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 4, 2020

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INDEX

EXHIBIT LIST

FEBRUARY 4, 2020

COURT OPENED (10:18 HRS.)

THE COURT: Good morning.

COUNSEL: Good morning, Your Honour.

THE COURT: Mr. Murray?

MR. MURRAY: Thank you, Your Honour. The Inquiry this morning is calling Dr. Faisal Rahman.

THE COURT: Thank you. Dr. Rahman.

DR. FAISAL RAHMAN, affirmed, testified:

DIRECT EXAMINATION

MR. MURRAY: Good morning, Dr. Rahman.

A. Good morning.

Q. Can you first of all state your name for the record, please?

A. Faisal Rahman.

Q. And can you spell your first and last name for the record, please?

A. First name: F-A-I-S-A-L, Faisal. Last name: R-A-H-M-A-N, Rahman.

EXHIBIT P-000068 - CURRICULUM VITAE OF FAISAL RAHMAN, M.D.

Q. Thank you. And, sir, I think we've been provided with your *curriculum vitae* which we had marked as an exhibit. I believe it's 68. So you'll have it there in front of you on the screen and also in the binder, I think in Volume 1. If you look in there after Tab 68 it will be there as well.

A. Okay, I have it on the screen.

Q. Whichever you prefer.

A. Yeah.

Q. Okay. And, sir, you are now the Chief of Psychiatry for the Eastern Zone of the Nova Scotia Health Authority, is that correct?

A. Yes, I am.

Q. You can get it where you'd like it. I'm a fan of paper too.

So perhaps you could tell us ... first of all, you've been the Chief of Psychiatry for the Eastern Zone since, it would appear, August of 2015?

A. Correct.

Q. Okay. And can you tell us what ... first of all, what geographic area the Eastern Zone is comprised of? What area that is.

A. Yeah. Eastern Zone is Antigonish County, Guysborough County, any area beyond Pictou County up to the Cape Breton, and the whole of Cape Breton.

Q. Okay.

A. Yeah.

Q. And all of Cape Breton?

A. All of Cape Breton.

Q. All right. And as Chief of Psychiatry for that area, what would your duties be?

A. Well, I have some administrative work as the Chief of the Zone, as well as day-to-day I am a staff psychiatrist at St. Martha's Regional Hospital, and then mostly do inpatient care, but I also do outpatients. I'm on call also and do emergency room coverage as well as the medical consultation liaison psychiatry on the medical units. That is if somebody needs a psychiatric consult on the medical unit at St. Martha's we all, psychiatrists, rotate through that. So it's a mix of inpatient and outpatient work but, primarily, it's inpatient work.

Q. Okay. So despite having those administrative duties, you maintain a practice and do those primarily inpatient but some outpatient work as well?

A. Absolutely.

Q. All right. Prior to your work as the Chief of Psychiatry in the Eastern Zone for, I guess, approximately 11 years you were the Chief of Psychiatry and Clinical Director at St. Martha's Regional Hospital in what was then GASHA or the Guysborough/Antigonish/Straight Health Authority, is that correct?

A. Yes.

Q. And your duties as Chief of Psychiatry and Clinical Director at St. Martha's, what were those duties?

A. Similar kind of duties. It's just that with the amalgamation of the health ... it used to be health districts before ...

Q. Yes.

A. ... it became four zones out of the nine districts and so I became the Chief of the Eastern Zone. Before, it was only GASHA, the Guysborough/Antigonish/Straight Health Authority, which was a smaller region but Cape Breton was added to it.

Q. I see. All right. And during the period of time that you were Chief of Psychiatry at St. Martha's Regional Hospital, if I'm reading your *CV* correctly, you also did some work as assistant professor in the Department of Psychiatry at Dalhousie?

A. Yeah, that's a faculty position that I received from Dalhousie. And so we get a family practice for residents, medical students, as well as sometimes medical students who want to go into psychiatry from foreign medical schools they rotate through St. Martha's and they do rotation with us. So we teach them basically ...

Q. I see.

A. ... and they follow with us and ... so that's ... we do provide some education ...

Q. Okay.

A. ... along with the clinical service in our department.

Q. Right. Okay. Great.

Now, Dr. Rahman, you received your medical degree, I think, in 1991 and you had a number of, I guess, placements until you kind of landed in the Antigonish area. You, I see, were or did an externship in neurology in West Virginia; you were a research assistant in the oncology research program at the Toronto Hospital; an externship in psychiatry at the Clark Institute of Psychiatry at the University of Toronto; an externship in Psychiatry at the VA Medical Centre affiliated with Georgetown University.

You did your psychiatric residency from 1998 to 2002 at the University of Minnesota, a fellowship in child and adolescent psychiatry at the University of Minnesota and a fellowship in geriatric psychiatric at the VA Medical Centre in Minneapolis.

There are a couple there that I just wanted to focus on briefly because they may have some particular relevance to what we're talking about here. I was curious about your work at the two VA medical centres: the one in Minneapolis and the other in Washington, DC. Those were veterans' hospitals, were they?

A. Absolutely. Yes.

Q. All right. And when you did your work at those two facilities, did you have occasion to work with soldiers or veterans?

A. Yes.

Q. And did some or many of those individuals have a presentation that involved post-traumatic stress disorder?

A. Yes.

Q. What can you tell us about your experience with that?

A. So during my residency and fellowship, University of Minnesota is actually attached to VAMC, Veterans Affairs Medical Centre, Minneapolis ...

Q. Yes.

A. ... and so we had rotations at the VA hospital during my first two years of residency.

I was on call at the VA hospital also where any acute emergency would show up. A lot of people had PTSD. There were veterans from Vietnam, Korean conflict, Iraq war veterans, as well as some Iran veterans who were trickling in by that time ...

Q. Yes.

A. ... in 2003 and 2004. We also saw some World War II veterans also ...

Q. Oh yes.

A. ... which were in their late 80s at the time. So that was my experience what we were doing during my residency.

I'd rotate ... I did inpatient care also there and did some outpatient clinics. And then after my residency was completed in 2002, I did some more work with (geriatric?) fellowship which was wholly and solely affiliated with the VA medical centre ...

Q. Right.

A. ... in Minneapolis. And for the whole year I was there to be at the time, and similarly did outpatient shift work and saw all kinds of former soldiers and veterans.

Q. Okay. And I would assume that a number of those soldiers and veterans presented with, I guess, complex presentations that involved PTSD and other conditions as well? There's co-morbidity, I think, with other conditions. Is that common?

A. Yes, absolutely. Yeah. Yeah. I mean, co-morbidity with PTSD ... about 80 percent of patients with PTSD have ... they do meet criteria for co-morbid and other psychiatric diagnoses, which could be depression or anxiety or substance use disorder and so forth. So certainly there was a co-morbidity

But there was an outpatient clinic, a PTSD clinic. Most of

them ... most of the patients were managed as an outpatient in the PTSD clinics. Very occasionally or rarely there would be somebody who would be hospitalized ...

Q. Yes.

A. ... for symptoms if there's acute exacerbation or something like that, but most of them were managed as an outpatient.

Q. Now in your practice in Nova Scotia, and in particular in this area in northern Nova Scotia, would you have had an opportunity to interact with patients who had that diagnosis of PTSD?

A. Yes, I have.

Q. I would assume fewer of those might be soldiers or veterans, though, given the nature of the population here?

A. Yeah, there are a few veterans. There are a few RCMP, people who have been affiliated with RCMP in the past, a few first responders in EHS and so forth. So it's a mixed population. But we do have patients who are ... we follow them ... follow up with them here, most of them they are refer resources, but sometimes people just want to follow with us locally ...

Q. Yes.

A. ... and those are the people that we see.

There are a lot of private therapists also who see veterans in the community, but if there's a crisis then they do come in to see us in the ER at times.

Q. Okay. And so there are private therapists in the area that do treat individuals with post-traumatic stress disorder?

A. Absolutely.

Q. Okay. And I would assume some of the victims or individuals who suffer with PTSD are not necessarily soldiers or first responders; others can suffer trauma in other ways and develop that condition?

A. Absolutely.

Q. All right.

A. Yes.

Q. And some of the individuals that you made reference to, such as first responders or soldiers, are there other ... to your knowledge, other opportunities for treatment, I guess, outside of the area? For example, we've heard about the OSI clinic, that type of thing, are you familiar with that?

A. Yes.

Q. And are those available to individuals in this area of the province?

A. They are available.

Q. But not locally?

A. Not locally. There is some tele-psychiatry going on now which has started ...

Q. Yes.

A. ... with the OSI clinic. But there are therapists in town also, in private setting, who are contracted by the VA and see these clients.

Some of them might also be seen in OSI clinic under different circumstances. I'm not sure about that, but I know that there are people who are being seen locally by private, as well as in public psychiatry, public mental health.

Q. Right. All right. Now, your practice again, here in the Antigonish area, Antigonish/Guysborough or eastern Nova Scotia, do you specialize in a particular area of psychiatry or do the psychiatrists in this area have to remain more ... maintain a more general practice, I guess?

A. There are certainly specialized psychiatrists who deal with these kind of situations who work in military hospitals and OSI clinics and VAs. As far as my practice is concerned, I'm a generalist.

Q. Yes.

A. In rural Nova Scotia psychiatrists have to be a generalist; we cannot ... we do everything.

Q. Right.

A. So I ... although I have fellowships in child psychiatry and ... which I don't tell ... I mean I don't see children.

Q. Yes.

A. And so I'm sub-specialized with child and adults in psychiatry as well as geriatric psychiatry, but I consider myself as a general psychiatric and we do everything. So we don't have any sub-specialized psychiatrists who work with us.

Q. Okay.

A. Yeah.

Q. Now at St. Martha's Hospital ... are you primarily there at St. Martha's? Is that your ...

A. Yes.

Q. ... physical location most times?

A. Yes.

Q. All right. And how many psychiatrists are there? First of all, I should ask you. St. Martha's is considered a regional hospital, is that ...

A. It's a regional hospital.

Q. Okay. And ...

A. So ...

Q. Go ahead.

A. Yeah. It's a regional hospital, it's the ... we cover about 50,000 catchment area in this hospital and we see people who come as far as a couple of ... two hours away, two and a half hours away. Even Strait Richmond Hospital in Port Hawkesbury is also under our catchment area.

Q. Okay.

A. Guysborough Hospital here is under catchment area, Canso, and so forth. So we do cover a wide region.

Also, the beds in the inpatient unit are provincial beds. We also get patients from all over the province. If there is no bed available elsewhere and we have a bed available, patients get transferred from other jurisdictions.

Q. So even from another zone, for example?

A. Absolutely.

Q. Okay.

A. I have three patients right now who are from Halifax.

Q. Okay. All right. And obviously we live in a ... I guess, a geographically vast area with a smaller population so people would typically have to travel to come to St. Martha's?

A. Yes.

Q. Right. Now the Department of Psychiatry at St. Martha's presently, how many psychiatrists do you have working there?

A. We have three adult psychiatrists and one child and adolescent psychiatrist.

Q. Okay. So the three adult psychiatrists would be yourself ...

A. Dr. Ian Slayter and Dr. Asma Ayyaz, who just started with us last year.

Q. Okay.

A. A year ago. And there's a child/adolescent psychiatrist by the name of Dr. John Krawczyk.

Q. Okay. Apart ... and so each of those ... you said I think a moment ago, part of your duties are to be on call, and we'll talk more about that later, but are each of those psychiatrists you have a rotation where you're on call, is that ...

A. Yes.

Q. Okay.

A. Yeah. Three of them, adult psychiatrists, do call ...

Q. Yes.

A. ... but a child psychiatrist, they don't do call.

Q. Okay.

A. Yeah.

Q. All right. And I understand that in addition to the psychiatrists in the Department of Psychiatry at St. Martha's there is also now a crisis team, is that correct?

A. Yes.

Q. Can you explain to us what that is and who is involved in that?

A. Yeah. So the crisis team's history is that four or five years ago, I think, we didn't have any crisis team at all so we have come a long way in the sense that we do have at least a crisis team. The different ... like in Halifax has 24/7 crisis team. In Sydney we have crisis team which is until 9 o'clock including weekends and holidays.

In St. Martha's we started it, it comprises of a social worker. We started with one staff now we have almost three staff. One is a social worker, one is an RN, registered nurse, and there's another one who is also an RN. They rotate and ... but our service is only during the weekdays, 9 to 6.

Q. Right.

A. We don't have anybody after-hours or weekends or

statutory holidays.

Q. Okay. And when did the crisis team ... you said initially there was one person, now we're at three. When did that come about, do you recall?

A. I am not sure about the exact date but I think this has been there for four or five years now.

Q. Okay. And it sounds like it's an evolving ...

A. Evolving, yes.

Q. ... feature? Yeah, okay. The RNs that are involved in it, do they have specialized training in mental health or do they come to have that as part of the crisis team?

A. Yes, they have specialized training.

Q. Okay.

A. They are mental health nurses and one of them is actually is a ... has training in (unclear) crisis in Halifax ...

Q. Yes.

A. ... and so they are well-trained mental health and addictions nurses and social workers.

Q. Okay. And right now, the crisis team is available or on duty, I guess, 9 to 5 or 9 to 6 you said?

A. 9 to 6.

Q. 9 to 6 on weekdays. What type of a service would they provide? If somebody came to the hospital with a mental health crisis or a mental health presentation, what might the crisis team be able to do for them?

A. So they do the initial assessment. There's a form that they fill. They interview the patients. They assess the ... you know, what they would ... they would do the symptom profile of most of the mental disorders and psychiatric conditions. They would do suicidal assessment ...

Q. Yes.

A. ... and obtain past psychiatric history as much as they can obtain, past medical history, social history, and they would obtain family history.

They will do the mental status examination of the patient and then they decide ... and then they have their assessment and then they collaborate with the ER physicians as well as the psychiatrist.

So psychiatrists are also on call along with the crisis team ...

Q. Okay.

A. We are the backup ...

Q. Right.

A. ... but we are consult service basically to the ER. So the crisis service is a consult to the ER. The patient is ER physician's patient, they refer them to crisis and they try to coordinate with them and work with the crisis team and the ER physicians.

And a lot of people who ... the planned disposition will be with the ER physicians. And in some cases they need us and either the crisis worker calls a psychiatrist or the ER physician can call a psychiatrist and we go down, see the patients. But I would say that there are a lot of patients who actually don't need to see a psychiatrist ...

Q. Okay.

A. ... who come in mental health crisis or whatever, and they're seen by the crisis team and they are discharged in coordination with the ER physician.

Q. Okay. And so an ER doctor would ... when they're through the weekdays, would typically call the crisis team first before, and then the crisis team would make a decision whether to call the on-call psychiatrist?

A. Yes.

Q. Okay. If the crisis team sees a person and feels that they may be appropriate for admission to the hospital, could

they make that decision in consultation with the ER doc or would you have to call a psychiatrist in? How would that work? Assuming it's a mental health situation.

A. Yeah. Yes, they can make a decision with the ER physician but a psychiatrist has to be involved during the working hours. Because we are ...

Q. Okay.

A. ... there, we are on call, and we would like to be involved and we are involved. Because those patients will eventually automatically be admitted under a psychiatrist and so we, psychiatrists, make the decision during working hours in the (unclear) crisis team and we have to be consulted. That's the usual protocol.

Q. Right. At other times, do other physicians, though, apart from the psychiatrists have admitting privileges to the psychiatric unit at St. Martha's?

A. Yes. We have ... ER doctors have admitting privileges and actually, St. Martha's is one of the places where we have a very much collaborative care model with family physicians. We've always had privileges for family doctors who work in the Antigonish area to have admitting privileges and we acted as consultants, psychiatrists to those patients.

Q. Okay.

A. Now things have changed because a lot of family physicians are not doing hospital practice and we have hospitalists now. Most of the hospitalists are doing inpatient hospital practice.

So now, in the last year or so, most of the patients are admitted under a psychiatrist. Before it used to be they were under a family doctor and we were the consultants. But even then we did a lion's share of the work ...

Q. Okay.

A. ... because they were on the Psychiatry unit and we were the ones that were managing them. But it was always nice to have a family doctor involved with us, because they know their patients well, and so that was an advantage and it still is. There are still some family doctors who still do that.

But the ER doctors have always had privileges to admit patients on the inpatient Psychiatry unit.

Q. Okay. Now the inpatient ... well, first of all, I should ask you, as you touched on this, but St. Martha's has an inpatient Psychiatric unit, there's also an outpatient clinic I guess ...

A. Yes.

Q. ... is that correct? All right. That sees patients. And that's physically in the hospital or on the ...

A. Yes.

Q. ... in one of the adjoining buildings ...

A. Yeah.

Q. ... I guess?

A. No, both the inpatient unit and our outpatient mental health and addictions department is on the third floor of St. Martha's Hospital.

Q. Okay.

A. The third floor doesn't only have the psych unit, it has other people.

Q. Okay.

A. They have a geriatric unit also ...

Q. Right.

A. ... on the third floor. Geriatric assessment and rehabilitation unit ...

Q. Yes.

A. ... that's GARU, which has actually more beds than we have. And we have the occupational therapist therapy department on the third floor.

Q. Okay.

A. And the rest of the floor is inpatient mental health and outpatient mental health services.

Q. Okay. So there's inpatient and outpatient on the third floor of St. Martha's?

A. Yeah.

Q. You're available to Emergency for patients who present there. Is there anything else that the Psychiatric Department at St. Martha's does or is that essentially ...

A. I think that would be the gist. We have a ... it's a designated unit. We have an on-call psych- ... we have ... somebody is on call 24/7 and we have the advantage of all sitting on the same floor at least. And even ... that helps because even if there is some crisis on the outpatient unit, a therapist is seeing somebody or the psychiatrist is seeing somebody there's a crisis. Crisis means that there is something that we need assistance with so we are all there to manage the situation professionally.

Q. How many beds would there be in the inpatient ...

A. We have ten beds.

Q. ... in the inpatient unit ...

A. Inpatient.

Q. ... at St. Martha's? All right. Okay.

So if we could I'd like to draw your attention back to the date we've been talking about, January 1st, 2017. At that time, you were working. And generally, you were working as a psychiatrist at St. Martha's, we've addressed that. And I understand you were the psychiatrist who was on call on the evening of January 1st, 2017?

A. I was on call.

Q. All right. Now we heard from Dr. Clark yesterday who was the emergency room doctor who saw Mr. Desmond when he attended at the Emerg Department at St. Martha's. Can you tell us perhaps your ... well, first before I ask you that maybe I'll ask you a couple of general questions.

Dr. Clark talked about his thought process as he determined whether it was appropriate to consult with a psychiatrist. In general, when Emergency Room physicians see somebody, what are the types of things that that physician would be thinking about in determining whether it's appropriate to call the psychiatrist on call for a consult or not?

A. Well, that's a question I think the ER physician would be able to answer better but at the same time I think the ... at the general psychiatric presentation their overall presentation in terms of their demeanour, in terms of their education, and in

terms of their safety, safety concerns, whether they are ... they meet the criteria for involuntary hospitalization or voluntary hospitalization. They will do the physical exam and that's their part, you know, that they will do.

So, again, they will try to assess and obtain as much information as they would from any other patient, moreso who comes with a psychiatric presentation, past history, you know. But, of course, it's not a full assessment, it's ... in the context of an ER setting. So I think that could be the information. They would have access to some records also and so forth.

But it's the whole overall picture whether they can manage the patient or they would need a psychiatric consultation, because a lot of patients are managed by the ER physicians. We are not called for each and every psychiatric presentation that the patient presents in the emergency room. A lot of them are seen by the ER physicians and discharged without us knowing about it because they feel confident.

Now different family physicians have different comfort levels in terms of dealing patients who present with mental health issues and we know that. So it would depend upon the ER physician's experience and comfort level ...

Q. Right.

A. ... how to deal with the mental health patients.

Q. And if we were ... if it's after-hours and the crisis team is not available ...

A. No.

Q. ... the nature of the consult with the psychiatrist, is it automatic that the psychiatrist is going to come to the Emerg Department or could it be a telephone consult? What form might it take?

A. It could be any. Not necessarily. They can call us for a telephone consult and they can call us if they want us to come and see the patient in person. They can also admit the patient in the inpatient unit and just call us to inform. Because that's a protocol in case they take our beds ...

Q. Yes.

A. ... the protocol but they should at least call the psychiatrist and let us know that they're taking our bed so I would know how many beds are left and (unclear) the situation.

And it sometimes depends when they talk to us and consult on the phone and if I feel or somebody else feels that, you know, maybe we can go and see the patient I usually tend to. It also depends upon the psychiatrist who is on call, but we all

tend to go and see the patients in person most of the times, but again, it could vary.

Q. Okay. So when you're on call I guess you have to be in some close physical proximity to the hospital so that if, need be, you can get there?

A. Yes.

Q. Okay.

A. Yeah.

Q. And I wanted to ask you one other question. We've heard a bit about the triage score that's used or the triage scale, I guess, that's used ...

A. Mm-hmm.

Q. ... in assessing patients, and I'd like to ask you a couple of questions about that. So a triage score ... let me back up. When a person comes to the Emergency Department I understand they're seen first by a triage nurse. Is that a typical protocol?

A. Yes.

Q. And that doesn't matter whether that's a physical issue or a mental health issue?

A. Yes.

Q. And the triage nurse will ultimately assign a score

one to five to the patient?

A. Yes.

Q. Okay. And I assume that the levels one to five have ... obviously they have meaning, but a slightly different meaning for mental health patients than patients with physical issues?

A. Yes.

Q. What's your understanding, generally, of that scale and ...

A. Okay.

Q. ... what it's meant to designate?

A. So the nurse arbitrarily decides what level. Of course there are some guidelines also. The level would mostly decide how quickly a patient would be seen by the ER physician.

Q. Yes.

A. My understanding is that I do my own assessment. The levels are there but they are for the ER physician but when it comes down to me coming or a psychiatrist coming down, then we do our own assessment regardless of whatever level it is.

Mr. Desmond, for example, was scored at level two. I looked at that at the time but later on also, and I'll tell you, the levels are level from one to five and level one is called

"emergent" and is called "resuscitation". It's just for resuscitation purposes. There is no psychiatric presentation on level two (sic) emergency basis.

Level two is actually emergent. First is resuscitation, level two is emergent, and the psychiatric indication in level two, which is emergent, is acute psychosis and extreme agitation, and Mr. Desmond did not meet that criteria. He was not psychotic and he was not agitated.

Level three is urgent and only people with acute psychosis and if there's plus and minus suicidal ideations, they meet criteria for level three. That's urgent.

And then there's less urgent, level four, in which it's depression and suicidal ideations and level five is the lowest level which has only psychiatric symptoms.

In my view, he met criteria for level five or below.

Q. Okay.

A. And that's how the levels are, in my understanding.

Q. And just to help us a bit with that, for a psychiatric patient to be scored, generally speaking, at level two requires acute psychosis and extreme agitation.

A. Extreme agitation.

Q. So just can you define "psychosis" for us? I think we

understand what it is but ...

A. Yeah. Psychosis, the definition would be, it's when people lose touch with reality.

Q. Mm-hmm.

A. It's how the brain processes information. It comprises of delusions, hallucinations, false perceptions, disordered thought process and disorganized speech and behaviour.

And so perceptions are hallucinations. They can be auditory. People can be hearing voices. They can be visual. They can be seeing things which are not there or they can be tactile. They can feel things that are not there. Those are perceptual false perceptions. Hallucinations.

Delusions are false fixed beliefs which are maintained despite being contradicted by what is mostly regarded as reality or it's not real.

Q. Right.

A. And then psychosis is a symptom.

Q. Yes.

A. It's not an illness. People can be psychotic in many other conditions also. It's ...

Q. So an analogy would be a fever is not a condition

itself, it's a symptom of another illness?

A. Absolutely.

Q. Yeah.

A. People can be psychotic with depression also. Depression with psychosis. People can be psychotic with postpartum depression and psychosis.

So just reality testing is not intact in those patients.

Q. Right. No, that's helpful, thank you. So for a psychotic condition to be acute, what does that mean?

A. That they're actively experiencing all these symptoms.

Q. Okay. So somebody may at times have a psychosis or have psychotic symptoms that come and go? Is that ...

A. That is a possibility. It depends what is the etiology, what's the cause.

Q. Mm-hmm.

A. Sometimes it could be substance-induced psychosis because a lot of patients who are psychotic, they have lost touch with reality in context of substance abuse. It could be alcohol, it could be marijuana, it could be many other illicit drugs and in other conditions also.

Q. Okay. So, again, circling back to the level two, the psychosis in the patient has to be acute, and coupled with that,

they have to be agitated or I think "extreme agitation" is what you said?

A. Yes.

Q. Okay.

A. Now I know about a few of the documents, but there's an old document in which it says that anybody who has suicidal ideations, for the nursing, I think nursing would know more about it, that anybody who would present with suicidal ideation should be at level two or three.

Q. Mm-hmm.

A. That is another place but Mr. Desmond did not even meet those criteria.

Q. Okay

A. Yeah.

Q. And I appreciate what you've said and what Dr. Clark said, that the score is just one piece of information. It's one person's opinion. I understand that. And that you each do your assessments, but just because we have the number, I'd just like to understand the scale.

So you said level three is, again, acute psychosis with ...

A. And plus or minus suicidal ideations.

Q. And what do you mean by plus or minus?

A. Well, they can be there, but they cannot be there, but acute psychosis is the prerequisite.

Q. Okay.

A. As long as ... if acute psychosis is there, then it will require.

Q. Okay.

A. Regardless of having suicidal ideations.

Q. Right.

A. They can be there. They cannot be there.

Q. And then level four is?

A. Level four is depression and suicidal ideations.

Q. Okay, and level five, finally, was?

A. Level five is only simple psychiatric symptoms.

Q. Okay. So, typically, and, again, I know there's no hard and fast rules, but one would assume the higher you are on that scale, the more likely an admission to hospital might be, and the lower you are, the more likely you would be seen and treated in the community? Is that a fair statement?

A. Not necessarily.

Q. Okay.

A. It will come down to the clinical judgment of the ER physician and then the psychiatrist because, you know, we get a

lot of people who will tell that they're suicidal just to be on the ... some people know the system and we have a lot of borderline personality disorders. We have a lot of other people that we know and a lot of people might meet the criteria of level one or level two or level three but that does not, I think, directly affect their likelihood to be hospitalized. I think that affects their accessibility to the ER physician in terms of the timelines.

Q. Okay. So really what it comes down to is that. I say higher. I mean the lower the number, I guess I should say, the more likely or the quicker they might see the ER doctor.

A. Yeah.

Q. Okay. Now, again, back to January 1st, you were on call that night and you had some contact with Dr. Clark, did you?

A. Yes.

Q. Do you recall what the nature of that contact was? How you first became involved in this or aware of it?

A. Okay. So I got a call on my cell phone that there's a gentleman in the ER, a veteran, he initially told me, who just needs a social admission and he has no place to go, to live right now, and if they could take a bed from me from the

inpatient ... for the bed on the inpatient unit. So ...

Q. And did Dr. Clark use the term "social admission"?

A. Yes. Yeah. And because he doesn't have any place to go, if he can take your bed to put him in on the Psychiatric Unit.

So I happened to be in the hospital at the time. I was doing rounds and I asked him a few more details about the patient and he told me. We had a brief discussion about the name of the patient and how old is he and he's a veteran and he had been seen by Dr. Slayter and Veterans Affairs.

So he mentioned two or three things, you know, seen by somebody here, so he was in our care, sounded like. He was a veteran. Then I asked him, Does he have any family? Is he with somebody or not? He said, No, he's alone. I said, Does he have any family? He said, He has a child and there's some conflict with the wife.

And so I was just ... casually, I said, Well, I'm here, so I will come and see the patient myself.

Q. Okay. And just before you go further ...

A. Yeah.

Q. ... we should perhaps ... you can have reference to the chart and the material.

A. Yeah.

Q. I think it's 68 or 67? Is it at 67? And perhaps we can even, if you want to flip over to page 33.

A. 33.

Q. Yeah. Is that the same page you have there?

A. 32?

Q. Or 32. There's two different paginations.

A. Yeah, 32.

Q. Yeah, okay. All right. And do you recall the time that you would've been contacted by Dr. Clark?

A. I don't have recollection but I saw it. It was around 7:30 or something like that.

Q. To the best of your recollection, does that generally accord with what you remember of the time and the call?

A. Yes, yeah.

Q. Okay. So you said that you happened to be in hospital that evening.

A. Yeah.

Q. And so you decided to go and have a look and meet with the patient. Were you to have been outside of the hospital, would this have been a situation where you feel you would have needed to go in and see him?

A. I cannot answer that. Not necessarily, but given that he was a veteran and he had a family and there's a conflict, I probably would have still come and seen the patient.

Q. Okay, and ...

A. Because I am the inpatient psychiatrist, also, I would have ... any of us had to see him the next day or the ...

Q. Right.

A. So I usually want to see people, how they present at the time, so I think I would have gone in and seen him.

Q. Right. And your recollection is that Dr. Clark's thought is that he would be somebody who would be admitted to the inpatient unit?

A. Well, it was just to have him stay overnight because that's what his presentation was like, so I won't say "admitted", but just to hospitalize overnight.

Q. Okay. And perhaps we can just speak about that. You used the phrase, and Dr. Clark did, "social admission".

A. Yeah.

Q. Can you explain what your understanding of that term "social admission" is?

A. Okay. So there's a criteria, strict criteria, to be hospitalized on the inpatient mental health unit. But by virtue

of what we do, we work in a biopsychosocial model and we have a lot of people who have a lot of psychosocial issues.

So sometimes they would come in and, for example, I had a fight with my girlfriend. I had a fight with my boyfriend. I had a fight with my wife. I was fired from my job, you know, I have some financial issues.

So different psychosocial aspects and they are feeling overwhelmed and they are not able to manage and they are in distress and I feel that coming to the hospital, it takes courage for somebody to come to the hospital to present. It's a good initiative. They are seeking help actively. So that ensures that they are making an effort to get some help.

So our threshold to help patients in that way. I'm talking about St. Martha's culture also in our psychiatry. We live in rural Nova Scotia. We don't have any shelters. We don't have any. These things make a difference.

In big cities, there's shelters there. I think this kind of social admissions probably are not as common in big cities, in Halifax, or where there are more resources.

So we entertain that and we try to help people as much as we can do. And we usually have beds and these social admissions are just for a night or two observation, and usually their

crisis is resolved within a day or two and we just try to help people.

They are some transients. We use the word "transients" sometimes. Somebody is crossing by Antigonish and they sometimes show up. These are the people who know the system and they would show up and would ...

So it depends if it's the middle of the night, it's late hours, there's no public transport, they don't have any money, they don't have any place to live, they are distressed. We try to help them.

Q. Okay.

A. So that's what we call social ...

Q. And that would be differentiated from, I guess, a formal admission for somebody who needs ...

A. Yes.

Q. ... treatment? Is that ...

A. Yes.

Q. Okay.

A. Yeah.

Q. So if a person is, I guess, admitted or taken in as a social admission, what typically happens with them? Do they receive or can they receive treatment or are they observed or

what happens?

A. So the way they are treating is not at all any different from anybody who is admitted or on observation. The service that they get is the same. It is just a matter of the length of admission, the length of hospitalization, the overall criteria of the presentation, but if they are there and they need something, we will try to help them. If they ask for something, if there's a subjective assessment done as well as objective, but we will treat them as anybody else if they need treatment.

Status changes also. Sometimes we have a social admission kind of admission, and then other things are real. They get more distressed the next day.

Q. Right.

A. They deteriorate. So they are assessed. So that is another reason to keep them that we assess them. Our staff assesses them, and their status can change also.

Sometimes a voluntary patient comes in and he comes in and next day he tells me that they are suicidal or something like that and I'll say ... and they want to go. So the situation changes. Their criteria, they start to meet the criteria of involuntary psychiatric hospitalization.

So it is a ground reality is that we just ... that's why we observe them, we monitor them on a constant basis and if there's any change in the status then we act accordingly.

Q. And a person who is under observation as a social admission, if they are taking a particular medication that's prescribed will the hospital, for example, administer those meds to them?

A. Absolutely.

Q. Right. So your anticipation, based on the information that you had from Dr. Clark, was that Lionel Desmond might be a social admission to the hospital.

A. (No audible response.)

Q. Before you went to see Lionel Desmond, did you access any other material or any other information about him that you might've had at the hospital?

A. Yeah. I heard his name and I was on the same floor. I went to the outpatient department and quickly took a look at our outpatient chart, which I sometimes do, and I looked at the chart and I saw Dr. Slayter's assessment there. It was a quick review of the assessment. I didn't do any in-depth analysis of the chart. It was quite lengthy, but it was a very elaborate and comprehensive assessment.

Q. And that document that you reference from outpatients, that would've been easily accessible to you, would it? How would you have accessed that?

A. That would be in our outpatient chart on the third floor on the mental health unit.

Q. So at the time, it was in a file cabinet or something, was it?

A. Yes, yes.

Q. Okay.

A. Yeah, absolutely.

Q. Would it have been stored electronically at that point?

A. No, no. That, what I remember, the charts, at the time in 2017, they were not scanned at the time. The scanning I remember started later on. It was mid-2017 or later in 2017.

At the time, the charts were all paper charts and it was a common protocol for the ER, when the patient used to arrive in the ER, the medical records, the charts, physical charts, used to come from medical records, inpatient medical charts. They would come to the ER, and so all this information ... but Dr. Slayter's note, because if that was an outpatient note that would not have been in those charts. That was an outpatient

chart maintained on our outpatient medical records space.

Q. So just so I'm clear, any inpatient records at the time, first of all, their availability to the ER doctor, they would be gathered in paper form and brought to the ER doctor?

A. Yeah.

Q. Okay. And outpatient records would not be available typically to the ER doctors?

A. No, they would not be typically. However, there have been times occasionally in the past that if somebody needs an outpatient chart from the floor, they can go and have the access.

Q. Mm-hmm.

A. They can go because it's similarly maintained, so they can get the chart if they want to but it rarely happens. It does not happen because it's an ER assessment, it's time limited they have ... Now it's easier because all these charts have been scanned. They are on the MEDITECH.

Q. So that system, MEDITECH, it's your recollection that that came into use when? You said roughly ...

A. Mid-2017.

Q. Mid-2017.

A. Yeah.

Q. So new inpatient charts that are created are created electronically on that system, are they?

A. Yes. I mean part of it but it's an ongoing process. Now even the paper charts or handwritten notes are scanned immediately.

Q. Mm-hmm.

A. And so the ER does not have to seek medical records from the medical records in paper. They are usually scanned and they are in the MEDITECH now for the last couple of years.

Q. Doctor, still, presumably, you use handwriting on charts, so if a chart is completed for somebody, an inpatient chart, that will be scanned into MEDITECH, will it?

A. Yes, now.

Q. Now.

A. Not at the time.

Q. Not at the time, okay. And outpatient charts, are those being scanned now into MEDITECH as well?

A. Yes. Outpatient charts, we dictate, so they are automatically in the system. That is my understanding. And the discharge summaries, the inpatient discharge summaries are dictated also, so they are in the system, but the non-medical records from the outpatient, they are still being handwritten

and so forth.

So it's a ... I think I should tell ... because I attend the program (unclear) meeting, this is in the process and this has been in the process for a couple of years and I think they're launching in spring of 2020. It's provincial scanning project and they are starting that, so most, probably all the medical handwritten or medical records documentation will be available electronically in the near future.

Q. That's province-wide, is it?

A. Yes, yeah.

Q. All right. So you said that you were able to locate and have a quick look at the outpatient consultation report that Dr. Slayter had done, and that's at page 26, I think. No. It's in the same tab, it's just back a bit. I think page 25 in your paper copy. Is that the document that you were referring to?

A. Yes, yes.

Q. Okay. Now this document seems to be about three pages long, and as you said, fairly comprehensive.

A. Yeah.

Q. It's dated December 2nd, 2016. So I don't know how you characterize it. You had a quick look at it? Is that ...

A. Yes, yeah.

Q. Okay. So would that include ...

A. I usually look at the front of it. He does a very good note and, you know, in the front of the assessment are recommendations and then at the end there's a treatment plan and I quickly browse through.

Q. Okay.

A. Yeah.

Q. All right. So you would have been aware, would you, that Dr. Slayter, in his assessment, had diagnosed Lionel Desmond with major depression, post-traumatic stress disorder, post-traumatic brain disorder, borderline delusions regarding his wife, R/O, which I think is "rule out", attention-deficit disorder? So possibly ...

A. Yeah.

Q. ... attention-deficit disorder, and that he had assessed his suicide risk as low? Would those things have all been aware to ...

A. Yes.

Q. You would've been aware of those things? All right. And you said you may have gone briefly to the conclusion or the tail-end of his report as well?

A. Yeah.

Q. I note in the last paragraph of Dr. Slayter's letter that he said, "I would normally see someone with PTSD once only to confirm the diagnosis and make recommendations. However, given the complexity of his case and given that he seems to be falling through the cracks in terms of follow-up by military and veterans' programs, I said I would follow him for a short while to help him get connected."

I don't know, would you, do you recall that, reading that, or ...

A. Yes, yeah.

Q. Okay. So you, I guess, had a sense then that Dr. Slayter felt that he might be falling through the cracks, if that's ...

A. Well, I don't think I can comment on that based on my interaction with Mr. Desmond.

Q. Mm-hmm.

A. This would be something that Dr. Slayter would be able to answer better.

Q. Okay.

A. But at the same time, this was at the time when he, when he saw him.

Q. Understood.

A. When I saw him, we usually are to assess patients as they present at the time.

Q. Um-hmm.

A. In my view, what he was telling me seemed .. So this was Dr. Slayter's first visit but now he's being followed up by Dr. Slayter.

Q. Um-hmm.

A. So even that, showing that note gave me a relief that this gentleman is being incorporated into our outpatient mental health. This could have been before that he could have been whatever Dr. Slayter's opinion was at the time.

Q. Um-hmm.

A. But it gave me a little bit of contentment that there's a plan and there is at least that he's being followed up by Dr. Slayter. Although I did ask Mr. Desmond ... He did miss an appointment with Dr. Slayter. I looked at the initial note and it did say that he's seeing a therapist on the same day that he saw Dr. Slayter, so I didn't go into the specific or in-depth detail, but Mr. Desmond did tell me that he is seeing a Veterans Affairs social worker and therapist and I presumed that this will be the person who he's seeing. So, to me, he was engaging, he was, you know, we would talk about his presentation, but I

thought we had a good plan until he will ... he is attached to the social worker, with the Veterans Affairs therapist, Dr. Slayter, with the hope that he will be seeing somebody in our psych clinic and so forth, so I was satisfied somewhat.

Q. Yeah, okay. So you had that report from Dr. Slayter. Did you have any of the other, older charts for him?

A. That was the only thing in the chart. I mean, there was not much ... I had, this was something striking for me to see, so that was very helpful.

Q. Lionel Desmond had an earlier, at least one Emerg or visit to the ER from October 24th. Did you have an opportunity to look at that chart, as well?

A. Yeah. Now that would be the inpatient chart.

Q. Yes.

A. Because that, our chart outpatient would not have that.

Q. Right.

A. But ...

Q. So this is the only thing in outpatient?

A. This is the only thing, but Dr. Slayter, I think he did mention in his note that he had seen him.

Q. Um-hmm.

A. Once before, in the same note, I think. I think either I got this from this note or I got it from the inpatient note, where he would have previous ER visits. So I was looking at the note, I was aware of that also this is not the first time, he's seen him a couple of times and will see him again.

Q. Did you have an opportunity to look at the inpatient charts?

A. I took a look at the chart but I didn't do any in-depth ... I mean this note and that chart we ... I had enough information from this note.

Q. Yeah.

A. Such a comprehensive note. And the diagnosis was established. I didn't do a whole symptom profile. In a context as an ER ... as an on-call psychiatrist, in the context of seeing somebody in the Emergency Room, it's not a full psychiatric assessment. It's a focused assessment. And these all were established diagnoses and I used these records and my, of course, my speaking to Mr. Desmond, that I ... these are very established long-standing diagnoses.

Q. Okay. And so the charts, the older inpatient chart would have been available to you and to Dr. Clark on paper, not electronically, do I understand that?

A. Yes.

Q. Okay.

A. Yes. So I don't completely but I have a recollection of looking at the chart either before I saw him or after, because I was involved with him for ... until he settled down. It was almost one and a half, two-hour period that off and on I was involved. And that used to be a protocol, that the charts used to come from the Medical Records at the time.

Q. Okay. So under that same tab there, if you want to go back to page 13 - I think it'll be marked as page 14 on our electronic. No, just in the same tab.

A. Oh, okay.

Q. Just back a couple of pages.

A. Yeah, 13.

Q. 13, I think there's ...

A. Yeah.

Q. So that ... And you may not have a specific memory of whether you looked at this chart or not but this is, it would appear, a chart from October 24th, 2016, where Dr. Slayter saw Lionel Desmond. Do you recall if you had an opportunity to look at that chart or not?

A. Yeah, I have a recollection but, see, he did mention

something about, in his note also. I do have vague recollection because I knew that his prazosin was increased.

Q. Okay.

A. And a new medication was started. When I was talking to him, like we did discuss some of that, and I had an idea that something was increased and something new was started.

Q. Mm-hmm.

A. So I do have some recollection.

Q. And just the next page there there's, in that tab, there's a document, a Crisis Response Service Mental Health Risk Assessment that I think was completed by Heather Wheaton, the mental health nurse at that same time, October 24th. Would that have been part of the inpatient chart as well?

A. Yes, yeah.

Q. And so when, if you had had an opportunity to look at the main chart, would that have been attached to it or would it be ...

A. That would have been attached to it but I don't have any recollection getting into this one.

Q. Right.

A. Because I had this previous one and this one, so I had enough information to go in and start doing my assessment.

I did not go in-depth and look at Heather Wheaton's assessment, no, I have to say that, yeah.

Q. Okay. All right. Understood. So you said based on the chart, and if we go back to page 33 - that would be 32 in your binder.

A. Yeah.

Q. You think it was around 7:30 that you would have seen him?

A. Yes.

Q. Okay. Now ...

A. He called probably ... But I had five, 10 minutes it took me to look at the doctor's, you know, chart and it would be, well, maybe 7:40-45. I was very quick, I just wanted to see him and ...

Q. Um-hmm. Okay. So you were able to deal with this fairly quickly?

A. Yes. Oh yes, yeah.

Q. And that, I assume, isn't always the case. You might be otherwise involved with a patient or something that wouldn't allow you to go to Emerg right away?

A. If I'm on call and they call me, depending upon what the acuity is, I'm there within 15, 20 minutes. We are on Level

1 call. (Unclear) to only half an hour. It depends upon ...
2 Sometimes police brings the patient. We want to be there
3 quickly so that we can relieve the police and so forth. It
4 depends on the presentation but we do attend to the patients ...
5 try to attend as quickly as possible.
6 **Q.** Okay. You said you're on Level 1 call. Is that
7 something to do with how fast you have to be able to ...
8 **A.** Yes, yeah, some more ... we have to be there within
9 half an hour or so.
10 **Q.** That's what you aim for ...
11 **A.** Yes.
12 **Q.** ... is to be there within or consult within a half an
13 hour?
14 **A.** Yeah.
15 **Q.** Okay.
16 **A.** We do that but sometimes what happens that they call
17 us as soon as the patient arrives in the ER.
18 **Q.** Um-hmm.
19 **A.** Have not been seen by the ER physician, have not been
20 medically cleared. Sometimes it takes a couple of hours for
21 them to be medically cleared to be able ... ready to be seen by
22 a psychiatrist.

Q. Um-hmm.

A. So it can vary.

Q. Right.

A. It depends when the patient is ready to be seen by the psychiatrist. The protocol is the patient has to be seen by the triage nurse and triaged and then the ER physician. Sometimes patients are directly transferred from other ERs, like, Strait Richmond or Guysborough Hospital or Canso Hospital. The physician, the ER physician directly calls us, on-call person, and we ... Then they are directly transported to the St. Martha's ER. Those patients don't have to go through the ER physician in St. Martha's. Those ones are the ones that we can go directly see them.

Q. Right.

A. Sometimes if we are, we know the patient, and some outpatients, some ER in the outskirts calls us, we sometimes directly admit patients to our inpatient unit and see them in the inpatient unit ourselves bypassing the Emergency Room, because they've already seen, been in another ER and seen and assessed by a doctor.

Q. Right, right. Okay. So in this case, well, obviously, he had seen by the triage nurse and by the ER doctor

...

A. Yeah.

Q. And because you were physically close in the hospital, you were able to get there fairly ... very quickly?

A. Absolutely, yeah.

Q. Okay. So where did you meet Lionel Desmond and what was the nature of the room you were in.

A. I initially went and had a quick word with Dr. Clark.

Q. Okay.

A. In terms of what's going on. And then I went into it's called a family room, where we do see ...

Q. Yeah. Sorry. When you spoke to Dr. Clark, did he give you any additional information when you spoke to him face-to-face in the ER?

A. Not more than he already had given me on the phone. Actually, by that time I had a little bit more information than him looking at Dr. Slayter's note.

Q. Okay.

A. So he had, basically, transferred care to me at that time. Once we get involved, the ER physician, it's almost like a transfer of care.

Q. Um-hmm.

A. So I had a couple of minutes talk and then I went to see him in the family room, with the comfortable couch and away from the hustle and bustle of the ER and that's when I saw him.

Q. Now mental health patients who present at the Emergency Department, they would typically be put, would they, in a room like the family room as opposed to a more traditional hospital room or does it depend?

A. It depends. Sometimes we have two or three patients, three or four patients waiting for us to be seen in the ER at the same time. I'm on call and I go there and two or three patients are there.

Q. Right.

A. So, initially, it's the family room that we use but there's another room now. It's for mental health patients that is specifically designated for mental health patients. That's called interview room. I don't know when ... Initially, when this ER was renovated, we had only this family room but I think that used to be an office and we asked for it and we wanted a separate, proper interview room, and we were granted that by the ER. So we have that room and we have family room. Both are equally in comfort and privacy and so forth. But if we have another patient ... For example, family room can be occupied by

some family sometimes.

Q. Um-hmm.

A. And so if we have only interview room and we have another patient, they can be in some other room. There are 10, 12 rooms. We see patients all over the place, but if these rooms are cleared ...

Q. Okay. And so the interview room and the family room, they don't have, like, a hospital bed, like, a traditional ...

A. No.

Q. No, no. Okay. So at the time, and I appreciate you're not the Emergency Room doctor, but do you recall how many beds there were in Emerg at St. Martha's at the time?

A. I don't recall. No, I don't recall how many beds were there but they had beds.

Q. Okay. And so at the time there was the family room. Since the renovations there's now the interview room as well?

A. Yes.

Q. Okay. And we've heard a little bit about the ward, the observation ward.

A. Yeah.

Q. What can you tell us about that?

A. So observation ward ... There's ER, which has

separate rooms, eight, 10 rooms, and then there's a six-bed observation unit, and it's very ... it's relatively private. It has ... it's partitioned by curtains and so sometimes patients are kept in those rooms. If there's no bed available on the Medical Unit or on the Psychiatry Unit these beds are used for that purpose. It's not common to have beds in the ER. It's pretty busy most of the time.

Q. Um-hmm.

A. But we had some beds in the observation area on that evening.

Q. Okay.

A. And those beds are beds, they're not stretchers.

Q. Okay.

A. I was there yesterday and, you know, they are not stretchers, they are proper medical beds, very comfortable. And they get ... they have a separate nursing complement attached to those patients on observation. They have nurses, they have ... they are treated as if anybody else would be treated anywhere else in the hospital.

Q. Okay. So you come down ... and I should ask you and I think, essentially, you've answered this, but you had the charts and the information that you had prior to going down.

Would there ever be a situation, knowing that a patient had been seen by one of your colleagues, one of the other psychiatrists, would there ever be an occasion when you might contact the other psychiatrists to get their thoughts on a patient before you saw them? For example here, Dr. Slayter, you know, had seen him. Would there be any value in that or ...

A. Well, any additional information would be ... could be of assistance, I do understand that. But we ... the on-call person sees patients who have been seen by many care providers, including psychiatrists, and as an on-call psychiatrist we have to make up our own decision. We have to do our own clinical practice, clinical assessment. So we don't call the other psychiatrists, that does not happen, because the other psychiatrist is not on call.

Q. Um-hmm. Okay.

A. We don't do it.

Q. So when you went to the ER you met Lionel Desmond in what was then or, I guess, still is the family room, was he alone or was he with anyone else?

A. He was alone.

Q. Okay. And to your understanding or knowledge had he come with anyone to the ER or was he alone when he came?

A. I don't have any knowledge of ... Because I had spoken to Dr. Clark on the phone, Is he alone? He said, He's alone. So I remember from that but I ... He was alone.

Q. Okay. And had you ever met Lionel Desmond before?

A. No.

Q. Okay. What were you initial observations of Lionel Desmond how ... when you first go in the room how he's presenting to you.

A. Very pleasant, engaging, maintained good eye contact, appropriate, forthcoming, calm and composed.

Q. Do you recall how he was dressed or how his appearance was?

A. I don't have ... but good hygiene, good demeanor, good grooming.

Q. Was he seated when you ...

A. He was seated.

Q. When you speak to him, or any patient in those circumstances, would you typically sit down, as well, or ...

A. Yes.

Q. Okay.

A. Yes, I sat down.

Q. And maybe generally you can just tell us before we

get into the details of your conversation with Lionel Desmond, how do you approach that interview when you're attempting to assess a patient? In other words, do you ask open-ended questions, do you probe? How does that work?

A. It's a mixture of both. The initial goal is to establish a good therapeutic relationship.

Q. Um-hmm.

A. And we use our rapport with the patient in the assessment also. So, yes, I mean, initially, it would be open-ended. What brought you to the hospital? How can we help you?

Q. Um-hmm.

A. And then gradually we... We are trained to probe, we are trained to ask questions. If there's something that needs further exploration or a follow-up, we would ask more questions. Psychiatrists, using our clinical judgment, we decide the scope and nature of questioning. We pursue questioning until, as per our clinical experience and clinical judgment, we have enough information to form an assessment, an opinion.

So it's a mixture of open-ended questions and closed-ended questions. When it comes down to issues with safety and issues with situations where, in terms of, you know, whether we have to keep somebody involuntarily then we tend to become more direct

also.

Q. Um-hmm.

A. That happens, too. So it's a general, you know ... He was a veteran, and maybe that was one of the reasons, him being a veteran and my experience with the veterans population, I did ... decided to come and see him in the first place.

Q. Would you be taking notes when you speak to the patient?

A. No. I usually ... I do my notes later on.

Q. Okay.

A. I usually don't. I think that they interfere, I think note-writing at the same time would interfere with my assessment and the type of relationship with the patient.

Q. I assume one of the things that you want to assess is eye contact and those types of things, you want to look at the patient as you're talking to them, is that ...

A. Yes, yes.

Q. Okay. So the notes, your physician progress notes, I think they're at page 37 in your binder - they'd be 38 on the exhibit.

A. Yes.

Q. Do those relate to the content of your conversation

with Lionel Desmond? Is that ...

A. Partly. This is not a verbatim transcript.

Q. Understood.

A. But usually, I should tell you I usually don't write such a detailed note in a short ER assessment.

Q. Okay.

A. So this is my note, yeah.

Q. All right. So you wrote about two pages of notes or so. Those would have been made, then, primarily after you or near the end of your interview with Lionel Desmond?

A. Yes. Yeah.

Q. Do you recall how long you spoke to Lionel Desmond?

A. About 30, 40 minutes. That was the timeline.

Q. Okay. All right. So you said, you described his initial demeanor, you said he was calm. Do you make any other initial assessments of things like I mentioned eye contact or affect or do you make those types of initial observations of a patient?

A. Yes. That's part of the mental status examination.

Q. Okay.

A. So that's .... we do that, the demeanor.

Q. Um-hmm.

A. And if there's any psychomotor agitation, retardation, how's his speech, how's his ... is he engaging fully, you know, what is his thought process, thought content, how's the mood and everything. So if you're discussing my note, I ... what I was looking for I did ask him a lot of direct questions also, because of the interpersonal conflict and so forth. And these are my standard questions in terms of mental status examinations and thoughts of hurting somebody else or thoughts of hurting himself and has he ever done this in the recent past or past suicide attempts, even to the point that is there any history of abuse, has he abused somebody or to the point of legal history. So I think I went to that extent to kind of ask all those kind of questions.

Q. Okay. And would those questions be typical of a mental status exam?

A. They are. In my practice, I usually ... we do usually ask these questions. These are standard questions.

Q. Okay.

A. In his context, because he had mentioned to me about police being involved in the past ...

Q. Um-hmm.

A. ... and stuff like that, which we can elaborate

later, but in this case I just wanted to make sure that there is no charges or peace bonds or restraining orders or anything like that.

Q. Um-hmm.

A. We do this all the time and we get patients all the time, you know, having legal issues, so just to be clear.

Q. So throughout your interview with him do I understand you that the mental status exam, if I could call it that, is something that's ongoing throughout your interview with him?

A. Yes.

Q. Okay. And you said kind of quickly the components of the mental status exam, the things that you look for. Can you just tell us again what those were, the general things that you're looking for in an interview with a patient.

A. Yeah. So the mental status examination consists of we see how the patient is presenting. What is their demeanor, how, they are, is there any evidence of psychomotor agitation or retardation or they are ... How's the speech, how they're comprehending things, are they able to understand us clearly, are they able to answer us, the questions clearly, are they forthcoming, is there anything wrong with their thought process or thought content. We ask about their mood also. How's the

insight, how's the judgment. There's a little bit of a cognitive assessment also - how's the memory, how are they managing. So this is, this is all part of the mental status examination, but also overall part of the overall assessment, psychiatry assessment.

Q. In the time that you were with Lionel Desmond, those 30 to 40 minutes, were any of the components of the mental status exam significant? Was there anything that was of concern?

A. No.

Q. Okay. So the difference between thought process and thought content, maybe you could just explain that to us.

A. Yeah. Well, thought content would be if there's any hallucinations, are there any false perceptions. Thought process would be are they able to be, they can understand me, are they talking logical stuff.

Q. Um-hmm.

A. Is it goal-directed, is it ... Thought content would also involve asking about delusions, hallucinations and so forth.

Q. And none of those were present?

A. None of them were present.

Q. Okay. And, sorry, that was thought content, was it?

A. Yes.

Q. And thought process?

A. Thought process is coherent, logical, goal-directed.

Q. Right.

A. You know, how the process, how they are. You ask a question, sometimes people are, it's called tangential, being tangential or circumstantial. So that is another way to describe that. In tangential, you ask a question, they would go in tangents.

Q. Um-hmm. Go off in other directions.

A. They would never come back to the same ... Circumstantial, there are ... So it's, these are different kinds of ... You know, is there any paranoia? They think people are following them, people are conspiring against them and so forth. In his case, about his ... I didn't do an in-depth analysis of the jealousy piece around his wife, but he did tell me that the jealousy, it used to be a problem but it is not a problem of his anymore. He had a clear connection between his marijuana use and jealousy, which he had stopped using early 2016, March 2016. So this is part of the mental status. Because I had this information I did ask him if he feels that she's going to leave

him for somebody else and he said no. So that, he was ... he did not exhibit or endorse any symptoms that suggested acute psychosis or paranoia.

Q. Okay. His speech was normal, was it?

A. His speech was clear, normal in speech, speech was normal in rate, rhythm, tone, and volume.

Q. You mentioned psychomotor agitation?

A. Very calm and composed. There was no agitation or retardation. He was calm and composed. He was not anxious, he was not fidgety, he was not in any way exhibiting any ...

Q. His mood, generally, seemed what to you?

A. He was distressed because of the circumstance. He didn't mention any ... that his mood is depressed or anything like that. His mood was ... His affect was pretty reactive.

Q. So mood and affect are two slightly different things, are they?

A. Yes. Mood is something that the patient tells us. It's more subjective.

Q. Right.

A. And objective is what we assess.

Q. That would be your assessment of the person's affect?

A. Affect.

Q. Okay. And in his case his affect was reactive, you say?

A. It was reactive.

Q. Which means what, he was answering you or ...

A. He was answering me and he was interested in answering in me. He was also ... We discussed other things also. He, his reaction was appropriate to the topic or to the subject of what we were discussing.

Q. Okay. So you were able to, then, communicate effectively with Lionel Desmond?

A. Clearly.

Q. So I assume ... Well, perhaps you can tell us, with respect to the specifics of his situation that brought him to hospital, what did you ask him and what did he tell you?

A. So he told me that there's a longstanding conflict between him and his wife and which affected his general relationship with her and then he told me about this incident that happened the night before, when they were returning from the New Year's party and his truck went into a ditch which started an argument between him and his wife. And then he told me that it just kept on escalating until the next morning and he became agitated and he pounded or punched the table or some

piece of furniture and he startled his daughter and he was very remorseful about that. His demeanor, his, again, affect changed when he was telling me that he was very remorseful and regretful of the incident last night and whatever happened that had brought him to the hospital.

Q. How did his affect change when he ...

A. Well, he became very remorseful, a little bit flat at the time, that he was remorseful and regretful. I asked him, Are you remorseful and regretful of your action? And he said yes.

Q. Yeah.

A. So then he started on that and then he ... I asked him a little bit about more problems ... a little bit more about his relationship and how long. He said this is longstanding.

Q. The conflict?

A. The conflict has been longstanding and he was ... he reported some financial issues also. And he did tell me that he felt he's a proud father and a proud, you know, he supported his family financially all his career, all his life. He indicated that he had paid for all the tuition fee, St. FX Nursing School tuition fee for his wife. And he told me that now that she's working, she's graduated and working, he does not see any of the

money. He did also tell me that he had all the receipts for all the fee that he paid for St. FX Nursing School.

So I asked about the accident, a little bit, you know. Why ... what happened? Like, I didn't go into details but I asked him, because it was New Year's Eve, I said, Were you drinking or anything like that? And he said that, No, he doesn't drink anymore but he might have had a few drinks, but she had more. And I asked to probe a little bit more, but he was not too keen to talk about that more. I felt that he was protecting her. I felt he was protective of her by not giving me more information about the drinking piece but he said he used to drink quite a bit in the past but he stopped drinking in early January or February of 2016, that's not a problem anymore. So that was the ...

And then we talked about other stuff also but about the relationship issue, I did explore the interpersonal conflict and relationship. And I had the impression at the time, I had the distinct impression and it just appeared to me a mixed picture and it gave me an impression that it could have been ... it appeared to be more of an interpersonal conflict, possibly, but not necessarily, related to PTSD. This is a longstanding conflict and this is not the first time.

Q. Did you ask ...

A. He also told me that whenever they have a conflict she calls the police, you know, on him all the time.

Q. Yes.

A. And he was a little bit frustrated about that because he has to leave the house. Each time she calls police, he told me that he leaves the house before she calls, when she threatens him or if she calls the police, before the police arrives he leaves the premises. And so I said, Where do you stay? And so he said he has extended family and he goes and stays with them and stuff like that. So in the same context, again if I can continue ...

Q. Please.

A. In the same context I asked him that ... so I asked him about access to guns.

Q. Um-hmm.

A. And because the police was involved and, you know, all that stuff, so I asked him, do you have any relation or access to guns and he said no. He said that in one of those calls when she called the police, the police arrived when he was still there and they took away his guns. So the guns were removed from the house. That's what he told me.

Q. Yes.

A. So then I asked him about, is there any physical abuse, have you ever physically abused her, and he said no, never. Have you ever done it before, in the past; no, he said no, I will never do it, I have never done it. And so I think that was the gist of the conversation regarding that. He said that if this continues, then he will have to find a place of his own, he wants to leave, and will have to work ... And that was his plan to kind of ... to have to talk to the VA social worker and the therapist to arrange a different living situation, I mean find another place to live. So I had ... At the time I had asked him that, Can I call your wife, can I talk to her, because that's something we do all the time, called collateral, and people do allow us most of the time. Sometimes they don't allow us initially and eventually they do allow us. But he said, No, no, no need to call her because ... I said, Well, what ... she will be worried where you are right now. You know, she told him to leave the premises and come back the next day.

Q. So you got a sense that she had asked him to leave the home?

A. Yes, yes, that's what he told, that she said, Leave the premises and come back home next day. So he said that this

happened, this is not the first time this has happened. This has happened in the past also and I'll ... she wouldn't worry, I'll be back the next day and I have done that before. I have stayed with family and extended family and so forth. So I said, What if she won't take you back tomorrow? Then, he said that, Well, I have stayed with other people, I have extended family that I can stay with, but it's just for overnight, I just want to stay here overnight and she will take him back tomorrow.

Q. So you understood that he had no other place to stay that night or ...

A. That night, yes. He was asking ... he asked to stay that night. And, again, in the circumstance, in my view, he, this ... he didn't have any acute symptoms of PTSD at the time. It was just a conversation that he had a fight with the wife and she had kicked him out of the house and he wants to stay overnight and so ...

Q. You said it was a mixed picture, that you thought the interpersonal conflict with his wife was a primary feature, I guess. Did you talk to him, though, about his military background at all in that interview, in that 30 to 40 minutes?

A. Yes, yeah. So very interesting conversation in terms of his military service and background. He had told me that he

was, you know, he was a professional soldier and he was went to Afghanistan for seven months and we did talk about his experience in Afghanistan a little bit.

Q. Um-hmm.

A. And he tell me what did he do there and he was part of the retrieval of body parts, and he told me one incident when he was in a trench and they was fighting going on, active combat. So I was ... I know about the lingo a little bit, active combat, active theater, you know, this and that, so he was pretty comfortable talking to me about that and told me about a few incidents where it was quite traumatic, you know, and there was fighting going on and he had to retrieve bodies during that period and so forth. So on the lighter note I did ask him that did you ever visit Pakistan because I'm from Pakistan.

Q. Yes.

A. So I wanted ... I was probing at how does he react or respond to this and he was very much interested to talk about ... He was very open and very much interested to talk about that part of the world and so my question about whether he has been to Pakistan, he said that, no, I've never been there but I have flown over it.

Q. Oh, yes. Okay.

A. So ... And he smiled at that, smiled at that. We talked about his family. And his family, again, conflict and the daughter involved and all that so I wanted to have a little bit more information. So I said, How old ... what's your daughter's name? And I still remember the word, you know, Aaliyah, Aaliyah. And my daughter was almost of the same age at the time.

Q. Yes.

A. So I still remember. And he did talk to me about her birthday. So that was another thing that the birthday. I said, Did you have the birthday? He said, Oh, yeah, we celebrated the birthday recently. And he, his, again, affect became bright when he was talking about his daughter. Yeah, we had fun, she had her 10th birthday. And so that ... in that kind of conversation that kind of ... we continued and he spoke about his daughter very affectionately and so ... And then again asked for, to be, you know, if he can stay there over ... So, you know, so in the context of the discussion that's what I can remember of that.

Q. Okay. And did he make or make some reference to his treatment for, either at OSI Clinic or in Montreal, did he make

some reference to that?

A. Yeah, yeah, yeah. That was a part of it. I asked him about past psychiatric history. You know, have you been to treatment? He said, I've been in treatment for, like ... No, it says ... he said I've been since 2007, but the other note the doctor ... It said 2011. I don't know where, you know, 2011. But, for me, he told me he's been for since he visited Afghanistan in 2007.

Q. Um-hmm.

A. So he had been treated ... in treatment and he told me about his most recent hospitalization at Ste. Anne's Center for a few months in Montreal, and that's a ... I know about that facility because some of our patients have gone there. That's a PTSD psychosocial rehab kind of a long-term facility through VA. But he said he didn't complete the program. He was there for a few months but he didn't like the inpatient setting of the program and it's too noisy and stuff like that. So he didn't elaborate too much on that, but he was there for a few months.

Q. Okay.

A. Yeah. He did talk about his past ... He did not remember much of his past medications, so... But I was not to change ... that was, we were just trying to help him. It was

not something that I would change all his medications at that time.

Q. Okay. He made reference to obviously his past alcohol and cannabis use. Did you have an understanding of whether he was consuming either of those substances at the time that you saw him?

A. I asked him, he denied it.

Q. Okay.

A. I had looked ...

Q. Okay. Both that particular night and in general?

A. In general also but it was that night also and that was part of the emergency record also but usually I do tend to confirm myself with the patient whatever is written in the emergency care record during my assessment. And I confirmed that and he said no, he even gave me January 2016 he stopped drinking. He had an issue ... I said, Well, was it an issue any time in your life drinking, he said at the time it was because he was trying to use it. And then marijuana, about the marijuana he said it's prescribed and it's very high dosage that was prescribed. I asked him because we have these veterans who are on very high doses of marijuana, eight grams, ten grams a day so he, at the time again, he did ... connected his marijuana

use to the paranoia and to the peace with his wife. He said, No, it didn't agree with me so I stopped using it at all, I don't use it anymore.

Q. Okay. He indicated that it caused him to be paranoid?

A. Yes.

Q. Dr. Slayter's report talked about a traumatic brain injury or I don't know if that's the term exactly he used but previous brain injury. You said in your mental status exam you do a bit of a cognitive assessment, albeit it seemed very superficial at that stage. Did you see any evidence when you were talking to him of a traumatic brain injury or was there any discussion of that?

A. I did confirm with him the same. Did you have a traumatic brain injury and he said yes, two or three times, and we didn't go into details but it were a long time ago.

So during the review of symptoms, he had a mental status examination, I did not appreciate any, as such any ... I didn't ask him indepth about that, but there was no overt cognitive deficits. He did say that he has issues with remembering things but overall it was not a traumatic brain injury kind of presentation.

In terms of his inpatient treatment, he did say that at

Ste. Anne's Center that it was too noisy and he had this ... so that, I picked on that one because it's TBI. Traumatic brain injury patients are sensitive to noise and light and so forth. But as such, traumatic brain injury symptoms, I did not see any traumatic brain injury symptoms. A lot of TBI symptoms can overlap with ADHD symptoms and with PTSD symptoms also.

Q. Okay.

A. There's an overlap and I know that TBI is very common in people with PTSD. I know that in military combat, military veterans and combat, people who are exposed to combat in Iraq and Afghanistan, there's a 48 percent occurrence of PTSD with mild traumatic brain injury. So I knew about all that but I've seen patients with TBI who have much more serious physical disability. He did not seem to have that level of disability from his TBI but I saw Dr. Slayter's note at the time and he did mention that and that is something I think that could have been explored further in the future, in terms of cognitivity and rehabilitation, but that was not the presenting issue at the time.

Q. Okay. And the symptoms of PTSD which he did endorse or describe to you, I think in your notes you said flashbacks, nightmares, disturbed sleep, low tolerance for frustration,

those are consistent, are they, with a PTSD diagnosis?

A. Yes. I again do the whole symptom profile because that was an established diagnosis but these all are consistent with PTSD. I know the definition of what are a lot of criteria for PTSD, they have to meet the criteria. I didn't do that each and every, you know, symptom profile but it was consistent, the established diagnosis was consistent with his presentation at the time.

Q. During that meeting with Lionel Desmond you said you asked about the interpersonal conflict with his spouse, his access to firearms, and we talked yesterday about the issue of suicidal and homicidal ideation. Those are topics that you address with patients in those circumstances?

A. Yes.

Q. And did you address them with Lionel Desmond?

A. Yes.

Q. Can you tell us about that, how you approached those topics with him?

A. I asked him straightforwardly, plainly, simply, does he have any thoughts of hurting somebody else, hurting himself, I know about the **IPTA**. I reviewed all the symptoms whether he meets the criteria for involuntary hospitalization and so forth.

In terms of relationship, yeah, he did tell me that he does not get any affection from his wife, these were his words "affection from his wife" and he is dismissive of him.

Q. She is dismissive of him?

A. Dismissive of him and these were the ones that in terms of relationship, I forgot to tell you at the time, but these were the ones. So they were discussed and again in the context, access to arms, possession of arms, that's a standard question that's not for him but anybody in conflict, and given my experience at VA in the context of that experience with veterans, I usually ask that. We usually ask this question, this is standard. A lot of people in rural Nova Scotia have guns and I see 15 or 20 people a week who come with suicidal ideations.

Q. How many?

A. 15, 20, depends if I'm on call, it could be 20 but 10 to 15 definitely, could be 20 also.

Q. And just for definitional purposes, suicidal ideation doesn't mean necessarily that they have an active plan, it's broader than that is it?

A. Absolutely, yes.

Q. What is it, how do you define it?

A. So the suicidal ideations, many people can have chronic suicidal ideations and then we specify them. Do they have any intent or plan or means and so forth? So we do sub-define that but actually in psychiatric literature, in terms of suicide attempts, having a firearm is not a risk to attempt suicide. It just assesses the lethality of an attempt, if there's an attempt it could be more so lethal but people can have guns, it does not increase their suicide risk as such.

Q. Their risk of attempting suicide?

A. The risk of attempting but if they attempt, the likelihood of it being lethal will make a difference.

Q. Okay.

A. People have different means to hurt themselves. A gun is one thing but people hang themselves. I have patients who have had thoughts of driving into the traffic with their cars, we don't take away ... you know, so there are different means, guns is one of that. I'm not a gun advocate but at the same time, that's the literature is but I was, in this case this is hypothetical, but in this case he told me he does not have any guns so this is a standard question, a standard assessment. And I have taken guns away from people ...

Q. Okay.

A. ... that happens very commonly.

Q. When you say ...

A. In an inpatient setting.

Q. You take them away meaning, what, you contact the police with that information?

A. We contact the police. We usually let the family ... tell the family to take away the guns and that is a common practice. This is not uncommon.

Q. So in this case though and as is your practice, you ask directly if ... well, how is the question phrased regarding suicide?

A. I would ask, Do you have any thoughts of hurting yourself or hurting anybody else? Do you have any suicidal thoughts?

Q. Okay.

A. And sometimes people get offended, that I did not tell you, I did not commit suicidal ... why are you asking me that? I said, This is a standard question, we have to ask it. By virtue of our profession we have to, that's how we are trained. So that's how I ask, I ask plain and simple, directly.

Q. And when you asked Lionel Desmond that question what ...?

A. He denied .. he denied any thoughts of hurting himself or in the past. In the same context, I do ask them about past suicide attempts and I asked him and he did tell me that he had one suicidal, what he called it, it was a gesture, it was not a suicide attempt. He said he did it to seek help.

Q. And that incident that he referenced, that prior incident, did he give you any more details or how did he describe that to you?

A. He just said that there was an interpersonal conflict, he had again connected it with the interpersonal conflict with the wife.

Q. Did he say where or when that gesture occurred?

A. In New Brunswick somewhere.

Q. Okay.

A. In New Brunswick.

Q. Okay.

A. And I said, Were you hospitalized? He said, No, no, I was in the ER overnight or something, she had called or something and they had discharged me so he was not even probably hospitalized at the time.

Q. Okay.

A. So that was ... that's a risk assessment and we do see

patients with previous past suicide attempts. We see people with many previous past suicide attempts and in this case, I had to assess him at the time how he presented.

Q. Okay.

A. And he was denying any of those thoughts at the time.

Q. Okay. So was there any additional information, to your recollection, about the New Brunswick incident or was that all he told you?

A. That's what he told me, yes.

Q. Okay. And there are, I assume, obviously in the literature, particular risk factors for suicide and I think the phrase we used yesterday was "protective factors".

A. Yes.

Q. Were any of those either risk factors or protective factors evident to you in your interaction with Lionel Desmond?

A. So this is part of the training that we are trained, it's pretty much ingrained in assessing the suicide risk that we do consider those factors. So they are protective factors but actually we have a suicide risk assessment tool now that was implemented in 2017 ... 2007, later in April, May, June, something like that. And if you look at that document, it says that the protective factors are not actually, you should not

base your suicide risk on the protective factors but at the same time they do help. He was future oriented, the way he talked about his family, his daughter, he had plans to follow with the outpatient service, he was connected with the social worker, with the therapist at the VA, so all those were protective factors at the time.

And, of course, there was some risk factors. Male gender is a risk factor, having PTSD is a risk factor, being in interpersonal conflict is a risk factor, his past suicide attempt or suicidal gesture would be a risk factor. So there were a few risk factors but it comes down the clinical judgement. It comes down to you get a lot of stuff but these are tools are to help assess suicide risk assessment but it comes down to the clinical judgement of the psychiatrist and at the time, he did not present with any of the ... it outweighed so he was assessed at low suicide risk.

Q. Okay. So let me just ask you about that. Suicide risk is typically ... Is it categorized, is it low, moderate ...

A. Yes.

Q. ... and severe?

A. Severe.

Q. Okay. And do those descriptors, severe, moderate or

low, are they associated with particular things, in other words, severe means a plan or something?

A. Yes.

Q. Could you just explain that to us?

A. If somebody says I'm suicidal and I have this plan, they would be categorized as severe.

Q. Okay.

A. Or if somebody's psychotic or they're very agitated, regardless of even endorsing suicidal ideations in person, if their presentation, it's an overall clinical picture. That's why it comes down to the clinical judgement ...

Q. Okay.

A. ... of the clinician. So it could be severe in case somebody's psychotic or manic or bipolar or endorsing suicidal ideations, have hurt himself recently, stuff like that. But there are many people who are chronically suicidal. There are many people who present to us with self-induced behaviour, cutting for example, and this is not the first time they have done it. Many people have had suicidal ... it also depends what is the rescue potential. Sometimes people, in attempting suicide ...

Q. Sorry, the what potential?

A. The rescue potential.

Q. Rescue potential.

A. Yes. Sometimes people, I think that's the right word I'm using, they will call even somebody even before attempting suicide. They do it in front of other people. Those are suicidal gestures so the suicide attempt with high rescue potential, that they can be rescued from that, they are not as dangerous as compared to low rescue potential. So it all depends. So that's how we ... it all ... there is no (unclear), that is also clinical judgement as to how you would categorize somebody having mild, moderate, or severe.

Q. Okay.

A. The checklist can give you an idea but it comes down to clinical judgement.

Q. If somebody is deemed a severe risk for suicide, would they typically be hospitalized?

A. They would be.

Q. Okay. Whether that's under **IPTA** or not?

A. In any way.

Q. Okay. If a person is assessed as a moderate risk for suicide, would they be managed as an inpatient or more in the community?

A. With more risk, the protocol usually is that they can be hospitalized but they're usually maintained in the community but there is a more robust or more frequent follow-up with them to assess their risk assessment. So they are followed up more frequently in the community whereas mild, they are not. They are followed up but not as frequently.

Q. Okay.

A. And with severe, again the clinical judgement. The severe to the moderate severe, they're hospitalized whether they come in voluntarily or involuntarily. I, myself, invoke **IPTA** a couple of times a week at least.

Q. Okay. And we're going to chat about it in a moment but so in mild, those assessed as a mild or low, are they synonymous, a mild risk ...

A. Yes.

Q. ... would be more typically managed in the community?

A. In the community.

Q. You assessed Lionel Desmond as low or as mild?

A. As low, low/mild.

Q. Okay. And just a moment ago you mentioned that you had developed or your department used a suicide risk assessment tool. When did that come into practice or into use?

A. So we always had a tool, different Health Authority than we used to be. We always had some tool that I recall but in 2007 the suicide risk policy came out. I know this because I again attend the (PRT?) meetings and it came to our leadership meeting and we approved it basically as part of that. So that was, I think it was April or May of 2017 and then it was approved after a couple of months but it was not implemented, I know when it was implemented in September of 2017 because the staff needed training for that, to use that tool. It's called suicide risk assessment tool kit, there's a form, and we use it very common, everywhere now.

Q. And it's in the form of a checklist, is it, or ...

A. Yes.

Q. ... factors that you assess?

A. It is a checklist, where at the end of the checklist it still states that it's the clinical judgement of, this list helps to assess but it comes down to the clinical judgement.

Q. And just in that same tab, page 16, this would be page 17.

A. Yeah, oh yes, yeah.

Q. And I'm just referring you to the document that Heather Wheaton completed on October 24th.

A. Yes.

Q. That may be, I don't know how easy it is to read with the photocopy but ...

A. Yeah, I can read it, yeah.

Q. ... at the bottom of that page there appears to be, was this an earlier version of the suicide risk assessment?

A. Yes, this is an earlier version, right, yeah. The new forms which the crisis team does it, has the new version, and the inpatient unit in almost every point of care when patients are moved, admission and discharge so forth, so this is an older version, absolutely.

Q. Does the newer version differ significantly from this one?

A. Yes, it does. The same, not too much, but it is a little bit different.

Q. All right.

A. It does have the levels - low, medium, severe and stuff like that.

Q. All right. The incident in New Brunswick that you made reference to, did he give you a timeframe, do you recall, of when that happened?

A. I don't remember.

Q. Did you get a sense that it was in the recent past or in the distant past?

A. It was distant past.

Q. Like more than year? Less than a year?

A. I think more than a year.

Q. Okay. Would having, apart from his description of that, would having the details, for example, from his hospital visit in New Brunswick if indeed there was one, would that, if that had been readily available to you, would that have been of any assistance to you in making your assessment?

A. Again, any additional information could have been helpful but in my case, in the ER what my role was in the ER and I had enough information in terms of what I asked him interview-wise and Dr. Slayter's note. I think regardless, even if that information, I would have more information regardless, it would not have been of any significant benefit. I used my own clinical judgement at the time.

Q. So using the questions or the approach to assessing suicide risk, you also have to assess whether there's some risk of him harming others. I assume a direct question may not elicit the same degree of individuals, the same kind of forthcoming answers or not, how do you approach that?

A. I still ask them directly.

Q. Okay.

A. And I did also ask him whether he has been physically abusive in the past towards his significant other and he denied in the negative.

Q. Okay.

A. So a direct question we do.

Q. Fair enough. And his response again to that was negative?

A. Yes.

Q. Having met with him and talked to him, did you feel that he needed any treatment that you would be providing, that night I mean?

A. No.

Q. Okay.

A. I continued what he was being treated with in terms of medication management.

Q. But in terms of new or additional treatments that night, did he present with anything that you needed to do?

A. No. No. I did order a couple of medications that we order in case somebody's in distress, lorazepam and another one is zopiclone for sleep and lorazepam but that was another piece

of, you know how rigid he was in terms of his, that he said, No, no, he has crashed, he said, I've been on these medications, they don't agree with me.

Q. Okay.

A. So please give me the ones that I'm already on so. I gave him one p.r.n. medication on an as-needed basis.

Q. Okay. And we'll talk about the medication but I'm just, at this point you were assessing, I guess, the plan for the night, whether he would stay as a social admission or not and did you decide that he would stay as a social admission?

A. Okay. So then we were about to complete the interview, the intervention, I said, Fine, what can we do for you and he said, you know, stay after all this conversation and I said, Well, okay, we have beds upstairs and we'll just put you in.

Q. And by "upstairs" you meant the third floor?

A. Third floor, mental health inpatient psychiatry unit.

Q. Right.

A. And at that time he told me, I was not aware of that before. He told me that his wife works upstairs. And until then I did not know. So ... Well, I said, I know most of ... you know, I know people in the inpatient unit. So then I

remembered that there was a new nurse who had started, had a couple of shifts on the unit, for orientation and I could connect him with her, Shanna, he said. Shanna. I said, What's her name? Shanna. And I connected but I didn't know her well.

So he said, Well, she works there and he expressed his preference to not go upstairs. And that was another thing, it sounded to me as he was protecting her. That he didn't want to have a rumour or a gossip of him being upstairs on the unit where his wife works and he said, If you can arrange something else I am not too keen to go ... be admitted on the Psychiatric Unit, you know, be there just for overnight. Just overnight. I mean nobody ... you know, you can just go up and we can ... No, he said, if you can do something else for me. And that's when I realized.

So I ... again it ... then I came out and I said, Let's see what we can do and it was he had no place ... the issue was he had nowhere to go, he was homelessness (sic). He needed a place to stay. We accommodated that.

I came out, spoke with Justin Clark and the ER staff around and they were gracious enough to say yes. That does not happen usually. If we have a bed upstairs people usually go upstairs. So the ER went out of way to accommodate his request. Then it

came down to who he will be ... and there was a very comfortable bed and comfortable room. I looked at it. Then it came down to who he will be admitted under. Usually in the ER most people are under ER physicians that I can know of but it was issue where the ER doctor was off duty in couple of hours and the new doc ... So I said, Okay, no, I will ... you just ... I can admit ... you can put my name.

And so we made the plan and the plan was already made that evening that he will stay and we arranged a bed in the observation part and prescribed the proper medication and he had said, Give me this, give me that and we complied with that and that's how ... he was very comfortable ... in the most comfortable location the Emergency Room.

Q. So there was obviously beds, or a bed available, in the Emergency unit. You said it was ... was it in the observation area.

A. In the observation area.

Q. So that's ... is that the area you described earlier with the five or six beds, I think?

A. Yes.

Q. Okay.

A. And we had beds on the inpatient mental health. We

had three, four beds at the time. I don't remember the exact number but the unit was open.

Q. Okay.

A. We were not particularly really busy ...

Q. Okay.

A. And he could have stayed there also.

Q. Okay. So he was under your care, I guess, but in Emergency. Is that the way ...

A. Yes.

Q. All right. Had you ever encountered that situation before where you had a patient under your care that stayed in the ER without going up to the third floor?

A. It doesn't happen that often because usually we have beds. They go upstairs there. But if we don't have beds then there is a possibility, maybe it happened once or twice before, if we don't have any beds then patient is under me after seeing him and there's nowhere to go then we put them under those beds. But it does not happen that often.

Q. If a person is kept overnight in the hospital for observation in circumstances such as this which we've described as a social admission, just so I understand the terminology, are they formally admitted to the hospital?

A. They're not formally admitted.

Q. And so what's the difference?

A. Well the difference is that they are likely to be discharged in a day or two and there's, as such, no difference in terms of because they don't meet the criteria to be ... he does have the criteria. We go out of way to accommodate these social admissions and try to help them out and usually the plan is that they will next day they will see a social worker or somebody, they can ... we can resolve the issue.

And so there's no ... again, there's no difference in the treatment for the care they receive in the hospital regardless of them being voluntary, you know, hospitalized or not. It is just a term used for ... it's, I think, there's a little bit of a difference in the paperwork and stuff like that but, otherwise, there is no difference in terms of the care provided to them.

Q. Okay. Because he was under your care you would give, I assume, instructions as to what should happen with him over the course of the night?

A. (No audible response.)

Q. Yeah. And I should ask you just before we get to that, is there a maximum amount of time that somebody can stay

in hospital in that capacity under observation?

A. Two to three days. Two days. Three days.

Q. Is that a hard and fast rule or is it more of a general policy or ...

A. It is a general policy.

Q. Okay.

A. If we keep longer then we have to hospitalize them and submit psychiatry. So there are only 48 hours, 72 hours. Within that time.

Q. So, again, because he was under your care you would give instructions to the staff in the Emergency unit as to what should happen with him through the course of the night?

A. Yes. So I wrote the admit order. Orders were there in the chart and he was being observed by the nursing staff in the observation unit. He was under me. They had ... they could ... he was stable so there was no reason for me to stay there with him. If there would have been any problems or issues then the staff would have called me and I would have taken care of that.

Q. Okay.

A. So that's how it works.

Q. Did you remain on call all night?

A. Yes.

Q. Okay. So when you're on call it's all through the night, is it, if it's your shift?

A. Yes.

Q. Okay. Yeah. All right. Okay. Now in the chart, again, under that same tab I think at page 35, it would be your 36. That document, that's your, at least at the top part of that that's your handwriting, is it?

A. Yes.

Q. And those are the instructions or, I guess ... well I guess the instructions that you had given with respect to Lionel Desmond's care?

A. Yes.

Q. Okay.

A. Absolutely.

Q. I'm good to keep going, Your Honour, or we can stop.

THE COURT: Well if it's a good spot we'll stop. Thank you. We're going to adjourn to 1:30. Thank you.

MR. MACDONALD: Your Honour, sorry, I just had a question by way of get some guidance. I'm just wondering since Dr. Rahman is under oath if you would be prepared to give a direction that he should not discuss his evidence with anyone during the lunch

break, including his counsel, whom I hold in high regard since he is under oath and there are many other lawyers waiting to ask him questions. That's a normal proceeding as you would know in Provincial Court and Supreme Court and you have the powers of a Supreme Court judge, you have the power to control your own process here at this Inquiry and I am not suggesting Dr. Rahman is going to do anything wrong I'm just suggesting it may be helpful for all to know that if that direction was made. Thank you.

THE COURT: All right. Anyone else want to comment? Thank you.

Doctor, during the course of the break until you return I will ask you not to have any discussions about the evidence that you have given to date.

DR. RAHMAN: Sure.

THE COURT: If you meet with your counsel, you can have other discussions with him. He would know the limitations of what the discussions can be. It does not mean you cannot, you know, have discussions but they are to be limited by those circumstances.

DR. RAHMAN: Sure.

THE COURT: All right? Thank you then.

COURT RECESSED (12:37 HRS)

COURT RESUMED (13:37 HRS)

THE COURT: Dr. Rahman, return to the stand, please. Dr. Rahman would still be under oath. Thank you.

Mr. Murray?

MR. MURRAY: Thank you, Your Honour.

Dr. Rahman, before we broke I think we were looking at the Exhibit 67, and in particular page 35, I think, of the ... I guess your ...

THE COURT: I think we were at ...

MR. MURRAY: ... instructions with respect to the care of Lionel Desmond when he was in hospital that night?

A. Yes.

Q. So I'd like to just ask you a couple of questions about that. So first of all, the first line you wrote was: "Observation under Dr. Rahman in the ER." So that's obviously indicating that he would be under your care whilst in the ER? Okay.

A. Correct.

Q. A couple of abbreviations, I think, are easily clarified. DAT, what does that mean?

A. Diet as tolerated..

Q. Some patients, I assume, have specific dietary needs depending on their ...

A. Yeah, some people are diabetic. So it's diabetic diet or cardio diet and ...

Q. Right.

A. ... so forth. So ...

Q. And he had no specific dietary issues.

A. No.

Q. Okay, and then AAT?

A. Activities as tolerated.

Q. Okay.

A. I mean he was up and about. So ...

Q. Right. And then, "Off unit accompanied." What does that mean?

A. So off unit accompanied means that the patient is stable enough to be able to leave the unit without any staff accompaniment ...

Q. Mm-hmm.

A. ... for 15 minutes every hour. So that's the lowest level of monitoring that we need to have somebody on.

Q. Okay, so a person with that off-unit-accompanied is able to leave ... in this case it would be the Emergency

Department for up to 15 minutes ...

A. Yes.

Q. ... each hour?

A. Correct.

Q. Okay, so if even somebody who's there simply under observation were to get up and walk out and be gone for 20, 30 minutes what would happen?

A. Well, then the staff will inform me about it.

Q. Mm-hmm. Would somebody go and attempt to locate the person or ...

A. Yes, that is a possibility depending upon the situation. Yeah, like, if anybody leaves. Or this is the same kind of level of observation we do on our in-patient units also. So I would like to at least ... even if they are voluntary and they are in the hospital, either in the ER or in the in-patient unit, we will try to look for them.

Q. Okay. And I assume there are certain psychiatric patients that you would have concerns if they left the unit?

A. Absolutely.

Q. Or certain conditions?

A. Yeah. Usually when patients are admitted on the psychiatry in-patient unit they are confined to the unit and

then their privileges are gradually increased as to maybe initially from confined to off-unit accompanied by staff and then as things improve they can be able to ... they're allowed to go out on their own.

But in this case, Mr. Desmond was allowed to be on his own, given that myself or the staff, we did not have any concerns about his safety.

Q. Okay. Now you did give instructions with respect to the meds, the drug regimen, I guess, that would be available to Lionel Desmond that night. Well, actually, before that there is another line, "Routine checks". I wanted to ask you about that.

A. Yes.

Q. How often would a patient, who is there for observation, how often would they be checked by nursing staff?

A. Every hour. And it could be *q.* 30-minute checks in case I write that and it could be *q.* 15-minute checks. And people can be on Level 1, which is constant observation, and that happens ... it's not too common not to happen that way.

Q. What type of a condition would necessitate that level of supervision?

A. Yeah, so if somebody is actively suicidal and they are not able to (unclear) for safety, that would be one scenario.

Another scenario would be they might be very agitated or aggressive. Or they can be manic. In those situations they need to be monitored on a constant basis. It could be, also, that we have therapeutic quiet rooms on the inpatient unit, as well as in the Emergency Room, actually.

Q. Mm-hmm.

A. Which is a locked therapeutic quiet seclusion room. They have cameras and in case somebody is that agitated or that aggressive or that manic that they need to be monitored by camera and are unsafe for themselves or other patients or staff on the unit, to be on the open unit, then they are confined to their room and we lock that door and monitor them on the camera.

Q. Okay.

A. That can be the extent of observation at times.

Q. In terms of less necessity for observation, you said it can be every 15 minutes, every 30 minutes, or every hour?

A. Every hour.

Q. Every hour is the minimum amount of routine checks?

A. Yes.

Q. Okay.

A. Correct.

Q. So in this case ... And so is that for everybody who

stays in hospital overnight?

A. It is again clinical judgment, how we assess and what do we feel a patient require in terms of his or her monitoring.

Q. Okay. So some patients might not require regular monitoring through the night?

A. Everybody is monitored. Once they're in the hospital everybody is monitored every hour.

Q. Okay.

A. That's the standard protocol.

Q. Okay. All right.

A. They can be monitored more frequently. That's ...

Q. Sure.

A. ... an option, but that's a standard minimal amount of monitoring.

Q. Okay. So in Lionel Desmond's case, is there something in particular that staff might have been looking for or being concerned about when they observed him every hour?

A. Yeah, they were looking at his general medical status, as well as his mental status, over the time period that he stayed with us. And in case they would have any concerns they had the option to call me. That's the usual monitoring.

Q. Would that have been if his presentation had changed

in some way through the night or ...

A. Yes.

Q. Okay. And a check involves what on the part of nursing staff? Is it just looking in and ...

A. Yeah. I'm not sure what the ER standards are in terms of checking, but I believe they are the same as on the inpatient mental health unit in terms of overnight, making sure the patient is sleeping or not sleeping or is well or is in distress. But they don't do mental status each time.

Q. Okay.

A. I think it's just a general monitoring that that patient is being managed safely.

Q. Okay.

A. Safety is the main concern. Safety would be the main concern here in case in terms of psychiatric patients.

Q. Okay. Safety of the patient and potentially safety of others.

A. Staff and other ...

Q. Staff.

A. ... patients.

Q. We heard some evidence yesterday about the way in which ... when somebody presents at the ER, if they are on any

prescribed medication, how that information is obtained by the Emergency Room. Sometimes patients, I take it, will have a list of their medication or actually have the medications. Other times, we heard, it comes from a drugstore.

Do you know how Lionel Desmond's medications, his prescriptions ... how that information came to the knowledge of staff?

A. Okay. When I assessed him I saw it's a medication reconciliation form that is completed and filled by the nursing staff and the medications are basically written down there.

Q. I think if you go over one page ...

A. Yes.

Q. ... you might find it there.

A. Yeah, so this is the reconciliation, and I looked at it and it did have all the names of the medications.

Q. Okay. Given Lionel Desmond's presentation and what you knew of him, were any of those medications ones that surprised you?

A. No. No, they are the usual medications that somebody with his diagnosis and presentation would be expected to be on.

Q. Okay. Now earlier in your testimony you said that when it was decided that he would be staying certain medications

were offered to him. What were those?

A. Those were lorazepam ...

Q. Mm-hmm.

A. ... and zopiclone.

Q. Okay.

A. And so I wrote them down, actually, yes, but when I told him Mr. Desmond indicated that he would not like to take these ones because he had been on them in the past and they didn't agree with him. So he was interested and keen to stay on the same medication that he had brought in.

Q. And just perhaps you can assist us. What is lorazepam?

A. Lorazepam is a benzodiazepine. It's medication for anxiety. It's an anxiolytic medication and it's also used to help relax and to help with the sleep also.

Q. Okay, and what was the adjective you used, I'm sorry? You said it was a certain type of medication.

A. Benzodiazepine.

Q. No, after that you said something else. An anti-anxiety ...

A. Anxiolytic.

Q. Yeah. What is that?

A. Anxiety medication used for anxiety are called anxiolytics.

Q. Okay. Thank you.

A. For depression they're antidepressants and for anxiety it's anxiolytics.

Q. All right. Thank you. Now lorazepam was not a drug that was on his list of regularly prescribed medications?

A. Yes.

Q. So what was your thought in suggesting that he take lorazepam that night?

A. That's a usual standard practice of ER physicians and psychiatrists, also, that that's a medication that can help. It acts very quickly and if somebody is distressed it can help the anxiety or the distress therein. It can help with sleep also. That's for the general criteria for prescribing.

Q. Did you get a sense that his level of anxiety or distress was such that he would benefit from that drug or ...

A. Yes, at the time I thought that it could help with the sleep and help him relax. Because we wanted to help him. And staying in the hospital in the ER or first night in the hospital, it is helpful. Given his diagnosis of PTSD, also, many people are on benzos and they do benefit from it on a

short-term basis. So that was one of the ideas that I had and I proposed and offered that.

Q. And the other drug, zopiclone?

A. Yeah.

Q. And what is that drug?

A. That's a sleeping aide that's also ... these are prescribed for sleep, sleep aides. And I had ordered both the medications on as-needed basis, as *p.r.n.* basis.

Q. Mm-hmm.

A. It was not something that I had planned to prescribe him on longer term. These are on as-needed if he has any trouble sleeping or if he has any anxiety or being in the hospital and so forth, that could help him. So that was an option. It was his option to take it or not take it.

Q. Okay. So would a patient typically coming in for the night ... if needed would they take both zopiclone and lorazepam or would they only take one?

A. Can be both. Both or one.

Q. Do they act slightly differently in a patient or ...

A. Slightly differently, yeah. Zopiclone has the same structure as benzodiazepines. They act on GABA receptors, and which are inhibitory receptors. It slows down the brain and

facilitates the sleep. Initially I would have tried lorazepam, but in case people still have problems sleeping, then I would go with another one just to be on the safe side. So sometimes they're given both together. Sometimes one is tried. If it doesn't work, then we go to the next level.

Q. And had he not indicated a desire not to take those drugs, had those been left on the plan, would the nursing staff have been able to administer those drugs or would they have had to contact you before doing so?

A. No, they would have been able to do it without, because that was the order and that is the whole idea, to help staff all night, also, in case patient have issue with sleep or anything. They can get that medication without calling the psychiatrist.

Q. And Lionel Desmond indicated to you that he did not want those medications?

A. Yes.

Q. He was familiar with them was he?

A. He was familiar. It sounded that he was familiar and he said that he had been on them in the past, and again, it did not agree with him. He would rather stick with the same medication that he had been on in the past.

Q. Okay. Now other medications you did prescribe and perhaps you can briefly explain these to us. So quetiapine, we've heard about that drug. What is quetiapine?

A. Quetiapine is a neuroleptic. It's an antipsychotic medication but it's very commonly used as a off-label use, evidence-based, again, for sleep and anxiety, and for depression also.

Q. Mm-hmm.

A. And he had been on it for some time.

Q. So its first use is antipsychotic but there is an off-label use which is supported in the literature for ...

A. Anxiety.

Q. ... anxiety and depression?

A. And sleep and depression.

Q. Sleep and depression.

A. Yeah.

Q. Do you know for what purpose he was taking quetiapine or why it was prescribed for him?

A. I was not sure but I think it would be the speculation that I felt that this is the cause of his anxiety and sleep for off-label uses. Because for the antipsychotic, the doses are very high. You have to go to 4 or 5, 600 milligrams to have an

antipsychotic effect with Seroquel. So the doses that he was on, especially the 25 milligrams quetiapine three times a day on as-needed basis, that was not a regular medication also.

Q. Right.

A. It was just in case he needs it. They had, I think, left it to him if he feels like, if the anxiety or something bothering him, he can take it. And the XR form 50 was for his sleep. So that was my judgment at the time.

Q. Mm-hmm. Okay. Again, so the brand name of quetiapine is Seroquel?

A. Seroquel, yeah.

Q. Okay, so the other form then. When you say the nighttime that's the ... I assume the quetiapine XR, or extended release?

A. Yes.

Q. Okay. And is that the same thing, an antipsychotic that has other off-label uses?

A. Yes.

Q. Okay. And you concluded that that was for sleep.

A. Yes.

Q. Again, because of the dosage or did he say that or ...

A. No, I didn't explore that with him, but according to

the dosage.

Q. Mm-hmm.

A. That's a usual dose that we prescribe if he want to use it as a sleep aid.

Q. So if he were to take quetiapine or quetiapine XR through the night that night it would be to assist. It would be as an anti-anxiety drug and to assist him with sleep?

A. Yes.

Q. Was it necessary, given that he was on those drugs, to consider lorazepam or zopiclone?

A. Those were his regular medications. I just prescribed them to be on the safe side in case because it was a different situation. He had come to the hospital. His situation was a little bit different, and so that was also prescribed as a *p.r.n.* basis in case if he needs it.

Q. All right. Additionally, there was the drug prazosin, which is for what?

A. Yeah, prazosin. It's an alpha-1 blocker. Basically it's an anti-hypertensive medication for blood pressure but it's not used for blood pressure there commonly nowadays because there are newer, better medications. But for PTSD it is used to help with the flashbacks and nightmares. So that's what he was

on. It is approved for that.

Q. Mm-hmm.

A. And prazosin, that was my understanding.

Q. Okay, and then trazodone. What's that drug for?

A. Trazodone. That's for sleep also.

Q. Okay.

A. And again, trazodone is an antidepressant by class.

Q. Mm-hmm.

A. It's an older kind of antidepressant which comes in the category of ... trazodone comes in the category of, yeah, serotonin antagonist and reuptake inhibitor. It's called SARI, S-A-R-I. Serotonin antagonist and reuptake inhibitor increases the amount of serotonin in the brain, but again, trazodone works as an antidepressant at very high doses. It's very sedating to be used as antidepressant, and way back, it used to be used that way.

But nowadays in modern medicine it's used to ... it's sedating. So it does help, at lower doses, 50 to a hundred milligrams, to help sleep. And it does not have as much of a dependence potential as compared to traditional hypnotics or medications that are used for sleep. So trazodone is widely used to help sleep.

Q. So really, both forms of quetiapine and the trazodone are all, really, to assist with sleep and to lower anxiety? Is that ...

A. Yes, and the mood also.

Q. And the mood?

A. And the mood also. Quetiapine is used for mood. I guess I asked him. I did discuss some brief discussion about his past history and medication management and he said that he had been on many medications in the past.

Q. Yes.

A. And these are the ones who have helped him relatively. And so I assumed that he had been probably tried on quite a bit of medication, the history of which he was not sure about which ones did he use.

Q. Mm-hmm.

A. I think Prozac or Zoloft are the two that he mentioned, but he said he had used quite a few by a previous psychiatrist. But he did not have any recollection of the names.

Q. Okay.

A. Yeah.

Q. And we can just go back a page, too. And finally, you

also made provision for him taking Tylenol if needed.

A. Yeah. I asked him. He had issues with his back, back pain, and that's something of a comfort medication also. And it's a *p.r.n.* in case he have any back problems or back pain or ...

Q. And the ES, I think, we established was extra-strength.

A. Extra-strength, yes.

Q. Did he complain of any back pain that night? Or any physical pain?

A. Not that I remember of.

Q. Okay, and I don't know, was there discussion of one more drug? Zolpidem?

A. Yeah.

Q. And how did that come up?

A. Zolpidem was something he ... it was in Dr. Slayter's note also.

Q. Yes.

A. Because I know I noticed that. Because zolpidem is more commonly used in US, and when I was there I used to use it. Zopiclone is more commonly used here. Somehow they're a similar kind of medication. But we don't get zolpidem in the hospital.

Q. All right, so it wasn't an option.

A. It wasn't an option.

Q. Okay. And is that also for sleep?

A. That is for sleep.

Q. Okay. A couple of the abbreviations just for clarity. You said *p.r.n.* is an abbreviation that means as-needed?

A. Yes.

Q. Okay. And perhaps we can just clarify a few more of these. *P.o.*? What is that an abbreviation for?

A. Oral. Oral.

Q. Okay. *Q.h.s.*?

A. *Q.h.s.* means at bedtime.

Q. Okay, and *t.i.d.*?

A. Three times a day.

Q. Okay. All right. Was it your anticipation or direction that any of these medications would be given to him first off when he was settling in for the night? Or how did you anticipate that happening?

A. Not all of them. It depended upon which ones did he take in the morning. I left it to the staff. I mean I ordered all these. Most of them, one at bedtime. Prazosin was at bedtime. Quetiapine XR was at bedtime. Trazodone was at

bedtime. So it was expected that he would get all these at bedtime.

Q. That all of the bedtime ones would be taken.

A. The bedtime ones, yeah.

Q. Okay. Right, so that's the prazosin. Sorry, the quetiapine XR and the trazodone.

A. Correct.

Q. Okay. After creating that plan or giving those instructions did you have additional involvement with Lionel Desmond that evening?

A. Yes, writing these medications and I wrote my note. And so I continued to, off and on, remain in touch with him and then once he was settled in the bed before I left I again went to his room and asked him is he comfortable, is he okay, and he replied in affirmative. He was pretty contented at the time and that's when I left.

Q. Okay. Do you recall roughly what time that was?

A. Don't recall. Don't have any recollection but probably it was 9:30 or something like that.

Q. Did you have additional work to do in the hospital that night or was that the end of your work in the hospital?

A. I think that was the end. Don't have much

recollection but I don't remember going up again.

Q. All right. And so the instructions that are there, the chart notes, those would have been written before you left?

A. Yes.

Q. And where are those left? Is that just on a person's chart or is it somewhere else as well?

A. On the chart.

Q. Okay. And if we just go over to the physician's progress note, which would be actually 37-38 in your ...

A. Yeah.

Q. And to the second page of that at the end, or near the end, you have the word "plan"?

A. Yes.

Q. So it's, "Observation in ER under Dr. Rahman. Refer to observation orders for medication," and then it's Seroquel 25 milligrams *p.o.* stat. So I take it the "stat" means immediately? Is that what that means?

A. Yes.

Q. Okay.

A. Yes.

Q. "Continue prazosin, quetiapine XR, trazodone," and then, "Will FU ...", which is follow up?

A. Follow up.

Q. "With therapist tomorrow"?

A. Yes.

Q. And was that a recommendation to him or was that your understanding of what was going to ...

A. That was his report to me that ...

Q. Did he indicate who he was seeing the next day or ...

A. No, he did not.

Q. Okay.

A. And I didn't elaborate. I didn't ask him.

Q. Okay. The term "therapist", though, I mean that could have been a physiotherapist. Was it your understanding that it was something to do with his mental health?

A. Yes, because he had mentioned it initially that he's followed up by a VA therapist and social worker.

Q. Yes?

A. And I assumed it was a mental health social worker.

Q. Okay.

A. That was initially in Dr. Slayter's note. It was mentioned that he was seeing a therapist on the same day.

Q. Mm-hmm.

A. On December 2nd. And then during the interview when

he discussed with his housing issues.

Q. Mm-hmm.

A. And so he had told me that in case it doesn't get resolved with his wife and she keeps on, he will have to then look into talking to the VA social worker again to explore other housing options. So that was my understanding.

Q. And then beyond that you, "Anticipate discharge tomorrow. Case discussed with Dr. Justin, ERP." ERP being emergency room physician?

A. Correct.

Q. So your anticipation was that Mr. Desmond would be leaving hospital the next morning?

A. Correct.

Q. Ultimately, he did leave the next day but had he expressed a desire to stay another night is that something the hospital would have accommodated?

A. Absolutely. And I did offer him. If he wants to stay for another day.

Q. You offered him that the first night?

A. I offered him the first night. I offered him the second in the morning, also, when he was leaving. Because usually the social admissions, when they come in, there was a

holiday on the 2nd and if there's a social worker involved, you know, they get involved and that's the usual, that we look at housing options or whatever and try to convince patients if they can involve ... you know, involve the family, then have a meeting or something in terms of reconciliation or something like that.

So this is the main gist of having them in for a day or two but he did not want to stay any longer.

Q. All right. Now having assessed him that night - and you've indicated what your view of his presentation was and what would happen with him - any time you're assessing a patient who presents with mental health difficulties I assume the **Involuntary Psychiatric Treatment Act** is at least in the back of your mind, is it?

A. Always.

Q. Okay. And you said earlier in your testimony that you do admit patients under that **Act** with some regularity?

A. Absolutely.

Q. Can you just give us a sense of that, how often you might admit patients under that **Act**?

A. One or two times a week.

Q. Okay. All right, so it's fairly common?

A. Fairly common.

Q. All right. There are certain criteria in our legislation and under the **Act**, obviously, for a psychiatrist who has conducted an involuntary psychiatric assessment and has formed certain opinions to have a person admitted under that **Act**, did Lionel Desmond, in your opinion, meet any of those criteria?

A. He did not meet the criteria for involuntary admission.

Q. So as I look at the legislation, it would require first that a person had a mental disorder, first of all. Could he be characterized as having a mental disorder given his diagnoses?

A. Yes.

Q. All right. Secondly, a person has to be in need of psychiatric treatment. His admission, could that in any way be considered psychiatric treatment or a need for psychiatric treatment?

A. No.

Q. Okay. In your assessment of him, and speaking to him, did you have a sense that he was threatening or attempting to cause serious harm to himself or others or had recently done so?

A. No.

Q. Or that he was likely to suffer serious physical impairment or serious mental deterioration if he were to be released from hospital?

A. No, that was not my assessment.

Q. And that he would require psychiatric treatment at a facility and not be suitable as a voluntary patient. I take it, then, that did not apply either.

A. No.

Q. All right. And finally, the **Act** requires that a person not have the capacity to make admission and treatment decisions. He had that capacity?

A. He did have the capacity.

Q. A person who is suicidal potentially, and who has some diagnosis that would constitute a mental disorder, that person presumably in certain circumstances could be admitted under the **Involuntary Psychiatric Treatment Act**?

A. Yes.

Q. Okay. And I appreciate this is a bit of a generalization, but the individuals who you do admit under that **Act**, are they sometimes or often or perhaps you can give us a sense of how often they're suicidal.

A. Most of the time but not always.

Q. Okay.

A. People can present with psychosis and bipolar mania. They would not have any insight or judgment and they would be hospitalized longer if they're psychosis or they're delusional and so forth.

Q. Even if they don't profess any suicidal ideation.

A. Absolutely.

Q. Okay.

A. Yeah. Because those are the ones who, in my view, would meet the criteria of likely to suffer for the physical impairment and mental deterioration or both. Those were the ones.

Q. All right.

A. And that commonly happens.

Q. Okay. So you said that after seeing Lionel Desmond settled in for the night that was the extent of your involvement with him that night?

A. Yes.

Q. Okay. Now were you on a regular shift the next day on January 2nd or ...

A. Yes.

Q. Okay.

A. It was a holiday. I was on call.

Q. It was another on-call situation?

A. Yes.

Q. Okay. Did you have some involvement or interaction with Lionel Desmond the next day?

A. Briefly, yes.

Q. How did that come about?

A. I got a call from a female and she told me that Mr. Desmond is requesting discharge and I asked if there was any concerns and she said no, there are no concerns. And I okayed that.

Now there's a little bit of a issue here because I thought when a female called me in the morning, I thought that's the ER physician, Dr. Jane Anne Howard calling me. She sounded like Dr. Jane Anne Howard, and so when I came down, only then I realized that it was not Jane Anne Howard when I looked at the order later on; that it was the nurse who had called.

And so I briefly saw Mr. Desmond just for not more than five minutes. He was ready to leave. I again offered him ... asked him how he is doing, and had a brief interaction with him, asked him about his medications and I reiterated to him to make

sure that he makes an appointment with Dr. Slayter, which he had missed in the past. And so he went home.

Q. Do you recall the time that you received the call initially from ...

A. I don't recall the time. It was around 10:30, 11-ish time period. The call probably would have come a little bit earlier but that's the time, probably, I came down. But I don't remember the time.

Q. Okay, so in the normal course ...

A. Yeah.

Q. ... had he not expressed a desire to leave, would anything have had to happen for him to be discharged or to leave?

A. No, nothing. Like, we can discharge patients on the phone also. If he's requesting discharge. The assessment was a continuation of the assessment from last night and the plan was already made that night. I had already made the plan. In case he would have endorsed some wish to stay in the hospital or if he were to have presented in a crisis or his status, mental status, has changed overnight, staff would have informed me and we would have reassessed that decision in terms of his discharge.

Q. Right.

A. But that was a possibility.

Q. But assuming nothing changed and his status didn't change and he didn't ...

A. No.

Q. ... request another night, did it require you to formally discharge him the next day or was he able to simply leave given that that was what was anticipated the day before?

A. Well, the protocol standard is that he required. He was under me. I was the attending psychiatrist, attending physician, most responsible physician. So technically I have to give the order to be discharged. So he could not leave without me saying that he's okay to leave.

Q. Okay. Yeah, although if he had walked out the door the next day and said, I'm leaving, before you were able to formally discharge him ...

A. Yeah.

Q. ... would anything happen?

A. I don't think so in this case if he would have left. If he would have left, then I would not have, because I didn't have any concern at the time.

Q. Okay.

A. This happens mostly in people who are informal, who are certified, or for some that we have concerns about. For example, if he would have been somebody who had endorsed suicidal ideation or who was noted to be psychotic and we didn't have any beds and we kept him in the ER, if that kind of a patient leaves, although he's voluntary, we would call the police.

Q. Okay.

A. We'll bring him back and that regularly happens. So in his case, we discharge people against medical advice also. So in this case, I would not have called anybody because that was a plan made the night before. If he would have left, then he would have left.

Q. Where a person is in hospital under observation only, such as Lionel Desmond, we still use the term "discharge". Correct?

A. Yeah. Yeah.

Q. Is the discharge process any different than a person who has a full admission to the hospital?

A. No difference in the discharge process.

Q. Okay. And again, in the normal course is there a particular time of day that somebody would leave hospital if

they were being discharged in the normal course?

A. Can you repeat the question?

Q. Sure. There was a call. You received a call that he wanted to leave and you said ...

A. Yeah.

Q. ... this was in the morning.

A. Yeah.

Q. Had he not expressed that desire at that moment to leave, what time is the discharge time? What time would he normally leave? What time would a patient normally leave hospital or be discharged?

A. There's no specific time.

Q. Okay.

A. Patient can leave any time. They can come any time. We are pretty flexible in Psychiatry in terms of discharge timing.

Q. Mm-hmm.

A. On the medical units there's a little bit of a protocol, by 11 o'clock or something like that. But in Psychiatry we are very flexible.

Q. So you receive a call and the time you're a little unclear on?

A. Yeah.

Q. From someone you believed to be, initially, Dr. Jane Anne Howard.

A. Yeah.

Q. And that person indicated to you that Lionel Desmond was anxious to leave.

A. Yes.

Q. You had, the night before, anticipated his discharge the next day.

A. Yeah.

Q. And what did you say back to the person? Or what was your response to the person or ...

A. I said, Okay, yeah, he can be discharged.

Q. Did you ask them anything or say anything to them?

A. I don't remember but I do remember I asked all the ... on the person on the other side said ... or she said that to me that there are no concerns.

Q. Mm-hmm. Okay.

A. And that was the whole conversation.

Q. And after that conversation you anticipated Lionel Desmond would be leaving hospital?

A. Yeah. Yeah.

Q. Okay.

A. No, that could have happened but then I thought to come down and take a look at him and he was about to leave. So I had last few minutes. He was still there.

Q. So I'm just curious about that, why you felt it was appropriate to come and see him in person the next day when you weren't physically in hospital.

A. I was in the hospital.

Q. You were. Okay.

A. Yes. Yes.

Q. I thought you said you were on call.

A. I was on call but I was doing rounds again. I was in the hospital.

Q. Got you.

A. I was on call.

Q. Okay.

A. So I was still in the hospital. I was doing stuff and then as I finish, I said, Well, I'll go down and take a look. That's how it happened. I would say I was just being diligent a little bit.

Q. Being?

A. Diligent.

Q. Diligent. Okay. And the person that you had spoken to on the phone actually was not Dr. Howard. It was a nurse, Maggie MacDonald?

A. Yes. Yes. Yeah.

Q. So you go down to the emergency unit. How long after getting the call was it before you went to Emerg?

A. About half an hour, 20 minutes. 20 minutes, half an hour, I believe.

Q. Okay. And you did, in fact, have an opportunity to speak with Lionel Desmond there?

A. Yes.

Q. Okay. When did it become clear to you that it wasn't Dr. Howard to whom you were speaking on the phone?

A. Well, as he was leaving he left and then I was talking to ... I went to Dr. Jane Anne Howard. She was there. And I said ... usually it's the ER bed, it doesn't happen that patients are there. So I told her I have ... my patient is going and gone and, So you will have your bed ... you can have your bed back.

Q. Mm-hmm.

A. And then I realized that ... well, she said, Well. Then I looked at the order later on. I spoke to her for a few

minutes and then I came back and the order was there written that it was a phone order of me by the nurse, and I didn't know that the nurse at the time. That was not a familiar name to me. So at the time I realized that I actually spoke to the nurse, not Dr. Jane Anne Howard.

Q. All right. Yeah, and that ...

A. So I spoke to her at the time.

Q. And that phone-in order, I think, is on page ... or I'll draw your attention to page 35 or page 36.

THE COURT: Is that our page 35 or ...

MR. MURRAY: It's 36 at the top, 35 at the bottom. And so the entry there on the 2nd of January at 11 o'clock, "Discharge patient for appointment with psychiatrist and TRBO from Dr. Rahman to M. MacDonald." Is that ...

A. Yes.

Q. ... the entry that you're referring to?

A. Yes, correct. Yeah. Yeah.

Q. And "TRBO" stands for what?

A. It's a read back order, telephone read back order, I believe.

Q. Yes? Okay, and "M. MacDonald" was the nurse to whom you had been speaking.

A. Yes. Yeah.

Q. And below that there's a signature, which I believe is your signature?

A. Yes, correct.

Q. When did you sign that?

A. So I wrote the note and I signed at the same time.

Q. Okay. What was the purpose of signing the note?

A. Usually phone orders used to be signed in the past. I think it's not a rule anymore. I think we don't have to sign the phone orders, but usually if I get a chance, if I do a phone order, I usually tend to sign it myself.

Q. Okay. Okay. I've gotten a little ahead of myself because I wanted to ask you about the nature of your interaction with Lionel Desmond when you went to the unit. Where was he when you found him?

A. He was in his room where he stayed overnight under observation.

Q. Okay, and how did he appear to you that morning?

A. Well, he was in a little bit of a rush. He wanted to be discharged, and I said, How was the night and how are you doing? I did a little bit of a mini mental status. I offered him if he ... you know, if he's okay, if he wants to stay

another night that would be fine. We still had beds upstairs if he wants to go upstairs.

I also said that if he wants to stay and doesn't want to stay in this hospital we can always transfer him to somewhere else if he wishes to. But he was not too interested in that. And anybody who goes, I discharge from our unit, I ask them if you're feeling safe to go home, you don't have any thoughts of hurting yourself, hurting anybody else. And he said, No, I'm fine to go. I reiterated again to make an appointment with Dr. Slayter, which I now know that he did return the next day to make an appointment with Dr. Slayter, as I asked him.

So that was good. I asked him about his medication supply. He said he does have supplies of the medication and he was obliged. He was obliging and he was thankful that we accommodated him and that was his attitude at the time.

Q. Was transfer to another hospital, had he wanted to stay another night, was that actually an option?

A. That would have been an option because, again, that was not an easy option. Because he did not meet the criteria. But in case his status had changed or if he has ... sometimes we tell somebody, you know, the option and they can come more forward. I gave him another opportunity that this is not

something that you have to be discharged and if you don't want to stay here we have a lot of options available. But he did not. I gave him that option that night, also, in case. But no, he was pretty comfortable with us.

Q. Okay, and you said you did another, I guess, mini mental status exam and what ...

A. Not mini ... it's a mental status exam.

Q. I just thought you used that phrase earlier when you said you ...

A. It's a brief ...

Q. Yeah.

A. Mini mental exam is something that we do for cognitive ...

Q. Yes?

A. For cognition. But, yeah, a mini status exam but not mini mental.

Q. Okay.

A. Yeah.

Q. Fair enough. And those same indicators that you referenced earlier that you had assessed the night before, how did those appear the next day?

A. Well, he was thankful we were obliging. Again, I

didn't do the full assessment because it was just a continuation of the assessment from the night before. Whatever I could interact with him, I did that and also told him, In case you feel you want to come back any time, we are open 24/7, come back, we are here.

Q. And just going back to your physician progress notes, that would be page 39 in the exhibit and 38 at the bottom of the page.

A. Yeah.

Q. You made an entry there that's dated 02-01-17, which I take it is January 2nd, 2017?

A. Yes, absolutely.

Q. Okay.

A. Yeah.

Q. And that relates to your interaction with Lionel Desmond the next day?

A. Yes. Yeah.

Q. So if I'm reading this correctly it says, "Patient feeling better. Requesting discharge. Will discharge to home. Does not meet criteria for involuntary hospitalization. Slept well. No SI and no HI." Which are suicidal ideation and homicidal ideation.

So those notes. Would they have been made as you spoke to Lionel Desmond or ...

A. No, much later ... later on. Not when I was speaking to him at the time.

Q. Right. Like some significant time afterwards or just after he leaves?

A. 15, 20 minutes, half. Within that time. After I was done with Jane Anne Howard, talking to her.

Q. Okay. All right. And is it typical to make a note on the chart in this fashion when someone is being discharged?

A. Ph, yeah, I mean that was the ER, and I didn't have any other (disclose?), there was only one page. And there was no space. So I do that sometimes.

Q. Yeah.

A. If I needed a paper I could have asked the nurse or the clerk, which I usually ask the clerk to bring me another paper. But it was a short assessment and as a continuation of the assessment the night before. And this is my standard note that I document on everybody that I discharge. This is the standard psychiatric practice.

Q. Okay. So again, you made a note that, "Does not meet criteria for involuntary hospitalization." You, I guess,

reassessed him in the morning with that in mind, with the legislation in mind?

A. Absolutely.

Q. Okay.

A. Yeah.

Q. And in the comment in the morning, no suicidal ideation, no homicidal ideation, were those addressed with him again in some way?

A. Yes. Yes.

Q. And, again, what questions would you have asked the next day?

A. Any thoughts of hurting yourself or anybody else?

Q. Okay. Now when you were, I guess, determining whether he would leave or not. Or I guess he was going to leave. But in dealing with the issue of discharge you said you talked to Dr. Howard, did you?

A. Yes. Yeah.

Q. Would you have reviewed all of the chart and the nurses' notes?

A. No, I didn't review the nurses' notes.

Q. Okay, and the medication list, what he took through the night, would that be information you would have reviewed or

would have needed to review?

A. I did not do that.

Q. Okay. Now your comment that he slept well. Was that in response to a question? Or how did that come to your attention?

A. I asked him. He said slept well. In my view, he appeared to have slept well. And it was a short assessment. I will gather that it will be under the circumstances in the ER. People sometimes don't sleep well in the emergency room. That's what he told me that he slept well and I documented that, although I saw the nursing note it was contrary to what I documented. But that's what he told me and I documented that.

Q. Okay. Fair enough.

A. Yeah. Yeah.

Q. So you subsequently had an opportunity to see the nurses' notes at 12:45, the nurse's entry that: "Patient stating unable to sleep. Medicated as per *p.r.n.* orders.

At 1:50 patient is stating still unable to fall asleep. Asking for his usual sleeping pill that he didn't take into hospital with him. Medication unavailable in hospital at present." I assume that says zolpidem, is it?

A. Yes. Yeah.

Q. Okay.

A. Yeah. Yeah.

Q. "Warm blanket provided. Will continue to monitor." And then, "6:35 patient states had poor sleep. Checked on hourly. No voiced concerns at present. Will continue to monitor." So there's three entries that he had some difficulty sleeping the night before.

A. Yeah.

Q. But to you he indicated that he slept well?

A. Yes.

Q. Does that suggest to you that he was perhaps less than forthcoming about the way he was feeling?

A. Well, I didn't see the chart and the chart I did not see until this all started. I didn't see. I didn't notice until the Inquiry started and stuff. I didn't see the chart again. But basically I will document what he told me and it was in the circumstance. People usually don't sleep in the ER that well. It's not uncommon. I would say that, you know, at the time that way it was presented, the quality of his sleep, the issue of the quality of his sleep, did not appear to me that it required further investigation on my part.

Q. Right.

A. He appeared to have slept well. In my view, he was forthcoming. He was not in distress. I had given him some options. I had talked to him about the follow-up plan and that's how it happened.

Q. Okay.

A. Yeah. Now in the hindsight, even if I have known about, I can say that about the sleep, I don't think that having not a good night sleep would be ... if he still wanted to go I would have still had no grounds to keep him.

Q. Okay.

A. Yeah.

Q. And I just wanted to direct you. Perhaps we could go just briefly to ... I guess we're on it there. No, we're on the right page. Just down at the bottom of the page there. The entry at 7:10 from another member of the nursing staff, "Report received from Lee Anne," who is another nurse, I believe, Lee Anne Graham. The vitals are noted there. "Patient stated restless TO night." Maybe throughout the night?

A. Believe so, yeah.

Q. Right. And then, "Flat affect." Did you make any observations of his affect in the morning as compared to the night before?

A. To me he was not flat affect. He was pretty reactive to me. He smiled when he said, Thank you very much.

Q. All right. Did he voice any other complaints or concerns to you before he left hospital?

A. No.

Q. Okay. You may have answered this partially, I apologize, but what follow-up he was going to engage in when he left? You said he made an appointment or was going to make an appointment.

A. With Dr. Ian Slayter.

Q. Yes.

A. That was one. And the other piece was that he was to follow up with the social worker and therapist at the VA.

Q. Okay.

A. Which I did not discuss the name who was going to follow up or the nature of treatment that he was supposed to be receiving.

Q. Okay. Just that it was planned or ...

A. It was planned.

Q. Was it your understanding that he had appointments made with the therapist and anyone else through Veterans Affairs?

A. That's what he told me. I had no way to confirm and I didn't confirm.

Q. Okay. And I wanted to address the issue of, again, just coming back to perhaps a patient like Lionel Desmond being less forthcoming with how he's feeling with his treating physician. Maybe some concern that, in particular, a former soldier who has been in a culture where he is required to be perhaps stoic and not disclose the way he's feeling. Is there some concern that, that type of a patient requires a different kind of approach to get the information from them and that they may hold back?

A. Yeah, so again, I did not think at the time that it was a case of under-reporting or minimizing. I've seen many veterans and I don't think that veterans minimize or under-report their presentation any more than a member of a general population. I actually find them more forthcoming, more straightforward. So in my view, that wasn't in my assessment at the time.

Q. Do you know of anything in the literature that suggests anything on this topic one way or the other?

A. I'm not aware of that.

Q. Okay. You said that when you met with Lionel Desmond

that morning it was in the same area of the unit that he had spent the night?

A. Yes.

Q. And how long were you with him?

A. Not more than five minutes.

Q. Okay. And did you recall seeing the nurse to whom you had spoken on the phone, Ms. MacDonald?

A. I did not see the nurse.

Q. Okay. Would you have known her then?

A. No, I did not know her.

Q. Okay, so ...

A. Yeah, I think she's not a regular. Yeah, I did not know her at the time.

Q. Were you present when he left hospital?

A. Yeah, he was leaving at the time.

Q. Okay.

A. Yeah.

Q. More generally, are there differences? Setting aside the issue of potential under-reporting or not, are there differences in the way that one approaches a patient from a mental health perspective who has a military background or something akin to that?

A. Well, not necessarily. I would not differentiate too much about that. Depending upon different presentations, each presentation can be different. But I had to be careful with Mr. Desmond because of the PTSD diagnosis and exploring that. It takes time. It takes time to develop rapport and develop a therapeutic relationship. So in that respect, I was careful in how I dealt with him.

Q. All right.

A. Yeah.

Q. You say you were careful with him?

A. Yes. Yeah.

Q. In what sense, in rapport building or ...

A. Rapport building and overall interviewing. But he was very forthcoming.

Q. Okay. Careful, and just so I understand, to ensure that you got all the information or what?

A. Yes, to get information and to make him feel comfortable in terms of trusting me and developing therapeutic relationship.

Q. Okay. In the time that you dealt with him on January 1st and January 2nd, I appreciate that some things have changed since that time, such as the records now being available

electronically and perhaps more records being available to physicians.

A. Yeah.

Q. Are there other things that have changed or are changing that would assist either a emergency room doctor or a treating psychiatrist with a patient who presents at ER?

A. Yeah, so of course there's a new suicide risk assessment tool that has been introduced in 2007 ... later in 2007. There were ...

Q. When you say 2007 you mean 2017? Or 2007?

A. No, it was 2007, I believe.

Q. Okay.

A. No, sorry. 17.

Q. 17?

A. Yeah, 17.

Q. Okay. All right.

A. Yes. Yeah. Yeah, yeah. A couple of years ago.

Q. All right.

A. Yeah, 2007 is when he ... yeah. So that Afghanistan trip.

Q. Right.

A. 2007. So there is that piece. That has been

implemented. Then there is Accreditation Canada requirement for organizational practice in terms of assessing and screening and interventions around suicidal ideations and with suicide. And we mental health services are working in close collaboration with the ER departments to implement the same. That's another improvement.

Q. So this is a protocol, is it, or ...

A. This is a protocol, yes.

Q. Okay.

A. That we are trying to work with them in terms of ... like suicidal assessment, this tool is probably not used by the ER as yet. And so we are trying to introduce that to the emergency room. Also, that anybody who presents with mental health issues, they should have it done.

There is a suicide prevention framework which was actually just announced a couple of days ago. That was initially came into being in 2006 and it has been updated in the last couple of days. So that is being done. There is a scanning project going on last couple of years, which we are planning to launch in spring of 2020. That was another piece.

We have a crisis line now in Nova Scotia for patients in mental distress. They can call crisis line. We have a central

intake. We are also sharing the quality assurance recommendations with other departments, these quality reviews that we do on patients and being shared by other departments in order to improve the service.

I think that's what I can think of right now.

Q. Are there other things or other improvements or other changes that you think could benefit physicians in ...

A. Yeah.

Q. ... those circumstances or would have benefited you or Dr. Clark?

A. One of the electronic medical records, so we can have access to. And I would entail that into like a simplified or centralized means to request medical records from other services or other care providers, whether it be VA or a site clinic and so forth. That would be really helpful.

Other piece would be that we have a crisis team which is ... we still don't have anybody after hours or over the weekends. And where I can imagine the places where they are 24 hours, they are much busier also.

Q. Yes.

A. Like Halifax and Sydney and so forth. But at the same time, having a social worker could have been helpful for Mr.

Desmond maybe at the time. As an on-call psychiatrist, I think I would ... you know, that would be something to be incorporated.

The other piece would be there's a ... I think physicians can be a little bit trained more for domestic violence category, domestic violence issues in medical schools or in residency programs, in other areas of practice. Violence amongst, you know, discord, interpersonal relationship and so forth.

And another piece would be that, you know, this issue with arms licenses. And I get a lot of requests for this taking away armed license and then people coming back to get armed license. And it would be helpful to have clear guidelines as to what is expected from a physician or a medical doctor in terms of filling out those firearms license request forms.

Q. Yes? Do you sometimes see those forms yourself?

A. Yes, yes.

Q. Okay. And have you completed forms like that in this province?

A. I have completed those forms and sometimes I have, you know, agreed with that and sometimes I have not. But there are no clear guidelines as to what they're expected. Because people can be stable and guns ... I mean a lot of rural Nova Scotia has

... in the household they have guns for hunting.

So the guns are more than ... and I know this because I deal with this. So there's their right. And people complain. And if you don't give them they start complaining. Because some people are stable for a number of years. As I said, I see 15, 20 people with suicidal ideation every week or every ten days. It's not indicated to take away guns from everybody. In certain circumstances is it indicated that we do.

Returning them is another issue. Returning armed license is another issue. Clear guidelines would be really helpful.

Q. All right. Just going back to something you said earlier. The protocol, the suicide risk protocol ...

A. Yes.

Q. ... is something that's going to be, or you hope to be, implemented in ERs? Did I understand that correctly?

A. Yes, I think in mental health, mental healthcare providers, I know the numbers because, again, I attend the program (unclear). About 94 percent of the staff are already trained with this suicide risk assessment tool.

Q. Yes.

A. But we want to spread it around, you know, in other areas also. And so there is a policy which is widely

implemented. Like in inpatient units we do it at every level, and definitely one of them before discharge. That would be something that would be ... it's already there. It just needs to be a little bit more propagated.

Q. So would the idea be that if a person presented at Emerg or the ER with a mental health presentation of any sort that the suicide risk assessment tool would be filled out or completed?

A. Ideally, it should be.

Q. Okay. That's what you're working toward?

A. Yes.

Q. So in this case, if that had been in place that ...

A. Yeah.

Q. ... protocol might have been completed by a healthcare professional when he first presented at outpatients?

A. Yes.

Q. Or Emergency?

A. Yes. So usually during the daytime when we have a crisis team there it's already been done. Just after hours and over the weekends and holidays and then when they're discharged it could be done also.

Q. At admission and/or at discharge?

A. Yes.

Q. And that would involve actually filling out the form with the checklist, I guess? Is that ...

A. Yes.

Q. Okay.

A. Yeah.

Q. I'm just about finished, Your Honour. I'm wondering if you were planning to take the break at 3, maybe we could have just a bit early and then I'll just see if there's any other questions.

THE COURT: All right. Thank you, Counsel.

We'll take a break about 15 minutes or thereabouts. Thank you.

COURT RECESSED (14:55 HRS.)

COURT RESUMED (15:12 HRS.)

THE COURT: Thank you. Mr. Murray?

MR. MURRAY: Thank you, Your Honour. Dr. Rahman, I just have a couple of questions just when I went through my notes, just a couple of things I wanted to touch on before I finish off, if that's okay.

A. Yeah, yeah.

Q. If we could have a look at the exhibit again, 67.

It's the hospital record. Actually right there. That's fine. These are the notes of the nurse or nurses who saw Lionel Desmond through the night. It would be page 33 there in your book, I think, at the bottom.

A. Yeah.

Q. I appreciate you didn't make these entries. These were made by the nursing staff.

A. Yeah. Yeah.

Q. But just to be clear, it appears that the entry is 19:10 or 7:10. "Patient assessed by Dr. Clark." 2000, which would be 8 o'clock or ... 20:00 hours, "Patient assessed by Dr. Rahman." 20:15, "Plan to keep patient overnight in Observation." That would suggest an interval of about 15 minutes. That's not your recollection of the time ...

A. No, that's not.

Q. ... that you spent with ...

A. These are approximate times and the kind of interview that I had with him and the time I spent, I could not have obtained that much of information in 15 minutes.

Q. Okay. And I wanted to ask you, as well, about Dr. Clark's call to you. You said that when he called you, the phrase he used or, I guess, the wording was he was taking a bed

or is that what you said?

A. Yes.

Q. That suggests that he had already made a decision that Mr. Desmond would be staying for the night. What was the purpose of the call? Was it also to consult or to what extent was there a consult with you?

A. I think it's both. In this kind of situation, ER physicians just call us to let us know that they're taking the bed away. So that would be one reason to give me a call. And the other reason is to have a consult on the phone. He did not ask me to come to the hospital, I volunteered.

Q. Okay. Were there questions, though, about what should be done with Lionel Desmond when he called you?

A. I don't recall that.

Q. Okay.

A. Once he discuss the case with me, I said, I am in the hospital. I come down and take a look myself.

Q. Okay.

A. Yeah.

Q. Right. Were you uncomfortable at that point with the patient being admitted or taking a bed on the third floor without seeing him?

A. No.

Q. Okay.

A. No.

Q. So Dr. Clark could have admitted Lionel Desmond to the third floor?

A. Absolutely. That happens regularly that ER physicians admit patients on our unit, in case we have beds, under these circumstances. Yeah.

Q. Dr. Clark, in his testimony yesterday, and I appreciate you may have different recollections of it and that's perfectly fine, but as I understood his evidence, it was to the effect that he was a little uncomfortable perhaps dealing with this patient, given the PTSD diagnosis and his inexperience with that particular condition. Did any of that get conveyed to you when he spoke to you or ...

A. I don't have that recollection.

Q. Okay. I know I'm jumping around a little bit here.

A. Yeah.

Q. There's just a couple of things. When Lionel Desmond spoke to you about the incident in New Brunswick, just so I understand, did he describe that as what you would describe as a suicidal gesture or a suicide attempt or what exactly was it?

A. Suicidal gesture.

Q. And what is a suicidal gesture?

A. "Gesture" is ...

Q. I assume that's not the term he used.

A. Yes. Yeah. No, I asked him it was attempt or a suicidal gesture or did you really mean to hurt yourself.

Q. Yes.

A. And his answer was that, No ... I was just trying to ... I did it to get some help.

Q. Okay. And did he say what it was he did?

A. I think he said he cut his leg.

Q. Okay.

A. It was a self-injurious behaviour, cutting a leg.

Q. Okay. That was your recollection of what he said?

A. Yeah.

Q. Okay. All right. And that would fall into the category of "suicidal gesture", would it? I guess you can define that term you're using ...

A. Yeah. That's how ... my cross questioning with him, that's how I ... my impression was, once he answered me that. And then ... because that's part of the assessment, past psychiatric history and any past suicide attempts. And he

denied any other serious suicide attempt.

Q. Okay.

A. So suicidal gestures or certain injurious behaviour, cutting is the most common that we see which is categorized in self-injurious in suicidal gestures.

Q. Okay.

A. That people don't really mean to hurt themselves but they just do it to seek some help or they feel relieved by doing this. Whatever they're feeling, there's an immediate release to that effect.

Q. And that would fall under the category of suicidal gesture.

A. Yes.

Q. Okay. When you reviewed the outpatient record, there was Dr. Slayter's comprehensive letter of December 2nd. You said you were comforted by the fact that he was being seen by Dr. Slayter and that that was ongoing.

A. Yes.

Q. Was there any thought ... not necessarily consulting Dr. Slayter right there that night, but consulting with him afterwards or notifying him that his patient was in the ER that night?

A. Absolutely. That's the usual protocol and I would have had talked to him the first chance I would have gotten. And then the other piece would be that I ... if I would have confirmed with the staff in case he had made an appointment with him. If he would not have then our protocol is that we would have called him.

Q. You would have called Lionel Desmond.

A. Yeah. The staff would have called him to make an appointment.

Q. Because he was in hospital?

A. He was in the hospital.

Q. Now that was as a result of a social admission but nonetheless?

A. Nonetheless. Because he did have, you know, the diagnosis and follow-up plan and given Dr. Slayter's note and the complexity of the situation, he had volunteered to follow-up with him and that was a good plan for me.

Q. The earlier chart from October 24th had the document completed by the mental health nurse, Heather Wheaton, and the suicide tool was completed as it then was. Given that he was in hospital January 1st/2nd, would it have been appropriate, had he lived, to have another risk assessment like that done?

A. January 2nd?

Q. Yes.

A. Can you repeat that?

Q. Given that he was in hospital when you saw him had he lived, I mean had he gone on to see Dr. Slayter and continued with his treatment, would another risk assessment like the one that was done on October 24th by Heather Wheaton, would it have been appropriate for another one of those to be done?

A. Yes. Well that was the plan. Once an appointment with Dr. Slayter would have taken place, then he would have assessed that anyways during his appointment.

Q. After he left on January 2nd, obviously the tragic events occurred on January 3rd.

A. Yes.

Q. You became aware of those fairly quickly, I assume?

A. Yes.

Q. Well, first of all, what was your thought when you heard that news?

A. I was devastated. I didn't expect this would happen. I was actually in our Admin room where all the secretaries are. And this news start to ... I didn't know the night it happened. I didn't have any information. On the 4th, I was in the room

with them, standing, and this news started to come through that something has happened. And so I just ... it sounded familiar that this is the same gentleman that we just saw him couple of days ago, like a couple ... you know, couple of days ago. And so the admin who was in front there, she said, Well, this is the same gentleman who just came to make an appointment with Dr. Slayter not that long ago. So that was the whole conversation. And at the time, we realize that this is the gentleman. So it was very shocking to all of us.

Q. After you learned of that news, did you revisit your chart? Did you come back to the notes you had made from the night to look at those again?

A. No.

Q. Did you make any additional notes after that?

A. Absolutely not. Yeah, the chart is usually sealed. Once this happened, the charts are locked and sealed and there's no access to the chart.

Q. We've talked about the tools that we ... that are used or to attempt to predict the likelihood or the risk of suicide.

A. Yeah.

Q. Are there any similar tools either available or in development or contemplated that would help to predict the risk

of harm to others by a mental health patient?

A. Well, I'm aware of the suicide risk assessment tool which does have ... that covers the thoughts of harming others also.

Q. Okay.

A. That's what I'm aware of. I'm not aware of any other tools in the making.

Q. Okay. All right. The suicide risk assessment tool, though, does address the issue of contemplating risk ... or harm to others?

A. Yes, I believe so.

Q. If the newer risk assessment tool ... suicide risk assessment tool, if that had been in place in January of 2017, had it been completed by someone at hospital or had you completed it and if you had had all of the other information that you had at that time, would it have made any difference to the decisions you made?

A. I don't think so.

Q. Okay.

A. And, again, I assessed him at the time, how he presented. And, again, I would repeat that we see many people who ... suicide attempts and previous suicide attempts. And we

ask patient directly. We rely on that information. As psychiatrists, we don't have any medical test or blood work or lab work that we can do that. We rely quite a bit on the interview and patient self-reporting and information. But given the whole circumstance I had no grounds to keep him in the hospital on involuntary basis.

Q. From the limited time that you were with him and what you know of him, I would suggest that had he lived, Lionel Desmond would have required a consistent structured treatment plan going forward for his myriad problems. Would the treatment that he would have had to receive, would that have been available in the rural setting where he lived in northern Nova Scotia?

A. I don't think we have that kind of expertise in our department in rural Nova Scotia or in rural Nova Scotia. I think he would ... as Dr. Slayter had indicated in his notes, that he would require specialized treatment in terms of his PTSD. But at the same time, in terms of his interpersonal conflict and ... it is a possibility that someone could have helped him. Dr. Slayter, himself, was trying to help him. We are consultants. We don't see people in follow-ups that often. But he, himself, took this task upon him to go out of way and to

provide the service and agreed to see him. So I think the plan that he was making, I do agree with that, that that kind of specialized treatment is not available in rural Nova Scotia and he was looking into incorporating him into an OSI clinic and so forth.

Q. Okay. All right, thank you, Dr. Rahman. Those are all the questions I have.

A. Thank you.

Q. Thank you very much.

THE COURT: Ms. Ward?

MS. WARD: Thank you, Your Honour.

CROSS-EXAMINATION BY MS. WARD

MS. WARD: Doctor, my name is Lori Ward and I represent the Attorney General of Canada.

A. Yeah.

Q. Just have a few questions. You spoke earlier about Mr. Desmond presenting a mixed picture. And you talked a bit about possibly the reason that he was presenting in the emergency room that day was more related to his interpersonal conflict than his PTSD. I wonder if you could elaborate on how

you separate those things. I mean Mr. Murray just said that Mr. Desmond had myriad problems, one of them being PTSD. But you've talked a bit about his interpersonal conflict being sort of ... if I could put it this way, of paramount importance on that particular occasion. Would that be fair to say?

A. Yes.

Q. So how did you differentiate between those diagnoses ... or that diagnosis and what he was presenting with that day?

A. It's not easy to differentiate. That is, again, my opinion, what information I got at the time and how his presentation was, under whatever circumstances. What was the major precipitant for him and a trigger for him to present himself to the Emergency Room? And the past history that I spoke to him about his conflict. So I am not ... I cannot, again, say for sure, but this is my assessment. It could be ... it could have been possible but not necessarily. I think that could be my response.

Q. Okay. And you also said that you thought his interpersonal conflict with his wife was of long standing. What went into that assessment? Like why did you form that opinion?

A. Well he told me that. It's his self-reporting that this has been going on for quite some time.

Q. You also said a few minutes ago that you thought more domestic violence training would be beneficial for doctors or hospital staff, I think. And you told us that you asked Mr. Desmond if he had been physically abusive with his wife and he denied it. Correct?

A. Absolutely. Yeah. Correct.

Q. Did you ask him if he had been abusive in any other way? I mean there are other kinds of abuse besides physical abuse. Did you explore those avenues or did you have any sense that ...

A. I did not explore that.

Q. Okay. In your opinion, would more domestic violence training feed into an assessment of a homicidal ideation? Mr. Murray was just asking about tools to assess homicidal ideation as opposed to suicidal. And I think your answer was basically that it's kind of a factor in that assessment tool but there's nothing really separate for homicidal ideation. Is that correct? **A.** Yes.

Q. So do you think that training on domestic violence would feed into that assessment of homicidal ideation?

A. That is a possibility. That can be helpful.

Q. I think you told us you see a lot of people with PTSD.

You mentioned veterans, RCMP members, first responders, EHS, and it's fair to say that those are all sort of occupational hazards for those people. But it's possible for any member of the general public to experience PTSD as a result of some kind of trauma. Is that right?

A. Yes.

Q. What are some other kinds of trauma that would lead to PTSD that you've encountered?

A. Yeah. A severe motor vehicle accident or death of a friend or a family relative. It does ... the definition needs to be ... there's a definition for PTSD and there has to be an exposure ... direct exposure to severe injury or sexual violence or death. So it would be one ... one is direct exposure, the other one is witnessing somebody, even witnessing a traumatic event happening to somebody else. And even hearing a traumatic event, that a family or a close family member or a close friend have gone through, or an exposure repetitive, an extreme exposure to the aversive details of a traumatic event. An example would be, in first responders, collection of body parts. An example for police or RCMP would be repetitive exposure to details of sexual violence or sexual abuse. So occupationally related, I mean it has to be severe enough to be not ... and

then different people have different coping skills. So that is one criteria.

The other ones are intrusion ... intrusive thoughts, intrusion thoughts, that is having memory of the traumatic event, having dreams of the traumatic event like ... and dissociative reactions like flashbacks, as if people ... somebody is feeling that people are ... recurring experience of the traumatic experience. And then with that there's a psychological reaction and psychological distress.

I mean there are a lot of other ... there's avoidance to the feeling and avoidance to the external reminders of the trauma is part of the ... so one has to meet at least one of these criteria. And then there is negative alterations in cognition and in behaviour also, that people have difficulty remembering part of the traumatic event. People have distorted cognitions when they feel that they are being ... distorted cognitions around the cause of the trauma and they tend to blame themselves. And they feel that they're responsible for that.

There's a mood component, also, that people have negative mood ... negative emotions, that they feel that ... there's a fear, there's a horror, there is a shame and so forth. There is ... so one has to meet two of these criteria. There's a feeling

that patients do feel that they are unable to feel the positive emotions, like loving feeling or satisfaction and so forth. They stop having ... they are unable to enjoy their usual activities of ... that they used to enjoy. There's a detachment, there's an estrangement.

And so I can ... well, there are ... these are the ... and there's difficulties with alterations in arousal and reactivity. There is ... they are ... there's a startle response. They're hypervigilant. They can be impulsive, they can have problems with memory, they can have problems with sleep, they can have problems with concentration and so forth. So there's a whole criteria that they have to meet.

It has to be there for at least more than a month, all these criteria. And then it has to be not because of the psychological effect of any drugs or medications or any medical condition. And it has to be severe enough to affect their occupational and social or any other area of important functioning in their life. There are subqualifiers. Some can be ... one is delayed expression. Sometimes PTSD symptoms do not appear immediately, although some symptoms might appear immediately. But if it takes six months then it's called delayed expression of PTSD. And then there are other qualifiers

like depersonalization and derealization where people feel that they are detached from their ... from one's body or from one's mental processes. And also detached ... and the surroundings appear to be unreal to them.

So these are all criteria. But the major criteria in all this, even in derealization and depersonalization and other dissociative reactions like flashbacks, their reality testing is still intact. They're not psychotic. So the reality testing is not a psychotic illness. The reality testing remains intact throughout all that.

Q. Thank you. Just one final question. Are you able to form an opinion, or maybe you are aware of statistics on this, but are you aware of the rates at which people with a PTSD diagnosis carry out a violent act such as homicide or suicide?

A. Well, PTSD, the rates are similar to major depressive disorder and it's about 10 to 15 percent people, they do commit suicide. I don't know about homicide. That's very rare, very, very rare. But suicide, I think 10 to 15 percent patients. And the prevalence is about eight to nine percent ...

Q. Of the ...

A. ... in the people ... in the population.

Q. ... population.

A. Yeah.

Q. Thank you, Doctor. Those are my questions.

A. Thank you.

THE COURT: Mr. Anderson?

MR. ANDERSON: I have no questions, Your Honour.

THE COURT: Thank you. Mr. Macdonald?

MR. MACDONALD: Thank you, Your Honour.

CROSS-EXAMINATION BY MR. MACDONALD

MR. MACDONALD: Good afternoon, Dr. Rahman. I'm Tom Macdonald. I'm the lawyer for the Borden family, as I've said, so that would be Shanna Desmond's mother, father, brother, and share co-representation with Ms. Miller, in terms of Aaliyah Desmond.

A. Yeah.

Q. Thank you. I wanted to ask you, what did you review prior to coming and giving your evidence here today?

A. What I reviewed, the chart and of course I reviewed the definition of PTSD that I explained.

Q. So let me just stop you. Where did you review the definition of PTSD? What did you use to review the definition?

A. I usually have my own textbook and ...

Q. When you say your own textbook, written by you or ...

A. Yeah. No, no. It's a DSM-5 criteria.

Q. Okay. And so when would you have looked at that?

A. I know the criteria. I was just trying to refresh my ...

Q. No. But my question is when would you have looked at that?

A. Yesterday.

Q. Okay. When did you look at the chart the last time?

A. Chart was in the last week.

Q. Okay.

A. Yeah.

Q. Electronically or paper?

A. Electronically.

Q. Okay. So do you have it on the documents that were provided from the Inquiry or something ...

A. Yes.

Q. Yes. Okay.

A. Yes. Yeah. Absolutely.

Q. Is that the only time you reviewed the chart since this unfortunate incident?

A. No. I reviewed it once the Inquiry was about to start a few months ago. I reviewed it then.

Q. Yeah.

A. And now in the last week or so.

Q. Did you, other than your lawyer, and I don't want you to tell me anything you discussed with him ...

A. Yeah.

Q. Did you discuss your evidence before you came to give evidence today with anyone?

A. No.

Q. You're sure of that?

A. I discussed it with my lawyer, like that's ...

Q. No. I don't want to know what ...

A. Okay. Yeah.

Q. ... you discussed with him. But anyone other than your lawyer?

A. No, I did not discuss.

Q. So not with Dr. Clark.

A. No. No.

Q. Not with Dr. Slayter.

A. No.

Q. Not with any of the nurses who are here today.

A. No.

Q. Okay. I'm not suggesting that you did. I'm just asking.

A. Yeah, yeah. No, no, I just ...

Q. You mentioned about your experience dealing with veterans and you had two stops along your career in the US at VA hospitals.

A. Yeah.

Q. Correct? Correct?

A. Yes. Absolutely.

Q. Yes.

A. Yeah.

Q. Is that where the bulk of your experience dealing with veterans comes from?

A. I believe so, yes.

Q. Is it fair to say, though, that dealing with Afghan war veterans is not something that you had very much, if any, experience in?

A. That could be correct. I saw a few (unclear) veterans in Minneapolis VA but, yeah, I think that could be about it. Not too many after that.

Q. You wouldn't have seen any in Washington, would you?

A. No. No, I don't think so.

Q. Well ...

A. Yeah.

Q. ... I think you wouldn't because, of course, you were in ...

A. Yes.

Q. ... Washington ...

A. In ... yeah.

Q. ... in 1997 and 1998. Right?

A. Yes. Absolutely. Yeah.

Q. And the Afghan War didn't start until ...

A. No.

Q. ... 2001.

A. No.

Q. Right?

A. Yeah.

Q. So now you were in Minnesota ...

A. Yeah.

Q. ... in 2003/2004.

A. Yeah.

Q. So the Afghan War was on. The Iraq War is on. But I noticed your fellowship was in geriatric psychiatry.

A. Yes. Yeah.

Q. So that means older people, doesn't it, older veterans?

A. Yes. Yes. Yeah.

Q. So the likelihood of young Afghan War/Iraq War combat veterans, seeing them in Minnesota, little or none, is that fair?

A. Yeah, it was ... there were not too many at the time. But I used to be on call sometimes and I used to be ... so during that time. But, you're right, I was doing a geriatric fellowship and most of my work was in the geriatric fellowship domain.

Q. Do you have any specific recollection today of ever dealing with an Afghan War veteran who was in combat and who was young like ... or Mr. Desmond's age? Other than him, of course.

A. Yes, I don't have much recollection but I remember a few people who had come to the ER there and I've seen them so that's a long time ago.

Q. Yes, and that's a different setting?

A. And there were not too many of them, most of them were from other wars.

Q. And that was in Minnesota?

A. Absolutely, yeah.

Q. And, of course, just to pick up on the point of my friend Tara Miller, that I'm co-representing Aaliyah Desmond with.

A. Sure.

Q. So I wanted to talk about charting for a moment. I'm guessing from a physician perspective it's important to put things in a chart, isn't it, when they see a patient?

A. Yes.

Q. That's fair?

A. Yeah.

Q. You're trained to do that in medical school?

A. Yes.

Q. Trained to do that in internship?

A. Absolutely.

Q. Trained to do it as a resident?

A. Yes.

Q. Not only trained to do it but I'm guessing it must be a little bit of a reminder in continuing medical education that people, doctors, physicians do that when they're upgrading or refreshing their practices. That putting a note in the chart is an important thing, right?

A. I agree with that, yeah.

Q. I noticed in some of your evidence today when you were answering questions from my friend, Mr. Murray, you were referring to a number of things that aren't in your notes from the chart.

A. Yeah.

Q. Any specific reason for that, why they weren't in the chart, that chart?

A. Well, at the time I didn't ... it's an ER assessment and I think I did document more than I usually do in terms of the ER assessment but I did not document everything. I had declared that before, it's not a verbatim transcript and that's how my recollection is, what I spoke to about Mr. Desmond and his responses so that's what I can ... the best information is what I have in the chart and through my recollection.

Q. And I think you said today in your evidence and you'll please correct me if I'm wrong, you don't or it's not your practice to take notes in front of the patient, psychiatric patients, mental health patients?

A. Usually I don't do that.

Q. You were here for all of Dr. Clark's evidence yesterday, correct?

A. Yes, I was.

Q. You heard it all?

A. Absolutely.

Q. Dr. Clark made a comment yesterday that he was, and I'm paraphrasing it, but cautious in terms of not necessarily believing everything a person says when they are in the ER for what I will call mental health issues, do you remember him saying that?

A. Yes, yes.

Q. Is that your practice, too, that you don't believe everything they say or take it at face value?

A. I think we psychiatrists are trained to probe a little bit ... probe ...

Q. Yes.

A. ... and ask questions and we have more training than the ER physician in the field of psychiatry. I think I had more information than Dr. Clark. Being a psychiatrist I was able to extract more information from him but at the end of the day it just comes down to what tools do we have, it comes down to information, the presentation and information that we have at the time, it comes down to the psychiatrist's clinical judgement and I did not have any reason at the time to believe otherwise.

To me he was very open and forthcoming and I did my assessment as per my own clinical judgement.

Q. So just so I can understand, Doctor, is it your evidence today that you believed everything Mr. Desmond told you in your interactions with him on January 1 and 2 of 2017?

A. I did not have any reason to believe otherwise.

Q. So you knew though, and you don't need to go through them unless there's a reason you want to, so if we speak of the chart and so now I'm talking about the chart that would cover January 1, 2017/January 2, 2017. I'm not telling you anything you don't know, he arrives on January 1st, he's discharged on January 2nd. You know from the chart that he indicated that he was at the hospital because, for lack of a better word, he had a fight with his wife, he had pounded the table, she threatened to call the police, correct?

A. Yeah.

Q. And you also know from your evidence today that he had told you that she had called the police on him I think "many times" was the word you used?

A. Yeah.

Q. And that's not in the chart, that's from your direct memory as you indicated, the calling the police many times on

him. I can tell you it's not in your notes but if you need to look.

A. Okay. Yeah, okay.

Q. You knew because you spoke with him ...

A. Yes.

Q. ... that he had firearms taken from him?

A. Mm-hmm.

Q. Did you ask him, by the way, whether he had reacquired them?

A. I didn't ask him that.

Q. And that, I'll just keep going along here. So wouldn't those be red flags in terms of taking everything he tells you at face value when ultimately he says the next morning I want to go home?

A. Well, that's how psychiatrists assess people. You know it's not, you're not 100 percent sure, there's always a risk. I will tell you that I (unclear) patients and I admit people every ... in a week I will admit 10 to 12 people, 10 to 12 people with suicidal ideations and we manage them, we assess them, we stabilize them and then I go with their word and our own clinical assessment through our multi-disciplinary treatment team when they are discharged and there's no guarantee what

they're going to do after they are discharged although they just came a few days ago with suicidal ideations. So that's, by virtue of the profession that we are in, our patients do carry a risk of hurting themselves.

Q. But is there a higher risk, in your medical opinion, when that patient is a combat veteran who would have seen combat every day for seven months in Afghanistan? Is there a higher risk, in other words, a person who used a weapon in - let me finish, please - who used a weapon in their job, who then had weapons taken from them, is that not a higher risk that would wave a red flag?

A. Not necessarily.

Q. Okay.

A. It all depends on how they presented at the time.

Q. What about a person, that patient with that background who presents and says I'm here today to Dr. Clark or to the nurses because I had a fight with my wife and she asked me to leave and I pounded the table and he later says to you she's called the police on me many times, wouldn't that raise the red flag moreso with the weapons background?

A. Again, not necessarily. We did offer him to stay and he did stay with us overnight.

Q. Yes.

A. But, again, to me he did not meet the criteria to stay in the hospital against his wishes.

Q. It seemed to me when you were giving some answers to Mr. Murray and if I'm characterizing it unfairly, please tell me. In many ways Mr. Desmond was in a sense, not a medical sense, directing his own care. What do I mean? You prescribed certain drugs, he didn't want to take them, so you prescribed others.

A. Okay. Yeah.

Q. You wanted and suggested that he go to the third floor, he didn't want to so he didn't, he was in the bed, the comfortable bed that you described.

A. Yeah.

Q. The next day he wanted to go home, you agreed with him. Is that normal? I'm just wondering what the trade-off is between the patient's wants and the psychiatrist ... the treating psychiatrist's needs.

A. It was a social admission. I was offering it as a courtesy, as a social admission.

Q. A social admission, though, of a person with a military combat background who had weapons taken from him, who

had had a fight with his wife, pounded the table, said to you that the police, she called the police on him many times, and then presents at the hospital. So it's a social admission with those factors surrounding it, correct? Correct, Doctor?

A. Yes, he had been assessed in the ER before, he had been seen by Dr. Slayter so this presentation had been, this was a chronic diagnosis. He did not present with any acute PTSD symptoms at the time.

Q. So you said earlier, again please I'm saying to you if I have it wrong, I want you tell me. He didn't present as psychotic to you, did he?

A. No.

Q. No. Is it fair to say you weren't there, I wasn't there, no one in this room was there but on January 3rd to do what he did, he must have been highly agitated and psychotic at the least, is that fair? From a practicing psychiatrist, chief of the eastern region, is that fair?

A. I believe his status changed in the intervening period.

Q. Yes.

A. He had 30 hours after he was discharged from the hospital. I believe that it happened in the intervening period

that the status changed.

Q. Do you believe he was psychotic and highly agitated when he killed himself and his family?

A. I cannot say about that, it would be conjecture. I did not assess him at the time.

Q. I understand, I understand, but you did assess him on the 2nd and he did this on the 3rd?

A. Absolutely.

Q. Is it possible that people can go from presenting as you have described him in your notes on the day of discharge to, well, you can use an adjective, but to the next day doing something that he did, is that ... have you seen that before?

A. That is possible.

Q. Have you seen it before before Mr. Desmond?

A. I have seen people committing suicide after discharge.

Q. The next day?

A. The next day.

Q. Have you seen them killing their families?

A. No, I've never seen that.

Q. So can psychosis come and go, those are my words?

A. It depends in the instance but he did not have any history of any psychotic illness. It does not ... he was not on

any drugs or anything like that. It would be hard for me to believe that he could have gotten psychotic in that period of time.

Q. But it is possible?

A. There is a possibility.

Q. We've heard Mr. Murray refer to and you I think touched on it, Dr. Slayter's December 2, 2016 report, psychiatric assessment. I believe I understood you to say you read it quickly or you looked at it quickly. I'm taking that to mean that you didn't read every word of it, is that fair?

A. Yeah, that's fair.

Q. Okay. You've read it since though, right?

A. Yes, I have.

Q. Is there anything in Dr. Slayter's December 2, 2016 report that would, in any way, have changed your clinical judgement on January 3rd if you had read every word of it on January 1st?

A. No, I don't believe so.

Q. So we've seen checklists and we hear about checklists. Dr. Clark spoke about he, I think, has an app now and we know that in June of 2017, the Nova Scotia Health Authority put in the policy, and I believe you said today, it's effective. It's

been used and effective in the sense it's been triggered, it's used. You know the policy I'm referring to?

A. Yes.

Q. Yes. And that policy, the last page at least from the copy I have, is a checklist. Do you know the checklist?

A. Yes, yes, yeah.

Q. Do you use that checklist today in your practice?

A. Yeah, we use it.

Q. Do you use it?

A. Yeah.

Q. Yourself?

A. Oh yes, yeah.

Q. Do you physically have a copy of it with you, do you have it on your iPhone, you know, do you look at it and go through every factor?

A. No. It's not in my ... I know part of it, what is it in the checklist ...

Q. Yes.

A. ... but it again comes down to a clinical judgement.

Q. Yes. So are you saying you don't look at every factor on the checklist when you assess a patient, Doctor?

A. Not every factor.

Q. Any reason why not, especially in light of what happened with Mr. Desmond?

A. I work primarily in the inpatient unit and we have our staff who does that when the patient is discharged and when they come in. I rely on them and then during the daytime and we have a crisis team, I do take a look at that also. So I use it in terms of my clinical judgement. I know a lot of things in that list which is not too different from the previous ones.

Q. So just so I can try to summarize, so as I understand your evidence, you use the checklist but you don't check off every item on the checklist, you leave that to others and you use your clinical judgement as the overriding factor, is that correct?

A. Yes.

Q. So your clinical judgement as a psychiatrist when you're treating a patient even today, tonight, if I presented at St. Martha's, that trumps everything, correct? It trumps the chart, it trumps the nurse's notes, it trumps whatever other psychiatrists have to say, you're the guy on the spot who is assessing me and so in your clinical judgement, you call the shots, is that fair?

THE COURT: I'm going to stop you. I'd ask you to

phrase your question a different way ...

MR. MACDONALD: Sure.

THE COURT: ... because your suggestion is that his judgement trumps and that's not what he said at all. What he said is he takes into account information that comes from a variety of sources and you have changed what he said when you put it back to him and asked him to answer it. So I'll ask you to ask it in a different way, respecting what he's already said.

MR. MACDONALD: Sure.

THE COURT: Thank you.

MR. MACDONALD: So now, Doctor, I was not trying to put words in your mouth and yes, trump ...

A. Yeah, that's fine.

Q. ... is the word I used but as I understood your evidence this morning, a number of times you spoke about the high level of importance you give to clinical judgement.

A. Yeah.

Q. And I think even if we could just perhaps turn for a moment to, so it's Exhibit 332.

EXHIBIT P-000105 - NSHA - SUICIDE RISK ASSESSMENT INTERVENTION POLICY

Q. And the last page, that's the form that we spoke of.

THE COURT: Sorry, the exhibit number is?

THE CLERK: 105.

MR. MACDONALD: Oh, I'm sorry, I'm looking at the begdoc number, yes, exhibit P-000105, Doctor.

THE COURT: 105?

MR. MACDONALD: It's the Mental Health and Addictions Policy and Procedure, Nova Scotia Health Authority. That's the one that became effective on June 30, 2017.

A. Yeah, I have it.

Q. If you could turn to the last page, the last page is the checklist, Suicide Risk Assessment and Intervention Tool.

A. Yes, I'm very familiar with this.

Q. Sure. So almost at the bottom just above the last block, it says Suicide Risk Level. "Risk assessment is based on clinical judgement and not based on number of items checked." That checklist is intended to guide the clinical decision only, see those words?

A. Yes, yeah.

Q. So does that mean to you that your clinical judgement is the most important part of your assessment of a patient with mental health issues?

A. That's true. The clinical judgement of a psychiatrist

is the most important thing but these checklists, I always see them, I always ... I take reference from that all the time. I see this list every day, a couple of times a day.

Q. And with Mr. Desmond's situation, your clinical judgement was the most important factor that you used to discharge him in coming to that decision?

A. Yes, that's correct.

Q. And I know that you said in your evidence as I understood it, it may have been an hour to two hours over that period, January 1st, January 2nd that you were around when he was around, is that fair, in the hospital?

A. Yes.

Q. 35 to 40 minutes you interacted in terms of an assessment, the work-up?

A. Yeah.

Q. Five minutes on January 2nd when you saw him when he was getting ready to leave and you signed the discharge?

A. Yes.

Q. So 40 to 45 minutes one-on-one interaction, that's fair, that's what you had with him during his stay?

A. Yes, that's the amount of time but he was in the emergency room overnight being assessed regularly by the staff

...

Q. Yes.

A. ... and his overall general status and mental health were being assessed during all that time.

Q. But you didn't look at the nurse's' ... the overnight nurses' notes. I think your evidence was that on January 2nd you had not reviewed the notes where she said he didn't sleep well and he told you he did sleep well?

A. Yeah, but I did talk to the nurse and confirm that he was doing ... there's no concerns, they had no concerns. And then I can also add that having a quality of sleep issue, that would not have changed the situation in terms of ... because that's not the criteria to keep somebody involuntarily in the hospital against their wishes.

Q. Understood. But if we could turn to a moment to your, and they're your notes but they're the typewritten version of your notes so that would be Exhibit 108, do you have that?

EXHIBIT P-000108 - TYPEWRITTEN CHART NOTES OF DR. RAHMAN

Q. So if you need to follow from your handwritten notes, that's fine but ...

A. No, I can ...

Q. ... your lawyer provided us with the typewritten

version.

A. Yes.

Q. Just so we're on the same page. So are you there by the way? Yeah, you're there, okay.

A. Yes, I can see it, yeah.

Q. So at the bottom of the first page, it says page eight at the bottom, do you see that?

A. Yes.

Q. January 1, 2017. So I'm just going to skip through your notes, I won't read them verbatim. "Retired veteran from army." Do you see that?

A. Yeah.

Q. "Served in Afghanistan for seven months and suffering from PTSD." Do you see that?

A. (No audible response.)

Q. You have to answer "yes" ...

A. Yes, yes.

Q. Or "no". "Lives with his wife of ten years and ten-year old daughter." Do you see that?

A. Yes.

Q. "Has H/O anger management issues ..." What does the "H/O" mean?

A. History of.

Q. "History of anger management issues and longstanding interpersonal conflicts with his wife." Do you see that?

A. Yes.

Q. "Apparently had a verbal altercation with his wife who apparently asked him to leave the premises until he feels more under control. He has been advised, he has intermittently been advised by his wife to spent night elsewhere and return home the next day or so." Do you see that?

A. Yes.

Q. And then you see a reference that his wife is employed at St. Martha's?

A. Yes

Q. Then if we flip over to the next page, "The wife had called police on him on few occasions in the past but he left the house before police arrived." Do you see that?

A. Yes.

Q. "He states that argument between him and his wife started last night." You see that?

A. Yes.

Q. Both, by both you mean husband and wife?

A. Yes, yeah.

Q. Okay. "Both continued to escalate until he punched/hit a table at which point she threatened him about calling RCMP?"

A. Yes.

Q. Okay. So if you add up all of those factors, aren't those all, each and every one given that he came to the hospital because of the altercation the night before, red flags to maybe take some other step than discharge?

A. We made an outpatient follow-up plan with him.

Q. Yes.

A. There was a plan to follow up. He was remorseful and regretful for his actions the day before and this is the history, this is a long-standing history. There was nothing acute in his presentation.

Q. But because it was a long-standing history of domestic violence or something akin to that, wouldn't that be a factor alone in terms of a red flag to maybe think about some other treatment than discharge, some other plan?

A. The plan was to follow with the psychiatrist.

Q. Yes, but some other plan.

A. And the VA social worker and VA therapist, that was the plan.

Q. But was it possible that there could have been another plan that could have been in place or additions to the plan because of the history of domestic issues?

A. Well, that would be something that I would have depended on the follow-up plan in terms of having a social worker and Dr. Slayter seeing him. There was no grounds for me to make a plan to forcefully involuntarily keep him in the hospital. So that was not the plan, I could make a plan for follow-up and I did that.

Q. And you knew when he was being discharged he was going home, right?

A. That's what he told me.

Q. Yeah, yeah, and that's in the chart notes, those are in your notes, right, "discharged to home"?

A. Yes, yes. And I had asked him that in case she won't take you back and he said well, he has extended family and he has other relatives that he can go to and that has happened in the past also.

Q. You said earlier to Mr. Murray that you had asked him about, I think you used the term arms ...

A. Yeah.

Q. ... firearms, I'll use the term "guns", why wouldn't

that be noted in the chart?

A. I cannot ... I did not document it. I can say that, but I have full recollection of asking him that so I think I forgot to document it.

Q. So it seems to me and I'm no doctor, 2017, 2020, someone presents like Lionel Desmond to the ER and eventually sees a psychiatrist, the questions that would be asked would be these: Are you thinking of hurting or killing yourself or somebody else? Do you have a gun? And are there any domestic violence issues with you and your wife, if you have one, or your partner? Would you agree those are important questions?

A. Can you repeat the question again?

Q. So it seemed to me if somebody like Lionel Desmond did, whether it's 2017 or 2020 ...

A. Okay.

Q. ... who report to an Emergency Department and they're eventually seen by a psychiatrist, maybe you, that they would be asked: Do you have ... are you thinking of hurting yourself or killing yourself or hurting or killing someone else or do you have any domestic issues or violence issues with your spouse, your partner and do you own a gun and do you have access to a gun. Is it fair that those are normal questions that would be

asked?

A. Yeah.

Q. And they'd usually be put in the chart, fair?

A. Yes. Yeah, yeah.

Q. So we know that there are domestic violence, that's my term, but references to situations that could be characterized as domestic violence in your notes and I've seen the notes where you used the terms SI and HI, suicidal ideation and homicidal ideation ...

A. Yeah.

Q. ... but no reference to guns. And just so I understand your evidence, you don't know why that's not in the chart but you do remember that you asked him, is that fair?

A. Oh, absolutely, absolutely.

Q. Okay.

A. And as a psychiatrist I can elaborate a little bit on that. If he would have said that he had guns, he still did not have any ... I did not have any grounds to, I could have requested him, given the history, you should, you know, give these guns for safekeeping but these were not the grounds to even ... I would not have removed the weapons.

Q. Well, you would not have removed the weapons but just

to go over it again, he did tell you he had his guns taken away?

A. Yes, yes.

Q. So that, in and of itself, is still not enough, in your judgement, to keep him or do something else besides discharge, the fact that he guns taken away from him?

A. Umm ...

Q. You know he's going home?

A. Guns were taken away ... so he had confided, he had told me that the guns are not there anymore. I just cannot think of any other plan except that what the plan was to follow with the psychiatrist, with a Veterans Affairs social worker and Veterans Affairs therapist at the time.

Q. Speaking of the plan, so it is what it is in terms of your interaction with him. At what point would it have triggered in you, and I know you mentioned it to him ...

A. Yeah.

Q. ... but you would override his decision when he said about do you want to call your wife or you calling Shanna Desmond and saying to her Lionel's on his way home. Is that something you could have done?

A. I think here if a person has information that comes ...

Q. Yes.

A. ... I think he, according to his presentation, according to my assessment, he had denied any of those thoughts and he did not give me permission so I respected he was competent, he has capacity to consent, and I honoured that.

Q. So you're not a lawyer and I know that. Are you saying no as a psychiatrist because of what he told you, your hands were tied, you could not have picked up the phone and called Ms. Desmond?

A. I could not have.

Q. Can you today, if a similar situation was to happen at St. Martha's tonight?

A. No, I don't think so.

Q. It has to rise to a different level?

A. Yes.

Q. If someone says I'm going to hurt my wife ...

A. Yes.

Q. ... and I'm leaving here and I'm going to buy a gun ...

A. Yeah.

Q. ... then you would be able to call somebody ...

A. Absolutely. That ...

Q. ... including the police, I guess?

A. ... that happens all the time.

Q. Okay.

A. And the families can also, you know, approach us.

Q. Yes.

A. That's another piece.

Q. So what ...

A. But in this case again, like it has to come up to a different level.

Q. When you say it happens all the time how often would it have happened in the last six months in Antigonish County or Guysborough County ...

A. In terms of ...

Q. ... in your experience? In terms of having to call the police or someone because someone is saying they are going to get a weapon and hurt their family.

A. I don't have any recollection of this happening in the last six months. I think I don't have any recollection of that happening for a number of years.

Q. Okay. So when you said to me it happens all the time ...

A. Yeah. Well, what I mean is ...

Q. Yes.

A. ... in case somebody is suicidal ...

Q. Yes. Oh, okay.

A. ... and we need to take the guns away ...

Q. Yes.

A. ... we involve the family, we involve the police. That does happen.

Q. So suicidal as opposed to homicidal?

A. Yes. Yeah.

Q. Is that fair?

A. Yeah, absolutely.

Q. I know in response to Mr. Murray, and you saw Dr. Slayter's December 2nd, 2016 assessment, it's not normal that you would call Dr. Slayter or call another psychiatrist. You're the psychiatrist there that night dealing with the patient, correct?

A. Yes.

Q. But you could have, I assume, called Dr. Slayter if you wanted to, assuming that he was around to take the call?

A. We don't do that.

Q. But could you have done it? Is it open to you to do it?

A. I would not do that because he's not on call.

Q. So, Doctor, that's not my question.

A. Yeah.

Q. If you, as the Chief of the Eastern Region Psychiatry ...

A. Yeah.

Q. ... wanted to pick up the phone and call Dr. Slayter because you saw the December 2nd, 2016 assessment in the file and his name on it, you could have called him, correct?

A. I could have called him but I would ...

Q. Understood.

A. ... but I would not.

Q. Understood. He may hang up the phone on you because you were calling him on holidays or ...

A. Well ...

Q. ... many reasons? I'm just being polite about it.

THE COURT: Sorry, do you want to answer the question? Go ahead and answer the question if you like.

A. Pardon?

THE COURT: Why wouldn't you call?

A. Because he is not on call. I am the psychiatrist on call and it's ... I'm making an assessment, I am doing my

clinical judgment. His presentation was not that ... we don't do that.

That's why we ... the people who are on call they need relief, they have their own quality of life. This is how medical profession works, that you just ... the on-call person is the ... is responsible for that patient.

THE COURT: If you read Dr. Slayter's lengthy report of December the 2nd and he seems to lay out all the details with regard to Corporal Desmond's life, would you expect that there would anything additional that you could get from Dr. Slayter by picking up the phone and asking him to simply repeat what was already in the report that you read?

A. Well, again, Your Honour, I would ... that's not the usual practice.

THE COURT: Yeah. Thank you. Mr. Macdonald?

MR. MACDONALD: Thank you, Your Honour.

So, again, in response to a question from Mr. Murray, Doctor, you said you had a discussion with Mr. Desmond and it related to hurting his wife, I think that may have been the word you used, but I did write down the words he said to you, "I will never do it. I would never have done it" or words to that effect. Do you remember saying that this morning?

A. Yes. Yeah.

Q. Yes. Again, against the backdrop of why he's at the ER and the notes in your chart and what's in Dr. Slayter's assessment about jealousy and delusional delusions because she's ...

A. Yeah.

Q. ... he thinks cheating on him ...

A. Yeah.

Q. ... why would you believe him when you asked him if he may hurt her? Why would you believe his answer?

A. Well, Dr. Slayter's note it says that those are ... in his assessment it's overvalued ideas ...

Q. Yes.

A. ... and so those are not delusions.

Q. Okay. So continue because it's a mixture of facts ...

A. Yeah. So ...

Q. ... that I put to you.

A. So I did ... I did clarify this issue with Mr. Desmond and he showed clear understanding that that used to be an issue when he was smoking marijuana; that it was not an issue anymore, and he could find a clear connection between his marijuana use and those thoughts.

Q. Okay. So in Exhibit P-67, that's the St. Martha's Regional Hospital materials and in there appears Dr. Slayter's report.

A. Yeah.

Q. And I'm looking at ... and I'm not sure what numbers are what. So it's page 26 and there's a number 2, so it's actually page 2 of Dr. Slayter's report.

A. Yeah.

Q. Do you see it? So the last paragraph, I'm going to read from about five or six lines down: "He also has overvalued thoughts of jealousy regarding his wife, sometimes bordering on frank delusions."

So do you remember reading that?

A. Yes. Yeah.

Q. Yeah, so wasn't he delusional?

A. No, it's ... sometimes ... okay. So it says, "overvalued thoughts of jealousy regarding his wife, sometimes bordering on frank delusions." Well, that's why I clarified with him. I asked him questions to clarify the paranoia and the jealousy. I think that would be ... I think Dr. Slayter would be able to better answer the question what did he mean by this.

As for my assessment looking at the note, these were not

delusions because delusions are fixed false beliefs, they are fixed, and he was denying that to me at the time. And Dr. Slayter's notes also say that at times he would not feel that way. So those ... that takes it out of the category of being delusional. Delusions are false fixed beliefs that are maintained regardless of the reality ...

Q. Do ...

A. ... or regardless of contradicted by the ... So, in my view, these are ... he was not delusional.

Q. Do you remember reading that reference to jealousy and delusions, frank delusions, in Dr. Slayter's report on January 1st or 2nd, 2017 when you looked at it?

A. I read this. Yes, I ... I ...

Q. Do you remember reading it then, though, on January 1st or 2nd, 2017?

A. Yes. Yes. Yes.

Q. Yeah. Okay.

A. No, absolutely I had a glance ...

Q. So I guess ...

A. ... of the report.

Q. ... I'm not understanding your answer. You know why he's at the Emergency; it's been a fight. He's told you things

in terms of the history with his wife, domestic violence. You've read a line in a report that's done two months ... one month before or a day ... even less than that, by one of your colleagues who speaks of delusions when it comes to jealousy and his wife. Why then ... help me to understand why then you would think he's not delusional?

MR. HAYNE: Your Honour, if I may? Just an objection.

He already put to Dr. Rahman whether he was delusional or not and then he used the term "delusional" in that question. So I think it's an inappropriate characterization of what Dr. Rahman said.

THE COURT: All right. Thank you.

Mr. Macdonald, given the comments, maybe ... not that you didn't, but I'd just ask you to maybe have a look at your question and ask it again.

MR. MACDONALD: Of course. Thanks, Your Honour.

So, Doctor, my question is this: Your colleague in the December 2nd, 2016 report/psychiatric assessment, Dr. Slayter's comment about frank delusions with respect to jealousy regarding Mr. Desmond's wife, you read that ...

A. Yeah.

Q. ... on January 1st, correct?

A. Yes, you are correct. Yeah.

Q. But then you later, as I understood your evidence, made an assessment that he's not delusional and you believed him when he said he would never hurt his wife, so why, given that your colleague seemed to make a different diagnosis a month before?

A. I would say that he also used overvalued thoughts of jealousy which is not delusional. And I assessed ... I clarified with Mr. Desmond whether this is still the case and he denied it. So to me, for my clinical assessment, he was not delusional.

Q. Okay. You didn't clarify with Dr. Slayter because you didn't call him, and we know the reasons why you didn't, fair?

A. Absolutely, yes.

THE COURT: Mr. Macdonald, the line that you read from Exhibit 67, the second page of that report, the Inquiry has it as page 27, it's page 26 at the bottom of the report. When you read it: "He also has overvalued thoughts of jealousy regarding his wife sometimes bordering on frank delusions." Now "sometimes bordering on" and when you read ... so my question is ... actually I'm going to ask the doctor a question.

A. Yeah.

THE COURT: So when you read the expression "sometimes bordering on" is that language that you would use in a psychiatric setting, "bordering on" and does it have a particular meaning? Does it mean it's crowding the edge of or does it exactly exist?

A. Yeah, that would be ... I think Dr. Slayter would be better to have ...

THE COURT: Dr. Slayter will answer that ...

A. ... will be the person to answer ...

THE COURT: ... question for us.

A. ... that question. Delusion is a delusion. I don't think there's something like bordering on delusion. So if someone has a delusional disorder I would call it just delusional disorder, not sometimes and ... or sometimes not.

THE COURT: All right. We'll ask Dr. Slayter. I understand we'll hear from him sometime in the next little while. Thank you. Mr. Macdonald, thank you.

MR. MACDONALD: Thank you.

A. Thank you, Your Honour.

Q. I'm just trying to shorten up a little if I can, Doctor, please bear with me.

THE COURT: Mr. Macdonald, I'll say this: there's no

reason to shorten up.

MR. MACDONALD: No, I understand, Your Honour. Sorry, for my own benefit, not ...

THE COURT: All right. Thank you.

MR. MACDONALD: ... yes, only because the way the evidence is flowing.

THE COURT: Thank you.

MR. MACDONALD: So once ... I'm going to use the term "hand-off" ... the hand -off of Mr. Desmond from Dr. Clark to you, you came in to see him ...

A. Yeah.

Q. ... you're then the managing physician with respect to Mr. Desmond, correct?

A. Yes, correct. Yeah.

Q. And you're then the physician in charge of the plan, correct?

A. Yes. Yeah.

Q. And it's your call to discharge him, correct?

A. Correct.

Q. Ms. Ward, I think it was very close to her last question and one of your answers was in talking about PTSD, that it was ... and I think she had asked about percentages and you

gave a percentage about suicides with people with PTSD or veterans with PTSD, I'm not sure which. Do you remember?

A. Yes, yes. Yeah, yeah.

Q. Okay. But you weren't sure about homicides but you thought it was very rare?

A. Yes, I believe so. Yeah.

Q. Any idea why homicides are more rare than suicides with people with PTSD?

A. I don't know.

Q. Okay. So you're not basing it on any empirical evidence that you personally have ...

A. No.

Q. ... when you made the comment that it was rare?

A. Yes.

Q. Okay.

A. Yeah.

Q. So you don't know whether it's rare or not?

A. No, I don't know.

Q. Okay.

A. I mean, I've been in practice for 25 years, I don't recall any of my patients with PTSD committing homicide. That's what I can say in my own personal experience.

Q. So ... and I know you touched on some of this with Mr. Murray as a result of the very tragic Desmond incident if I can call it that. Specifically, what changes have been made at St. Martha's or in your region to address, if any, that situation?

Were there any changes in procedure or protocol that have been made since January 3rd, 2017?

A. Well, I mentioned the suicide risk assessment ...

Q. Yes.

A. ... you know, assessment, but not particularly in St. Martha's Hospital. We are a provincial program and whatever the changes are done, it's now provincially.

Q. Okay.

A. And I did mention about recently a couple of days ago, I think yesterday or day before yesterday, this suicide prevention framework being updated. I have not taken a look at that as yet, but it was initiated in 2006, it's updated.

Accreditation Canada also requirement of organizational practices around suicide assessment and intervention and so forth. So we are working with other departments than within our department our ... most of the staff/care providers are trained. So these are the evolving things.

The charts are being scanned and everything will be

electronic hopefully in the future. I think that's what I can report to you.

Q. Dr. Rahman, one of the things that struck me when I read Dr. Slayter's report and then your notes, your chart notes, it seemed to me that ... and I, of course, did not know Mr. Desmond ... that he may have been two people. In other words, he was one person when Dr. Slayter was doing the assessment because we know it's a, I would guess, thorough assessment, it's a couple of pages, it seems to be intense. That's on December 2nd, 2016. And then with you, you've spent a shorter period of time with him and you seemed to observe that he seems to be a different person, you know, more upbeat and you think he was truthful and that kind of thing. So can people present without a diagnosis of schizophrenia ...

A. Yeah. Yeah.

Q. ... can they be in effect two people, quotations?

A. I won't say two people, but I would say each presentation can be different.

Q. Okay. So as a result of the Desmond situation, are you aware of any reviews of what happened at St. Martha's have been undertaken and what the results of those reviews may have been?

A. Yeah.

MR. ROGERS: Your Honour, if I may? I just wanted to raise, I believe, I'm going by memory, it's Section 67 of the **Medical Act** that speaks that "no person shall answer any question regarding certain types of quality process reviews", and I believe that it would extend to this forum as well. And I'm happy to find that actual provision but I wanted to raise that in case Mr. Macdonald is getting into that area.

THE COURT: Right. I think that the question can be asked if there was a ... and I'm going to call it a quality assurance review was conducted under that legislation and that's the answer, that's the end of that question.

A. Was there one done?

MR. ROGERS: And, Your Honour, I'll also raise an additional point. In addition to the **Medical Act** that my friend Mr. Hayne referred to, there's the **Quality Improvement Information and** ...

THE COURT: That's the legislation ...

MR. ROGERS: ... **Protection Act** ...

THE COURT: ... I'm referring to.

MR. ROGERS: ... that **QIIPA**, and there's obviously a privilege of protection associated with that.

THE COURT: If the question leads to that answer, that's the end of that line of questioning because the legislation prevents it, period.

MR. MACDONALD: So are you saying though, Your Honour, I can ask the doctor the qusteion if he's aware?

THE COURT: You can ask if he's aware ...

MR. MACDONALD: Yes.

THE COURT: ... of what, if any, reviews took place ...

MR. MACDONALD: Yes.

THE COURT: ... in the hospital, and if he says there was a quality assurance review under the legislation that's as far as that question goes.

MR. MACDONALD: Doctor, you heard the Judge frame the question; do you want me to ask you again or do you understand the question?

THE COURT: I'm going to stop you just for a second ...

MR. MACDONALD: All right.

THE COURT: ... because I believe that the Doctor had said somewhere in his evidence that there was a sharing of information from a quality review ...

MR. MACDONALD: Yes.

A. Yeah.

THE COURT: ... of the other departments.

Now that didn't go so far as to actually necessarily get within the four corners of that particular piece of legislation although it was close.

If you ask the question again and it leads to that answer then, again, that's where it might ... that's where it will have to stop so ...

MR. MACDONALD: So, Doctor, are you aware whether there were quality reviews as a result of the Desmond incident?

A. Yes, that's standard practice ...

Q. Okay.

A. ... anything like that happens, like in the medical field it's ... the mortality rounds, M&Ms, and in Psychiatry we have quality reviews regularly.

Q. Has your practice changed?

A. I'm always learning.

Q. Like every doctor in the world I'm assuming?

A. Not in this ... any incident it's a learning process for me in terms of providing quality care to the community, to the people of Nova Scotia, and it's a learning process. So my practice is always evolving and trying to get myself better all the time.

DR. FAISAL RAHMAN, Cross-Examination by Mr. Macdonald

Q. So, Doctor, as Chief of Psychiatry of the eastern region ...

A. Yeah.

Q. ... 21 years practicing as a psychiatrist, could a Lionel Desmond situation happen in Nova Scotia tonight?

THE COURT: You don't have to answer that question, Doctor. That is ... it's just too speculative to put the question to the doctor.

MR. MACDONALD: Fine, Your Honour.

What, if anything, would you do or recommend to the Inquiry, Doctor, to prevent another Desmond situation?

A. I have already given my recommendations while answering ...

Q. And you stand by those?

A. ... Mr. Murray. I think I will stick with the same recommendations.

Q. Thank you. I have no further questions.

A. Thank you.

Q. Thank you, Your Honour.

THE COURT: Thank you.

Mr. Rogers, we are not going to continue this afternoon, it's 4:30. In the normal course of events ... we continued the

other day because we could get finished with the witness within half an hour of normally the end of the day, and we are not going to be able to do that. There are too many counsel that still have to ask questions of Dr. Rahman, so we are going to adjourn.

Doctor, you are available tomorrow?

A. Yeah, sure. Yeah.

THE COURT: Thank you very much.

We are going to adjourn until 10 o'clock tomorrow morning. All right?

Doctor, earlier I had given you a direction with regard to discussing your evidence, I'll just continue that direction to not discuss the evidence that you have given to date with any person. You can have discussions with anyone you like about any other subject matter but this. All right?

A. Okay.

THE COURT: Thank you.

MR. MACDONALD: Your Honour, I'm sorry, I'm just wondering if maybe you might be of the view to expand the direction not only to include any evidence he's given to date but any evidence that he's going to give in this matter going forward in this block, i.e., tomorrow.

THE COURT: All right. I don't know what he will say.

MR. MACDONALD: Well, I'm thinking if he got a cup of coffee and someone asked him about the Inquiry and he decides to say a little bit about what he may say tomorrow, that's all. I'm just saying it to cast a wider net, I guess, Your Honour.

THE COURT: All right. So apart from having discussions with your counsel or maybe family, maybe you can just avoid having conversations with people, generally, about the Inquiry for now and that way there will not be any difficulties created. All right?

MR. MACDONALD: Your Honour ...

A. Sure.

THE COURT: Thank you.

MR. MACDONALD: ... I'm very sorry to be up again, but I would include counsel and family in the directive. I don't think he should discuss his evidence ...

THE COURT: I'm not going to include counsel and family. He can have a discussion with his lawyer about any matter he chooses to discuss but for the Inquiry. His counsel would know that as well.

MR. MACDONALD: Oh, I didn't hear the "but for the Inquiry".

THE COURT: So if they want to talk about other matters

then that's fine.

MR. MACDONALD: Okay. No, no, I understand, I didn't ...

THE COURT: All right. I'm not ...

MR. MACDONALD: ... think that the Inquiry ...

THE COURT: ... giving him permission to talk to anyone about the Inquiry.

MR. MACDONALD: All right, understood. Thank you.

THE COURT: Thank you.

A. So I want to be clear. I cannot talk to my counsel at all or my family?

THE COURT: Well, when you have a discussion with your lawyer, your lawyer will know the limits of the discussions so be guided by what he tells you.

A. Okay.

THE COURT: If he tells you, no, we cannot talk about that then do not talk about it.

A. Yeah.

THE COURT: If he cuts you off or if he ... all right then he does not want to talk about it. I trust him to know the limits, all right? If you go home and somebody in your home asks you how it went today, I am going to give you permission to tell them how it went today. All right. Thank you.

Anything further? Good. 10 o'clock tomorrow morning.

A. Okay.

COURT ADJOURNED (16:40 HRS.)

CERTIFICATE OF COURT TRANSCRIBER

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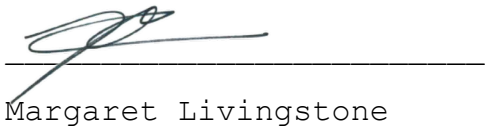

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February 7, 2020