admission as opposed to something further?
13 **A.** Yes. I'm not a psychiatrist, so ... and ... so that
14 would largely be based off the assessment of the psychiatrist.
15 But from my point of view, yes, I would call that more of a
16 social admission. But ...
17 **Q.** Okay. And, lastly, the Inquiry has heard evidence
18 that may be, again, second- or third-hand that suggested that
19 Mr. Desmond told some others, potentially some family members,
20 in the day or two after he left St. Martha's that he wasn't kept
21 there because the hospital or the third floor, the Mental Health
22 Unit, was full. Do you have knowledge as to whether there were,

1 in fact, beds available on the third floor or the psychiatric
2 floor at St. Martha's that day?
3 **A.** The only knowledge I have is based off of my
4 conversation with Dr. Rahman, who told me that the patient
5 preferred not to go to the ward. So, presumably, there were ...
6 that was a possibility at the time.
7 **Q.** And there was certainly a bed available in the
8 observation area where Mr. Desmond remained that night.
9 **A.** Yes.
10 **Q.** Thank you.
11 **THE COURT:** Ms. Miller?
12
13 **CROSS-EXAMINATION BY MS. MILLER**
14
15 **MS. MILLER:** Thank you, Dr. Clark. My name is Tara
16 Miller and I represent Brenda Desmond and also share
17 representation with Mr. Macdonald of Aaliyah Desmond. I'm going
18 to pick up on a few threads and topics that were previously
19 canvassed by all other counsel.
20 **A.** Sure.
21 **Q.** I'm going to start with this concept of social
22 admission. I think I have a pretty good handle of your

1 explanation about why oftentimes people will be kept in hospital
2 for not really a medical reason but more of a social reason.
3 You gave the example of the individual who would be homeless and
4 not to be releasing him at night into the cold. And then my
5 friend had asked you about Lionel staying in the observation
6 area of the emergency room and whether or not that was a social
7 admission. And I think your response, I don't want to misstate
8 it, was that all you really know about that was what Dr. Rahman
9 told you and that Lionel had some discomfort with being on the
10 third floor.
11 **A.** Correct.
12 **Q.** Okay. And we'll certainly talk to Dr. Rahman
13 tomorrow. But is it your understanding that had Lionel not
14 expressed discomfort with being on the third floor, that he
15 would have been admitted to the third floor?
16 **A.** Yes.
17 **Q.** And would that then have been a formal admission or
18 would it have been a social admission?
19 **A.** No. The location is irrelevant.
20 **Q.** Okay.
21 **A.** Yes. He was under the care of Dr. Rahman and happened
22 to physically be in the observation area. A formal admission

1 would have been determined by Dr. Rahman and not by myself.
2 **Q.** Okay.
3 **A.** So ...
4 **Q.** Yeah.
5 **A.** But the physical location does not.
6 **Q.** So he could have been formally admitted to the third
7 floor with two things: if he was comfortable going there; and
8 then if Dr. Rahman felt that that was necessary from a treatment
9 perspective.
10 **A.** Correct.
11 **Q.** Okay. I want to talk about risk factors again, and
12 you've spoken about them and we've heard about them and they're
13 important, as I understand it, in the context of identifying
14 suicidal and/or homicidal ideation. Correct? Those are the
15 risk factors that you're talking about in terms of reviewing
16 with the patient to assess whether or not they're at risk of
17 harming themselves or others?
18 **A.** So you would assess suicidal and homicidal ideation by
19 directly asking the patient.
20 **Q.** Correct.
21 **A.** And then whether they say "yes" or "no", you
22 independently look at risk factors.

1 **Q.** Right. You don't rely solely on the patient saying, I
2 don't have any suicidal ideation, or, I don't have any homicidal
3 ideation.
4 **A.** Right.
5 **Q.** The analysis is far broader than that. You don't ...
6 **A.** Correct.
7 **Q.** ... take the patient ... for example, if they say, No,
8 I don't have any, that's not the end of the analysis. Correct?
9 **A.** Correct.
10 **Q.** And, in fact, it's very important to go through those
11 risk factors ...
12 **A.** Correct.
13 **Q.** ... to elucidate and determine whether or not there is
14 actually something there that should be of concern to you or any
15 other of the assessing doctors. Is that fair to say? Without
16 relying on the patient saying, No, I don't have this.
17 **A.** That's correct. Now generally the risk factors are
18 more relevant when someone is suicidal.
19 **Q.** Fair enough, but you're still making that assessment.
20 **A.** Yes.
21 **Q.** Even if they say they're not suicidal.
22 **A.** Correct.

1 **Q.** Okay. That's part of your sort of broader mandate
2 when they come in, particularly with a mental health complaint.
3 Is that fair to say?
4 **A.** Correct.
5 **Q.** Okay. And you had talked about when you do that risk
6 assessment independent of what the patient has told you you
7 would typically have a very detailed review of your notes in the
8 ER information if you were planning on managing that patient.
9 **A.** Correct. I would typically include risk factors and
10 protective factors as part of my disposition plan.
11 **Q.** Right, and you have ...
12 **A.** Patient's being discharged ...
13 **Q.** ... notes about that.
14 **A.** ... this is their follow-up, this is their risk.
15 **Q.** Yes.
16 **A.** Yes.
17 **Q.** That would be part of your detailed note-keeping if
18 you were planning on following up with managing them yourself.
19 **A.** Correct.
20 **Q.** But in this case, you didn't do that because you were
21 transferring care to Dr. Rahman.
22 **A.** Correct.

1 **Q.** Okay. What are protective factors? You mentioned
2 that before.
3 **A.** So there's a number of them. So things that would
4 suggest safety. So they have family, they have pets. We use
5 the term "future oriented". Someone who says they're suicidal
6 but they're talking about things that might happen a year or two
7 from now.
8 **Q.** Okay.
9 **A.** There's a list of ...
10 **Q.** Okay.
11 **A.** ... things such as that.
12 **Q.** And again, you talk about a list, and I think you said
13 that, you know, every medical student has them sort of drilled
14 into their ...
15 **A.** Yeah. And we're tested on them and ... yeah.
16 **Q.** And you're tested on it. And Mr. Russell had asked
17 you questions about being aware of a criteria sheet. And you
18 said you weren't specifically aware of that. But ...
19 **A.** Correct.
20 **Q.** ... you know, doctors will use an app and you have
21 them ingrained in you when you go through them.
22 **A.** Yes.

DR. JUSTIN CLARK, **Cross-Examination by Ms. Miller**

1 **Q.** Okay. I just wanted to ask you to take a look at that
2 same exhibit, page 7, Dr. Clark. Yes, on the screen. So this
3 is a document which is contained in the St. Martha's Hospital
4 materials and it is from a visit that we know. Lionel Desmond
5 had an emergency room visit in October, October 24th, 2016. And
6 this document is called Mental Health and Addictions Crisis
7 Response Service Mental Health/Risk Assessment.
8 Have you seen this? I'll ask this two ways. Have you
9 seen, generally, this type of an assessment form before?
10 **A.** Yes.
11 **Q.** Okay, and then it appears this had been filled out
12 specifically with respect to an assessment of Lionel that was
13 done in his October 24th, 2016 visit? Is that fair to say?
14 **A.** Yes.
15 **Q.** Okay. And would you have had access to this when you
16 were reviewing his documents on MEDITECH?
17 **A.** I believe so.
18 **Q.** Okay. Now ...
19 **A.** If this was completed in the Emergency Department, and
20 part of the emergency chart, I believe, I would have access to
21 this.
22 **Q.** Okay, and we'll hear from other witnesses on that, but

1 I assume, if you turn to page 4, you see the emergency room
2 record from October 24th, 2016.
3 **A.** So it's included in ...
4 **Q.** It looks like it would logically, from your
5 perspective, be included? Does that ...
6 **A.** Yes.
7 **Q.** ... make sense? Okay, so this is a very detailed
8 assessment and it goes from page 7 to page 10. It's four pages
9 of detailed information, which I assume is to assess mental
10 health/risk assessment, and that's what the document is
11 entitled?
12 **A.** Yes.
13 **Q.** Okay. Would you ever have occasion to fill this sheet
14 out in the course of your role as emergency room doctor?
15 **A.** No.
16 **Q.** Okay. Is this a type of document I think that you
17 said that during daytime hours there would be a crisis team who
18 would typically fill out this assessment and then hand it off to
19 a psychiatrist?
20 **A.** And I guess discuss with the psychiatrist.
21 **Q.** Okay.
22 **A.** And oftentimes they will also discuss with the

1 emergency physician as well ...

2 **Q.** Right.

3 **A.** ... the disposition plan.

4 **Q.** Okay. So an emergency room physician or a

5 psychiatrist would not fill this document out.

6 **A.** No.

7 **Q.** It would be somebody on the crisis response team?

8 **A.** Correct.

9 **Q.** And those folks go home at 5 o'clock-ish.

10 **A.** Yes.

11 **Q.** Okay, so after hours if you show up with a mental

12 health challenge, a situational issue, no one's going to fill

13 out or take the detail ...

14 **A.** Of this particular form, no.

15 **Q.** ... of this document. No? Okay, and when I look

16 through it. I want to take you to page 9, Dr. Clark. The

17 bottom section of this page talks about suicide risk assessment

18 and we see interview risk profile, individual risk profile and

19 ... I can't really read that. Protective factors. So would

20 these be the risk factors and protective factors that you had

21 talked about earlier that would exist?

22 **A.** Yes.

1 **Q.** That every doctor knows sort of by rote but these
2 would be those risk factors?
3 **A.** Yes.
4 **Q.** Okay, so when I look through this list I don't see
5 anything in here that assesses whether or not somebody has a gun
6 or access to a gun. You see that? But based on your evidence
7 ...
8 **A.** So ...
9 **Q.** ... I understand that that is something that you would
10 have raised and typically do raise.
11 **A.** So on these lists it's usually described as access to
12 lethal means.
13 **Q.** Okay.
14 **A.** You're correct. I don't see it written on here but
15 ...
16 **Q.** Yeah.
17 **A.** ... typically you would see it on a list such as this.
18 **Q.** Okay. That is what you would envision it should have,
19 access to a lethal ...
20 **A.** Yes.
21 **Q.** ... weapon. Because it certainly could be a knife or
22 a sabre or something like that.

1 **A.** Correct.

2 **Q.** But you'll agree with me that on this risk assessment

3 there is nothing that would trigger someone to ask ...

4 **A.** Yes.

5 **Q.** ... about a gun or anything of that nature? Okay. Is

6 there anything that you can see here about recent separation or

7 marital breakdown?

8 **A.** On the list of risk factors?

9 **Q.** Anywhere in this section, interview risk profile,

10 individual risk profile, and protective factors. Anything in

11 there that I'm maybe not interpreting?

12 **A.** The bottom of the first column, recent crisis conflict

13 loss.

14 **Q.** Okay, and that, from your perspective, would include

15 marriage breakdown or separation?

16 **A.** Yes.

17 **Q.** Okay. If you determine that somebody does have access

18 to firearms - either they own them or they can get access to

19 them - is there anything, any system that you can access, to put

20 the police on notice that this person may be a potential risk to

21 themselves or others, Dr. Clark?

22 **A.** Yes, you can notify the police and the police will

1 confiscate the weapon.
2 **Q.** Okay, so that would happen, that you would pick up the
3 phone or ...
4 **A.** I've never initiated that myself ...
5 **Q.** Okay.
6 **A.** ... that I can recall but I know it happens quite
7 commonly.
8 **Q.** Okay, and to your knowledge, how does that happen?
9 **A.** In the cases that I can recall, a patient's friend or
10 family member call the police. The police take the weapon. One
11 way or another, the patient ends up in the emergency room. So
12 it's usually it happened before I would do my assessment.
13 **Q.** Okay. Is there ever a case where a person would be in
14 the emergency room and you would identify that they have some
15 risk factors but not enough to warrant invoking **IPTA** ...
16 **A.** Right.
17 **Q.** ... an involuntary admission? But they have some risk
18 factors that would include having access to a gun but not enough
19 to trigger involuntary admission. Is there ever any situation
20 where you'd still take that information about some concerns but
21 not enough to meet this very high threshold and let the police
22 know?

1 **A.** No. They would go together.
2 **Q.** Okay, so if it's not going to meet the **IPTA** threshold
3 that information could conceivably just get lost in the system.
4 **A.** Correct.
5 **Q.** Okay, and ...
6 **A.** I guess it depends what you mean by "lost in the
7 system".
8 **Q.** Well, it would be captured somewhere in the medical
9 records but it would never be actioned on to any other agency
10 ...
11 **A.** Right.
12 **Q.** ... for review or oversight.
13 **A.** There may not be indication to act on it, yeah.
14 **Q.** Okay. Similar on that line of questioning, if you ask
15 a patient if they have access to a firearm and they say no ...
16 and you said earlier you don't always take things that a patient
17 ... certainly, this wasn't the case that you had any suspicions
18 here, but you don't always take what patients tell you at face
19 value.
20 Is there any way for you to check in any government system,
21 police, firearms? Is there any way for you to check if you have
22 a niggling worry about access to firearms? Is there any way you

1 can check that as a physician?
2 **A.** Not that I'm aware of.
3 **Q.** Okay.
4 **A.** Other than checking with family members or friends.
5 **Q.** Would you agree that there's value in you being able
6 to access an independent system to verify the presence or
7 absence of a firearm or access to a firearm when you're making
8 these risk assessments?
9 **A.** Yes.
10 **Q.** Okay. And would you agree it would be helpful to have
11 some specific authority which would allow you to disclose to the
12 police the presence or access to firearms in a situation that
13 doesn't invoke **IPTA** but still causes you some concerns? Would
14 it be helpful for you to have that specific statutory other
15 authority to let the police know just in case?
16 **A.** I don't know.
17 **Q.** Okay. Training. Training, you talked about
18 continuing medical education, which certainly we, as lawyers,
19 are familiar with in our profession. We do legal education
20 training. My sense is that it can be very largely self-
21 directed?
22 **A.** Correct.

1 **Q.** Yeah, and you talked about, you know, you can fill
2 some of those components by listening to podcasts?
3 **A.** Correct.
4 **Q.** Can you fulfill all of those components on your own
5 self-directed?
6 **A.** No.
7 **Q.** No. Okay. So is there some that's actually
8 structured and mandated by the College of Physicians?
9 **A.** Yes, there's different categories of the credits.
10 **Q.** Yes?
11 **A.** And some of them, it would need to be something like a
12 conference or a talk.
13 **Q.** Okay.
14 **A.** Accredited talk. But some can be self-directed.
15 **Q.** Okay. But within the categories that the College of
16 Physicians would mandate you still have the ability to pick and
17 choose what you want to attend.
18 **A.** Which topics you attend.
19 **Q.** Which topics.
20 **A.** Yes.
21 **Q.** Yes. Is there anything that's mandated and
22 specifically required for you as an emergency room physician by

1 either the College or the Nova Scotia Health Authority?
2 **A.** Not that I'm aware of.
3 **Q.** Okay. So if there was specific training on
4 identifying risk factors, for example, that have been gathered
5 from data from death review committees that suggest there may be
6 some risk links to deaths in marriage relationships, there's a
7 possibility that you would never take that training without it
8 being mandated. Is that fair to say?
9 **A.** Correct.
10 **Q.** Okay. And since this incident happened in January of
11 2017 are you able to share with us, from your perspective,
12 anything that has changed in terms of process, policy, the way
13 your duties are carried out, Dr. Clark, that you believe is in
14 response to this situation that we're here today about?
15 **A.** In my personal practice?
16 **Q.** Yes.
17 **A.** I don't think anything has changed. I continue to
18 have a low threshold to involve my psychiatry colleagues.
19 **Q.** Mm-hmm.
20 **A.** Yeah, I don't. I can't think of anything specific
21 that has changed.
22 **Q.** Okay. That's your personal practice and then broader

1 than that, have there been any changes that have been mandated
2 by St. Martha's, by the Health Authority that you understand or
3 believe would be as a response to the death of Lionel Desmond
4 and his family members?
5 **A.** Not that I'm aware of.
6 **Q.** Okay. I have one last question and it involves
7 charting. When you're charting in hospital records is the
8 general rule of thumb, Dr. Clark, that you stay within the lines
9 on the page and, you know, if there's a blank you put a line
10 across to indicate that there is nothing else that's filled into
11 that space?
12 **A.** I mean you can tell from the nurses' notes that that's
13 routinely done with nurses. Every ...
14 **Q.** Right.
15 **A.** ... single line.
16 **Q.** Yes.
17 **A.** I would say that would rarely, if ever, be done by
18 physicians.
19 **Q.** Okay.
20 **A.** If there's a very large portion of the chart that's
21 not filled in a big line through it would be common, but
22 individual lines ...

1 **Q.** Okay.
2 **A.** ... I've never seen that.
3 **Q.** And would you also say that with physicians you would
4 see charting material outside of those lines, maybe scrawled in
5 the bottom of the page or in the margins?
6 **A.** Yes, and often we will print what we call a progress
7 note if you want to continue an emergency room record and you
8 need more space to write.
9 **Q.** Okay. Those are my questions. Thank you for your
10 time, Dr. Clark.
11 **THE COURT:** Mr. Rodgers?
12 **MR. ROGERS:** Thank you, Your Honour.
13
14 **CROSS-EXAMINATION BY MR. RODGERS**
15
16 **MR. RODGERS:** Dr. Clark, I'm Adam Rodgers. I'm
17 representing the personal representative of Lionel Desmond,
18 Corporal Desmond. I'm here to jump around a little bit because
19 most of my colleagues have covered off the topics, Doctor, but I
20 guess thinking of risk factors you identified, and you talked
21 about someone who is future oriented, an individual who is
22 future oriented.

1 Would examples of those kinds of topics include, say,
2 searching for real estate, getting a gym membership, returning
3 shoes to get new shoes, those kinds of things? Would that be
4 what you would consider future oriented?
5 **A.** I guess I would consider those things future oriented.
6 It would need to be something that was specific to the day that
7 the crisis is taking place. So I guess if you assess a patient
8 who is suicidal in the Emergency Department and they bought a
9 gym membership the next day ...
10 **Q.** Yes.
11 **A.** ... then that may indicate that they're future
12 oriented. But it doesn't say much if they thought it the
13 previous day because something may have happened from that time.
14 **Q.** Sure.
15 **A.** Now I guess I would be more referring to having a
16 conversation and someone casually talking about the future as if
17 it will happen. So they may talk about something, a wedding
18 they plan to go to in the summer ...
19 **Q.** Okay.
20 **A.** ... for example.
21 **Q.** All right, so ...
22 **A.** It would be unusual to have a very concrete plan that

1 they're going to go home and kill themselves yet they're
2 casually talking about going to a wedding the next summer.
3 **Q.** Sure. Okay. I understand that. Now I want to ask a
4 question. You said maybe 10 to 15 percent of the individuals
5 coming through the emergency door have a standalone mental
6 health situation. Can you tell us ... you know, maybe not in
7 percentage terms. It might be difficult. But how often would
8 someone come in in Corporal Desmond's situation, where he's
9 apparently fairly calm and trouble at home, preexisting mental
10 health, and yet has the awareness to calmly go in and seek help.
11 Is that an unusual presentation?
12 **A.** No.
13 **Q.** One might think that if a person was in a mental
14 health crisis that the ability to present calmly might be a
15 difficult thing for them to do but ...
16 **A.** Well, commonly people present. People have calmed
17 down by the time I see them in the Emergency Department.
18 **Q.** Yeah.
19 **A.** A crisis may have happened and brought them there, but
20 there may be a period of time in which they have become calmed
21 down.
22 **Q.** Okay, and marital difficulties. Presuming that that's

1 not an uncommon complaint or element of what's presented to you.
2 **A.** Correct.
3 **Q.** All right. Question for you, Doctor. You indicated
4 you had limited experience with younger military veterans or
5 maybe military veterans of any age, but what about training as
6 whether it's in medical school or as a resident? Is there any
7 specific training that you receive for how to manage individuals
8 that are military veterans?
9 **A.** Well, I guess the focus would be more on their mental
10 health or medical issues, specifically the PTSD or co-occurring
11 conditions that often happen with PTSD.
12 **Q.** Yeah.
13 **A.** So we'd learn about those extensively and ...
14 **Q.** One of the questions I have is, for those with PTSD is
15 there any part of your training that would say, Well, these
16 individuals have a harder time with bureaucracy, with taking
17 instructions, with following through on things? Is that
18 something, in your experience, that ... or in your training
19 that's identified?
20 **A.** Yes, those things could be part of features of
21 symptoms they would have.
22 **Q.** You mentioned that you were a member of the Society of

1 Rural Physicians of Canada, and this is a broader question than
2 is specific here. But are there questions of social isolation
3 or are those topics that are raised in the context of that
4 organization? I'm thinking of, in this particular case,
5 socialized isolation of a veteran. Maybe not having a community
6 of like-minded people or peers to whom they could relate. Is
7 that something that comes up in the context of that
8 organization?
9 **A.** Not that I'm aware of.
10 **Q.** You've talked somewhat extensively about the suicidal
11 and homicidal ideation questions and the framework, the mental
12 framework, that you go through when you're asking these
13 questions. This may be more of a question for the
14 psychiatrists, but is there any concern that asking the question
15 might suggest the option?
16 **A.** No. No, there's no concern for that. My
17 understanding ... you're right, it's probably a better question
18 for a psychiatrist.
19 **Q.** Yeah, I guess it's a question ... is that described to
20 you in a way that, Hey, make sure you ask the questions in a
21 certain way so that you don't suggest ...
22 **A.** No, my understanding is there's overwhelming evidence

1 that it's better to ask directly.

2 **Q.** Okay, and finally, just a question. You talked about

3 your drives and listening to medical podcasts. Is there a good

4 variety of medical podcasts out there?

5 **A.** Yes, there is, yeah.

6 **Q.** Okay, and what are some of the ones you listen to?

7 Are there any that are sort of top of mind?

8 **A.** Well, usually the ones that are specific to emergency

9 physicians.

10 **Q.** Okay.

11 **A.** Do you want the names of ...

12 **Q.** Sure.

13 **A.** EM:RAP is one. Called EM:RAP. ERcast is another one.

14 But there's a few.

15 **Q.** Law has not developed a wide variety of podcasts for

16 the benefit of us traveling lawyers. So I was curious as to the

17 extent of the options out there.

18 Okay. I believe ... yes, those are all my questions,

19 Doctor. Thank you.

20 **THE COURT:** Mr. Hayne?

21 **MR. HAYNE:** Yes, thank you. Just a few questions, Dr.

22 Clark.

1 **CROSS-EXAMINATION BY MR. HAYNE**

2

3 **MR. HAYNE:** You were asked a number of times regarding
4 your ability to access other medical records that were not in
5 MEDITECH or SHARE, for example, and some examples were presented
6 to you. Dr. Slayter's consultation note from December 2nd, 2016
7 and an ER visit from New Brunswick that was referenced by Mr.
8 Russell. In particular, with respect to the ER visit in New
9 Brunswick, you were asked questions about whether you had
10 information regarding a previous attempt at suicide, and I think
11 your evidence was that that would be something you'd consider
12 perhaps as a risk factor. Is that right?

13 **A.** Correct.

14 **Q.** Okay. And you also gave evidence, and correct me if I
15 mischaracterize it. But that if your plan was to manage a
16 patient, a mental health patient, yourself where suicide risk
17 may have been an issue you may have listed in your chart note
18 more details regarding risk factors and protective factors. Is
19 that right?

20 **A.** That's the typical place I would document that.

21 **Q.** And when you were presented with this information sort
22 of in the hypothetical form I believe it was your evidence that

1 ... it was that if you had this information it may have made you
2 more likely to consult Psychiatry in sort of in an abstract
3 sense. Is that right?
4 **A.** Correct. It would make me more concerned.
5 **Q.** Right. And in this case, however, you did, in fact,
6 consult Psychiatry. Correct?
7 **A.** Correct.
8 **Q.** And so the lack of having those records had no change
9 to your process in the sense that the end result was the same
10 and you did consult Psychiatry. Correct?
11 **A.** Correct. I was also concerned because I had a lack of
12 collateral information. So that was one of my concerns as well.
13 **Q.** Again, just a few questions. I'm jumping around. I
14 believe it's Exhibit 67 that we've been looking at, and the
15 emergency chart record. The vital signs, and it's not up in
16 front of us right now. But that's fine. I'll read them. The
17 vital signs that were recorded, they would have been recorded by
18 the triage nurse? Is that right?
19 **A.** Correct.
20 **Q.** Okay. And in this case the heart rate is 75. That's
21 beats per minute?
22 **A.** Correct.

1 **Q.** Respiration rate is 18.
2 **A.** Correct.
3 **Q.** And the blood pressure is 115 over 79.
4 **A.** Correct.
5 **Q.** And from your perspective, those are all within the
6 normal range. Correct?
7 **A.** Correct.
8 **Q.** And those vital signs are consistent with your
9 assessment of no acute distress. Would you agree with that?
10 **A.** Correct.
11 **Q.** And also consistent with a reference by the triage
12 nurse that Mr. Desmond presented as calm and speaking quietly.
13 **A.** Correct.
14 **Q.** You were also asked some questions about triage score,
15 and I think your evidence was, and correct me if I'm wrong, that
16 you look at the vital signs and then you look at the text
17 description of the assessment by the triage nurse. That's your
18 primary focus ...
19 **A.** Yes.
20 **Q.** ... over and above the actual score itself.
21 **A.** Yes. I'm well aware of the score, but more relevant
22 to me is the vital signs and the description.

1 **Q.** Right. And then you take that information and then
2 you assess the patient directly. Correct?
3 **A.** Correct.
4 **Q.** And is it fair to say that the most important
5 information is that information that you obtain when you're
6 assessing the patient in front of you. Is that right?
7 **A.** Correct.
8 **Q.** And just one quick little clarification. In your
9 handwritten chart note you say - I just want to make sure I get
10 it correct here. "No harm to family per patient." And your
11 evidence was that "per patient" was that you were indicating
12 that that's the information you receive from Mr. Desmond.
13 Correct?
14 **A.** Yeah. Another way to phrase that would be "according
15 to the patient" there was no harm done to the family.
16 **Q.** Right, but again, that's the information from the
17 patient.
18 **A.** Correct.
19 **Q.** But you also had no information to indicate otherwise.
20 Is that right?
21 **A.** Correct.
22 **Q.** Thank you. Those are my questions, Your Honour.

1 **THE COURT:** Okay.
2 **MR. MACDONALD:** Your Honour, excuse me, I had one question
3 arising from a question by counsel. I'm wondering if I could
4 ask it, it's by way of re-direct (sic).
5 **THE COURT:** Go ahead.
6 **MR. MACDONALD:** Thank you very much.
7
8 **CROSS-EXAMINATION BY MR. MACDONALD**
9
10 **MR. MACDONALD:** Dr. Clark, my friend Mr. Rogers asked you a
11 question about ... and I'm paraphrasing and you correct me if I
12 have it wrong and I'm sure my friend, Mr. Rogers, will very
13 quickly. Dr. Rahman providing gold standard of care in terms of
14 Mr. Desmond. As I understood your response, it related to the
15 fast response to you by Dr. Rahman when you called him. Is that
16 your recollection?
17 **A.** I guess ...
18 **Q.** You called him and he called back quickly.
19 **A.** ... what I mean was that he came to see the patient
20 quickly ...
21 **Q.** Yes.
22 **A.** ... and that he came to see the patient in the

1 evening, which would not be typical.

2 **Q.** Understood.

3 **A.** Typically a patient would wait until the next day to

4 see a psychiatrist.

5 **Q.** Okay. But as far as the treatment itself by Dr.

6 Rahman of Mr. Desmond, you weren't there.

7 **A.** Correct.

8 **Q.** And you're not a psychiatrist. So you're not in a

9 position to characterize it as gold standard or not gold

10 standard, are you?

11 **A.** Correct.

12 **Q.** That's fair, right?

13 **A.** Correct.

14 **Q.** Yes. Thank you, Dr. Clark.

15 **THE COURT:** And I took Dr. Clark's response to be gold

16 standard in terms of response given the time and all the other

17 factors, that that's really what he was talking about. So I

18 just may have a couple questions. Just give me a minute here.

19

20 **EXAMINATION BY THE COURT**

21

22 **THE COURT:** When you use the expression "situational

1 crisis", what does crisis mean? Like how does something become
2 a crisis? You know, you look at Mr. Desmond's vital signs at
3 the time that somebody's doing triage ...
4 **A.** Mm-hmm.
5 **Q.** ... and you'd expect if there was some kind of a
6 crisis, I would think in terms of there being some, you know,
7 physical manifestation in one of the functions that you're
8 measuring would be indicative of that. So what does crisis
9 mean?
10 **A.** So the term "situational crisis" is used a lot. I'm
11 assuming it's a drop-down menu where you put the complaint on
12 the triage sheet. It's basically something that's used when
13 there's nothing else specific to use.
14 **Q.** So something that's happened that's very upset and
15 can't be managed on their own and so they come to see you in the
16 mental health context?
17 **A.** It could. It could apply to that but it also could
18 apply to anything that doesn't have a specific physical symptom
19 or anything very specific or psychiatric symptom. So if a child
20 was agitated and acting up at school and somehow they ended up
21 in the emergency room. They might say that.
22 **Q.** Okay.

DR. JUSTIN CLARK, Examination by the Court

1 **A.** It has nothing to do with how the patient is in the
2 triage room. Basically the person's deciding, How do I describe
3 this overall situation? You know, it's easy if it's ankle pain.
4 You just put "ankle pain". But if something's going on with
5 them and there's a bunch of details and you're only, you know,
6 writing in on a document you kind of just pick this one. So it
7 could literally be referring to a lot of ...
8 **Q.** All right.
9 **A.** ... different situations.
10 **Q.** Okay. I understand. Is there a suicide prevention
11 policy that you're aware of that would relate to any of your
12 conduct behaviours in the ER Department of the St. Martha's
13 Hospital?
14 **A.** There's no policy that I'm aware of, no.
15 **Q.** Are you aware of a suicide prevention policy as it
16 relates to youth in the Province of Nova Scotia?
17 **A.** No.
18 **Q.** No? Okay. When the nurses are doing the triage I
19 take it they have access to the MEDITECH as well or is that just
20 the physicians have access to it?
21 **A.** They have sign-ins for MEDITECH.
22 **Q.** They can sign in and access whatever is there? In

1 other words ...

2 **A.** I'm not ...

3 **Q.** ... can they see exactly what you see? Or do you ...

4 **A.** I don't know.

5 **Q.** You don't know? Okay. When you were interviewing Mr.
6 Desmond I know you decided that in terms of managing his
7 circumstances you weren't comfortable doing it without a
8 psychiatric consult, in which case you would hand him over to
9 the psychiatrist.

10 **A.** Correct.

11 **Q.** Okay. Short of that, if you had been comfortable ...
12 maybe it's a bit hypothetical. But would you have admitted him?

13 **A.** I don't have the ability to admit someone to the
14 Psychiatric unit.

15 **Q.** All right. If he had ...

16 **A.** Yes.

17 **Q.** ... said to you ... if you had made the determination,
18 All right, so do you have another place to stay tonight, and he
19 said, No, I don't have anywhere to go tonight, I just can't go
20 home till tomorrow, I'm going to respect what the request was,
21 can I stay here, would you have the authority to say, All right,
22 you can stay here for the night? And then if he stayed there

1 for the night you would continue to observe him for the rest of
2 the night as you would anybody else that stays in the hospital?
3 **A.** So I have the ability to have someone in observation
4 ...
5 **Q.** Mm-hmm.
6 **A.** ... under my care.
7 **Q.** Under your care.
8 **A.** I would do that quite frequently.
9 **Q.** Okay, so if it came ...
10 **A.** So, for example, someone who has fluid in their lungs.
11 I can put them in observation overnight and reassess them in the
12 morning and if their symptoms have improved I can discharge them
13 myself. But in this case the patient was in observation under
14 the care of Dr. Rahman, not under my care.
15 **Q.** Dr. Rahman.
16 **A.** Yeah.
17 **Q.** But if you hadn't made the psychiatric referral and
18 you were prepared to let Mr. Desmond go on his way ...
19 **A.** Okay.
20 **Q.** And whatever other advice you would have given in
21 terms of your management of whatever the plan was to manage his
22 situation, if he'd asked you to stay there he would have been

1 permitted to stay there in observation overnight.

2 **A.** It's hard to say what I would have done.

3 **Q.** All right. I won't press you on it. I appreciate

4 it's a bit ...

5 **A.** I would need a lot more ...

6 **Q.** It's a bit hypothetical.

7 **A.** ... information to ... if I were the one coming up

8 with a management plan ...

9 **Q.** Yeah.

10 **A.** ... I would need a lot more information than I had at

11 the time that ...

12 **Q.** Yeah.

13 **A.** ... I consulted Dr. Rahman, yeah.

14 **Q.** And that may or may not have affected your decision

15 ...

16 **A.** Exactly.

17 **Q.** Is what you're saying. Yeah, I understand that.

18 Thank you.

19 You talked about an app that you have. If you're looking

20 at risk factors or you're looking at something on your app, you

21 log the time and you can use it as part of your continuing

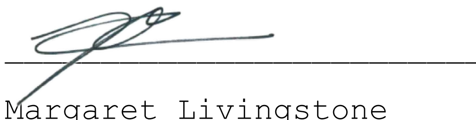
22 education credits. So is there one particular app that you use?

DR. JUSTIN CLARK, Examination by the Court

1 **A.** Yes.
2 **Q.** Or do you have a number?
3 **A.** There's an app called UpToDate, which is basically a
4 reference for anything in all of medicine. There's articles
5 written by every specialist on basically every topic.
6 **Q.** Mm-hmm. So you can go to the app if you want to just
7 refresh your memory about risk factors, suicide prevention? You
8 would go on there and ...
9 **A.** Correct.
10 **Q.** ... take a few minutes and read what's there as a
11 refresher?
12 **A.** Correct.
13 **Q.** And that's all the questions I have. All right.
14 Thank you, Dr. Clark, for your time. You're free to go, and
15 we'll stand adjourned till tomorrow morning at 10 o'clock.
16 All right. Thank you, then.
17
18 **COURT ADJOURNED (17:06 HRS.)**
19
20
21
22

CERTIFICATE OF COURT TRANSCRIBER

I, Margaret Livingstone, Court Transcriber, hereby certify that the foregoing is a true and accurate transcript of the evidence given in this matter, **re Desmond Fatality Inquiry**, taken by way of electronic digital recording.



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DARTMOUTH, NOVA SCOTIA

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