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 5, 2020

COUNSEL: Allen Murray, QC, Inquiry Counsel
Shane Russell, Esq., Inquiry Counsel

Lori Ward and Melissa Grant,
Counsel for Attorney General of Canada

Glenn R. Anderson, QC, Catherine Lunn and
Adam Norton, Esq.
Counsel for Attorney General of Nova Scotia

Thomas M. Macdonald, Esq., and
Thomas Morehouse, Esq.
Counsel for Richard Borden, Thelma Borden and
Sheldon Borden
Joint Counsel for Aaliyah Desmond

Tara Miller, QC,
Counsel for Estate of Brenda Desmond
(Chantel Desmond, Personal Representative)
Joint Counsel for Aaliyah Desmond

Adam Rodgers, Esq.
Counsel for Estate of Lionel Desmond
(Cassandra Desmond, Personal Representative)

Roderick (Rory) Rogers, QC, Karen Bennett-Clayton
and Amanda Whitehead,
Counsel for Nova Scotia Health Authority

Stewart Hayne, Esq.
Counsel for Dr. Faisal Rahman and Dr. Ian Slayter

INDEX

EXHIBIT LIST

February 5, 2020

COURT OPENED (10:02 HRS.)

THE COURT: Good morning.

COUNSEL: Good morning, Your Honour.

THE COURT: Dr. Rahman, could you return to the stand, please? Good morning. Dr. Rahman is still under oath. He was excused yesterday afternoon at the close of the evidentiary session.

Mr. Rogers?

MR. ROGERS: Thank you, Your Honour.

DR. FAISAL RAHMAN, previously affirmed, testified:

CROSS-EXAMINATION BY MR. ROGERS

MR. ROGERS: Dr. Rahman, I introduced myself to you earlier this week. I'm Rory Rogers, counsel for the Nova Scotia Health Authority. Good morning.

A. Yes, good morning.

Q. Doctor, you indicated in your testimony yesterday that on the night of January 1st there were beds available on the psychiatric ward or the Mental Health and Addictions Ward on the third floor of St. Martha's Hospital. Is that correct?

A. Yes, correct.

Q. And it may be obvious given your position, but can you tell us why it is you were aware that there were beds available on the third floor of St. Martha's that night of January 1st?

A. Because I was on call and usually the on-call person is aware of how many beds do they have on the inpatient psychiatric unit. I think that was the reason ...

Q. Okay. Thank you.

A. I knew about it.

Q. Now in addition to that you also referenced yesterday

that even if there were not beds available - I appreciate that you testified that there were - that in any event there's a provincial policy which you described as psychiatric beds available on a provincial level. What do you mean by that?

A. Yes. So that happens regularly, not only in St. Martha's in our Eastern Zone but all across Nova Scotia hospitals, that psychiatry beds are provincial beds. So in case a patient needs to be hospitalized or needs to stay in the hospital and there's no bed available in that particular facility we will find a bed for that person in the province.

Q. Is that's what's referred to as the patient flow bed management system?

A. Yes.

Q. So if a patient needs a psychiatric admission at St. Martha's and there are no beds available what's the process for them determining how to access a psychiatric bed elsewhere in the province?

A. So now we have this process and system that there's a central number that we call and they keep the numbers to keep the tabs where are the beds available. And we get the information from them and then we contact the specific facility. This is more formal now, but even in the past, in the last 15

years, even when the system was not there the psychiatrist used to contact different hospitals nearby and talk to the on-call psychiatrist themselves and used to make sure that if there's a bed available we would (unclear).

Sometimes there's no bed available in the province. Then we keep people in the emergency room or somewhere safe where they can be monitored safely until there's a bed available.

Q. Thank you, Doctor. And yesterday you testified that as a result of that availability of psychiatric beds at a provincial level there are three patients from Halifax who are currently in St. Martha's. Is that through the process you indicated?

A. Absolutely, yes.

Q. And you talked about admitting somebody to a psychiatric ward or a mental health and addictions ward. Is there a provincial-wide policy with respect to admissions criteria into psychiatric wards?

A. Yeah, there's criteria, but usually if a psychiatrist assesses the patient and we talk to the other psychiatrist where there's a bed available we have a discussion. And usually one psychiatrist decides. The other psychiatrist reciprocates. And it's the (honour?), also, to kind of take on the care of the

patient.

So it's a professional courtesy, also, that if somebody has ... a psychiatrist has assessed a patient and if they need an inpatient hospitalization, usually that's what is needed provided the bed is available elsewhere, and the psychiatrist at the other facility most of the time accepts the patient.

Q. Thank you, Dr. Rahman. Next, we know that Lionel Desmond on January 1st of 2017 came into St. Martha's Emergency Department presenting with a mental health issue, but in your testimony yesterday you referenced an alternative means of obtaining some assistance or help and you referenced a provincial telephone crisis service. Can you tell the Inquiry what that is?

A. Yeah, we have a crisis service, a mental health crisis line, available now since last year. Not exactly sure about the date, but there's a phone number where patients can call, or anybody can call, if they're in crisis if they need mental health. Or they have option to present to any emergency room near by or call 9-1-1. But there's a specific number for mental health crisis now.

Q. And so that's a 1-888-number?

A. Yes, 1-888, yeah.

Q. And that links them to what service and what trained personnel, to your knowledge?

A. Well, I think the personnel there are social workers and therapists and maybe some nurses also. I'm not sure of the specific complement of the staff there but they are professionally well trained in mental health issues. They receive the call and they discuss the patient's situation and sometimes patient just need to talk to somebody. Issues are resolved.

And then they decide, advise and recommend the individual who is calling about the disposition plan, that could we go to the ER or come to the hospital. Or probably they just ... it is all it would be and then ... or they can be referred to outpatient mental health in the area where they are calling from.

Q. So that service is then available 24/7?

A. Yes.

Q. And it's staffed with specialized staff with mental health training. Is that fair?

A. I believe so.

Q. Okay. Thank you.

You also referred at some length yesterday to an evolution

in process by which paper records in mental health and addictions have been digitized or made available in an electronic format. How long has that process been ongoing to take mental health and addiction paper records and converting those into a means to have them available electronically?

A. I think it's still in the process. It has been going on for as long as I can remember, a couple of years, and it's called Provincial Scanning Project. I think we are launching it in spring of 2020 with full force, I believe. So I don't know the specifics, again, how long it's going to take, but the process has started. Some of the charts have been scanned.

Like, as I told yesterday, that I think mid-2017 this has been happening, but not all charts are electronic. They are moving towards electronic charting. A lot of charts have been scanned so I think it's in the process. I don't know the specifics.

Q. So is it fair to say that some of those paper mental health and addiction records have over the past approximately two years been moved into an electronic format?

A. Absolutely.

Q. And at some point this year the plan is to go live or have all of the paper mental health and addictions records in

the province available electronically. Is that your understanding?

A. That is my understanding.

Q. Okay. And so when we think of the type of records you're talking about you referred yesterday to the consult note of Dr. Slayter from Lionel Desmond's visit on December 1 of 2016 and that was the record, I believe you said, you had an opportunity to review before you went down and saw Lionel Desmond on the night of January 1st? Is that correct?

A. Yes, correct.

Q. And that record, that note that was prepared by Dr. Slayter, is that one of the types of paper records from mental health and addictions that either now has been scanned and made available electronically or will be some time this year?

A. Yes, I believe so. This is my understanding.

Q. I think I said December 1st. It may be December 2nd but that's the note that you saw. Correct?

A. December 2nd, yeah.

Q. Thank you.

A. And I should add that previously we used to have, like, inpatient charts when we had to dictate them. We had to get a physical chart and go through the chart in order to

dictate the chart summaries. So now, because I do inpatient mostly, now I can sit in my room on my computer. I can put in the number, the record number, and the whole chart is scanned in the computer.

So that's a real advantage for me to just sitting in my room. You know, I don't have to go anywhere. And the whole chart. Whether it's handwritten notes, nursing notes and occupational therapy notes, I believe, are in the system. They are typed already in the system, but the other physician notes and some of the other stuff which is handwritten is also scanned. So that's what I have seen in the last couple of years.

Q. And, Dr. Rahman, the Inquiry has heard reference in some detail to the plan for One Patient One Record, an electronic chart that would be available ...

A. Yeah.

Q. ... more generally. Is the process that you've described - taking the mental health and addictions records and having that available in electronic form - separate and distinct from the goal of moving to One Patient One Record?

A. I think it is moving toward One Patient One Record.

Q. Okay.

A. I think these are the steps.

Q. Okay. Thank you.

A. Yeah.

Q. You also made reference to the mental health crisis team at St. Martha's.

A. Yeah.

Q. And you identified that currently that service is available with specialized staff and psychiatrists typically on a 9 to 6 basis. Correct?

A. The crisis team with the psychiatrist but there's an on-call psychiatrist 24/7.

Q. Sure, and I'll talk about the psychiatrist in a moment, but in terms of the availability of the service at 9 to 6, that's the availability of the specialized staff, either a nurse with special mental health training or social workers with mental health training. Is that correct?

A. Correct.

Q. And I think yesterday you indicated that currently at St. Martha's the mental health crisis team has a complement of three specialized staff. Is that correct?

A. Yes. Yeah.

Q. At the time of Mr. Desmond's visit to the Emergency

Department in January of 2017 was the complement smaller?

A. I don't have the recollection. I think there were three people.

Q. Okay.

A. Two or three. Yes, that's what I remember.

Q. And we probably will have some evidence in terms of the change ...

A. Yeah.

Q. ... in complement, but is it your recollection that the complement has evolved from one specialized staff at one point ...

A. Yes.

Q. ... now to three?

A. Yes, absolutely. I remember the times when we did not have any crisis team.

Q. Yes.

A. So the psychiatrist used to be ... we used to be on call during daytime also, and the ER or anybody would call us directly and it used to be quite difficult if you're doing inpatient or if you book patients in the outpatients and then there's an emergency call on top of that. The crisis team, then we had a crisis worker, with one worker, and then I think we

increased to two and now we have three. We currently have two working. The third one is on medical leave right now but I think we are trying to ... working on that and depending upon ... but the position is there. So we have evolved in that way.

Q. With that increase of the specialized staff complement from one to three, there's been an associated increase in the hours of availability of the service to what it currently is to 9 to 6. Correct?

A. Not necessarily. I can say yes, I think it used to be until 5 or 4. It's now until 6, number one. Number two is that not three of them are working as a crisis at the same time. It depends. One or two is. Depending on how busy we are, one or two are working in crisis. And we also have something which is called Urgent Care Clinic that we started.

So Urgent Care Clinic would be the one that if the crisis sees somebody and they feel that these patients can be managed and not required to be there for outpatient mental health ... some of them are situational crisis or somebody who needs short-term interpersonal therapy or cognitive behaviour therapy on a short-term basis.

Urgent Team can see these patients a few times, two or three times, to resolve the issue and diffuse the situation. In

case they need to be seen more or on more regular basis or on long-term basis, then these patients are referred to outpatient mental health.

So in this way, it has made a difference in the workload and the wait times for outpatient mental health staff who actually need to see people, who actually see people who really need to be seen.

Q. Yeah. Earlier in response to my questions you indicated that in addition to the specialized staff, the nurses and the social workers in the mental health crisis team, there's also availability of a psychiatrist. Is that the case currently?

A. Yes.

Q. Was that the case in January of 2017 when you came to see Mr. Desmond?

A. Yes.

Q. So if in the evening hours after the mental health crisis team is not available, or on weekends or holidays, has a psychiatrist always been available on call?

A. Yes.

Q. And then the relationship between the mental health crisis team and emergency department, describe what that

relationship is, if you would, Doctor. Is it a consult service that the crisis team provides to the Emergency Department?

A. Yes. So with consult service, our crisis team is a consult service also. So when the patient comes in they are triaged and just seen by the ER physician first and then if the ER physician feels that there is a need for crisis team or mental health services to get involved after medically clearing the patient and so forth, then we are consulted.

The crisis team, if they're available, they are typically the ones who see the patient. Then the crisis team member works with the ER physician to plan disposition and treatment and disposition. But if the crisis team worker alone or in collaboration with a ER physician feels that a psychiatrist needs to see a patient, then a psychiatrist consult is generated and we are called and we go down and see the patient.

I should clarify one thing that ... this has been mentioned in the past also. Psychiatrist on call 24/7. We have three psychiatrists and we have three family doctors who work with us in our call schedule at St. Martha's. These three family doctors have been doing psychiatry calls for more than 20 years almost. They are very experienced and has special interest in mental health and psychiatry. They are very much trained in

that.

But they're not alone. There's always a psychiatrist behind them. So, for example, I am the one who is always on call with them in case they have any issue or in case they have any problem. They can always call me. And I'm available. That very rarely or seldom happens that I really need to come to the hospital but I'm available on the phone. If they ask me to need to come to the hospital I will come in but they're so experienced and they're so well versed with psychiatric emergencies that we hardly need to come in. But there's psychiatric backup.

So three psychiatrists plus three family doctors. This has been in place for a couple of decades now.

Q. Dr. Rahman, you also indicated in your testimony yesterday that you were familiar with the mental health crisis team service that's provided in at least two other areas. You referenced Sydney, that has some slightly additional coverage over and above what's available currently at St. Martha's, and you referenced Halifax also having availability. Is the determination as to what services are available driven in part by the need and the demand?

A. I think that comes into consideration. Sydney,

because I am the zone ... I work in those zones. So Sydney is until 9 p.m. and it's over the weekend and over holidays also. And it's a relatively busy ER in Cape Breton Regional Hospital. And psychiatry is all stationed. The ER is in Cape Breton Regional. And Halifax is busy and they have crisis team also.

Q. And given your zone responsibilities, would you be involved in dialogue and assessment as to whether there is a need or benefit to allocate more mental health and addictions resources to mental health crisis teams? Is that something that's part of an ongoing consideration and assessment in terms of allocation of resources?

A. Yes. I have been part of all the negotiations from not having any crisis team up until now that we have three.

Q. Okay. Thank you.

Mr. Murray asked you a number of questions that gave rise to you referencing the Nova Scotia Health Authority's suicide risk and assessment policy, and when Mr. Macdonald asked you some questions there was specific reference to that document. And at various times in your evidence I think you referenced the policy as being either 2007 or 2017. It was a 2017 policy, correct?

A. Yes, 17. Yes.

Q. Okay. Could we pull up, please, that exhibit, which is Exhibit 105? Do you see that in the screen in front of you, Dr. Rahman?

A. Yes. Yeah.

Q. So we see that this is titled Mental Health and Addictions Policy and Procedure Suicide Risk Assessment Intervention, which is abbreviated SRAI, monitoring and management for mental health and addictions?

A. Correct.

Q. And we see an approval date of April 26th, 2017 and an effective date of June 30th, 2017?

A. Yes, correct, yeah.

Q. Is that accurate that this would be the approval and effective date of this policy?

A. I believe so, but I know that we had to train staff and it was not implemented until September, at least September of 2017.

Q. Okay, so given that Mr. Desmond's admission or visits to St. Martha's was on January 1 and 2 of 2017, this policy would not yet have been in effect. Is that fair?

A. That's correct.

Q. And I want to take you to the provision as to who this

policy applies to and you'll see that in the title box. And it says, "Applies to mental health and addictions licensed healthcare providers trained to complete the suicide risk assessment." Is that an accurate description as to who this policy applies to?

A. Yes. Yeah.

Q. So it is to specialized mental healthcare providers. Fair?

A. Correct.

Q. And just to clarify that, if we go to the next page, page 2 of that document, if we look under the heading of Policy Statements. If we scroll down a bit.

A. Yeah.

Q. We see that it's referenced, "Licensed healthcare providers," which is defined as LHP, "must assess patients/ clients for risk of suicide." And then if you scroll down to number 2 we see it states: "When screening for suicide risk reveals a patient is at risk of suicide, then a SRAI must be assessed completing the SRAI tool by and limited to the following licensed healthcare providers (LHPs)." And it references registered nurses, physicians including psychiatrists, psychiatry residents, social workers. And over

on the next page psychologists and any other clinician who is responsible for the independent practice of a mental health assessment.

A. Correct.

Q. And so we see that this is aimed at what's defined as licensed healthcare providers. Is that fair?

A. Yes.

Q. And then in terms of a definition of who's a licensed healthcare provider, can we flip to the definition section which is at page 11 of the document? And at the very bottom of that page is the definition of "licensed healthcare provider".

A. Mm-hmm.

Q. And we see, Dr. Rahman, that it defines that licensed healthcare provider, or LHP, as registered nurses, psychiatrists, psychiatry residents, social workers, psychologists, and any other clinician who is a member of a self-regulated health profession. And these are the key words I want to take you to: " ... who is responsible for independent practice of mental health and addictions assessment, treatment, planning, and discharge from out-patient or community-based mental health and addictions."

So, again, is it fair to say that this policy is aimed at

individuals in mental health and addictions with that specialized knowledge and training in mental health issues?

A. It looks like that to me.

Q. Okay. Thanks. Then can we go back to page 3 of the document? Under section 2.1, Dr. Rahman, it says: "All licensed healthcare professionals identified in 2 above (that I took you to a moment ago) must complete a training session on the SRAI policy and SRAI tool."

In your testimony yesterday I think on one, maybe even two, occasions you made reference to 94 percent of certain staff who have training in this suicide assessment or suicide tool.

A. Yes.

Q. Is that reference you made to 94 percent in relation to this indication of the need for training to be completed for those healthcare professionals with that specialized training in mental health and addictions?

A. I am not sure. My understanding, it's the mental health staff, mental health and addictions staff. Licensed health professionals, LHP, I don't know what the ... the ER staff is included in that, all hospital included in there? I need some clarification on that.

Q. I didn't see in the definition of this policy that it

was applying to ER staff. I thought it was applying to specialized trained ...

A. Yes. Yeah.

Q. ... mental health staff.

A. So if that's the part, so LHP would be, then, affiliated with the mental health and addictions. And that would be my understanding, 94 percent of psychologists and social workers and people who are affiliated with the mental health and addictions services who have direct dealing with the clients or would be trained for that.

Q. So when you talked about that 94 percent of individuals who are trained those are mental health and addictions personnel who have been trained in this policy and the SRAI tool we'll talk about in a moment? Is that your understanding when you referenced that training yesterday?

A. Yes.

Q. Okay.

A. Yeah.

Q. You talked yesterday ... and if we can scroll down to item number 4 on the same page.

A. Yeah.

Q. This indicates that patient-client personal health

information can be disclosed without patient consent if there is reasonable grounds to believe that sharing this information will avoid or minimize an imminent or significant danger to any patient or client. 4.1 says all patients, clients must be made aware of this at the outset of any MHA contact. Disclosure could be to family, police, or others involved in a patient's/client's care.

You referenced in your testimony yesterday certain circumstances where information of a personal health information could be disclosed despite the normal privacy requirements. Is this a reference to that?

A. Yes. Yeah. (Unclear) trumps all this.

Q. Okay. Then can you turn next to page 5 of the same document? And section 2.2. 2.2, Dr. Rahman, is entitled Assessment For Suicide Risk To Be Conducted by LHPs, or licensed healthcare professionals, in MHA or mental health and addictions.

A. Mm-hmm.

Q. So is it your understanding under this policy that suicide assessment is to be undertaken by those specialized mental healthcare providers?

A. Yes.

Q. And that's part of what you did in relation to your assessment of Mr. Desmond on January 1 of 2017.

A. This tool was not available then.

Q. I understand.

A. But a similar help, there's a similar kind of suicide risk assessment. Tools had been available through all in the mental health and addictions services for a number of years.

Q. And as part of what you did on January 1st was a suicide assessment or risk assessment. Fair?

A. Yes.

Q. Then if we flip over to page 15 we see an Appendix B to this policy that describes suicide risk ...

A. Mm-hmm.

Q. ... monitoring level?

A. Yeah.

Q. And it flags the three types of risk that I think you talked about in general terms, and you see the words that they use here were low, moderate, and high. Those are sort of the three standards that you referenced in your testimony yesterday. Correct?

A. Yes, correct.

Q. Then the last document I want to take you to this is

what is at page ... may not have a page on the document. It's the last page of this exhibit. So this is titled The Suicide Risk Assessment and Intervention Tool, and there's a checklist there. Is this what's referred to as the SRAI tool?

A. Yes, correct.

Q. And I appreciate this only came into effect sometime in the middle of 2017. I understand from your testimony earlier that there was a previous iteration of this that had been used prior to this version.

A. Yes.

Q. And this version we see talks about interview risk profiles, individual risk profiles, and various other headings. Correct?

A. Yeah.

Q. And I know there had been some questions that had been put to other witnesses with respect to whether there was any consideration of access to guns or lethal methods. If you look under the heading Interview Risk Profile is there a tick-box that makes reference to that?

A. Yes.

Q. That's the one that says, "Access to lethal means"?

A. Yes. Yes, I ...

Q. Okay.

A. ... see that.

Q. In response to questions put to you yesterday, my recollection is you indicated that it's not simply a question of looking how many ticks or checks are in a particular box, but it's necessary for you as a psychiatrist or anyone using this tool to exercise their clinical judgment in making any determinations or assessments? Is that fair?

A. Yes, right.

Q. So it would be fair to describe each of these boxes as prompts or a mechanism to ensure that there was dialogue or discussion about those areas as part of any interview with someone presenting with mental health issues?

A. Yes, that is my understanding, yeah.

Q. And just to compare this to the one that we do see in the St. Martha's records. If we go to Exhibit 67 and page 15 through 17 of the formal exhibit ... and that's one number off from the number at the top of the page.

THE COURT: Just going to stop you for a second, Mr. Rogers. We have documents and some of the documents you'll see when they were entered electronically into the database that we use, that you have, some of the documents that the Inquiry

entered, it was necessary to create page numbers for those documents, and so this is for all counsel.

When you see a document like Exhibit 67, if you could, I'm going to ask you to ignore any other page number except for the page number in the top left-hand corner that we've entered so that we can all be consistent on those documents. Some documents may have ... and you might have a page 2. But that particular document, our page 2 number, top left corner, it doesn't necessarily relate to the bottom page number. And there's a reason for it because of how we deal with selected documents and how they're given exhibit numbers, like, throughout the course of these proceedings.

So if we could try and remember to do that that would be helpful. Sorry.

THE CLERK: Excuse me, Your Honour, also I would note page 7 is a lighter copy of the document and it may be easier to read.

MR. ROGERS: I had just been flagged that by my colleague. So we would go to page 7, and thank you, Your Honour, we will refer not to the page number that was entered on our version but the Inquiry number. So we'll be ...

THE COURT: Thank you.

MR. ROGERS: ... looking at page 7. So if you look ... Maybe we can go just to look at the entire page if we could.

A. Mm-hmm.

Q. And so you see this is a Nova Scotia Health Authority mental health and addictions crisis response service mental health risk assessment, and we see that it appears to be a three-page document. Could we flip to page 8 for a moment? And then to page 9. And we go back to page 7.

So we see this was a risk assessment that was completed in October 24, 2016 and is it fair to say this was the form that was in place at that time?

A. Yes, correct.

Q. And then if we go to page 9. And scroll out, if you could, to the whole page. We see at the bottom, Dr. Rahman, there's a box that also has a checklist of various items and it's titled Suicide Risk Assessment. Is this the version of the suicide risk assessment tool that was in place as of, I guess, October of 2016 through to and including January of 2017?

A. I believe so.

Q. Okay.

A. Yeah. Yeah.

Q. And the version I took you to a moment ago in the 2017

represents a revision or enhancement to that policy and that check-box. Is that fair?

A. Yes.

Q. Okay.

A. And I think there is some change in the form. So it's more in-depth and detail.

Q. Okay.

A. The new form.

Q. And do you have any knowledge as to whether there is work ongoing currently with respect to that form to even add more requests for information or to elaborate on that form or is that something you're able to comment on?

A. I don't know.

Q. Okay.

A. Wouldn't be able to comment. I should clarify yesterday. There is no risk for homicide in the new form and in this form. I thought there is one but there is none.

Q. Okay.

A. So I just wanted to clarify from yesterday's statement.

Q. Thank you, Dr. Rahman. Those are all my questions.

A. Thank you.

THE COURT: Doctor, if either the old form or the new form doesn't have provide particular direction with regard to questions in relation to a homicidal risk how do you deal with that?

A. We usually ask patients directly, Your Honour.

THE COURT: Do you ...

A. That is part of the standard psychiatric assessment. They're not there but that's a standard assessment.

THE COURT: That's your standard assessment but it's not the standard ... it doesn't come from the tool. It comes from practice.

A. Correct.

THE COURT: All right. Thank you. Sorry, Ms. Miller?

MS. MILLER: Thank you, Your Honour.

CROSS-EXAMINATION BY MS. MILLER

MS. MILLER: Dr. Rahman, we met yesterday. My name is Tara Miller and I am counsel representing Brenda Desmond ...

A. Yes.

Q. ... Corporal Desmond's mother, and also Aaliyah Desmond ...

A. Yes.

Q. ... that I'm sharing with my friend Mr. Macdonald. His daughter.

I'm going to just pick up on a few questions Mr. Rogers for the Nova Scotia Health Authority had asked you with respect to Exhibit 105. That is, I understand it, the new policy that was implemented effective June of 2017?

A. Correct, yeah.

Q. This applies to, as I understand, licensed healthcare providers who have specialized training in mental health. Correct?

A. Correct, yeah.

Q. But it also includes information, as I interpret it ...

A. Yeah.

Q. ... if you look at page 5 of the 17-page document. It also talks about initial suicide screening. I can take you to that page at section 2, Suicide Risk Screening and Assessment. So it says, "Screening for suicide risk can be completed by any staff member working in a direct care role of a patient or client."

Is it my understanding or assumption that means that

anybody in contact with a patient is able to do initial screening for risk, whether they have specialized training or not? And if they identify issues, then it gets referred to the licensed healthcare providers with the more specialized training to do the risk assessment?

A. Yeah, that's ...

Q. That's correct?

A. That is my ...

Q. Okay.

A. ... understanding, yeah.

Q. And is there any guideline for screening criteria for suicide risk that can be completed by any staff member? I don't see anything like that in this document. Is there another document that would give criteria guideline tools for screening for the suicide risk that any staff member can complete?

A. I am not aware of that. I work in inpatient mostly. So when patients are discharged I know that we have LPNs and RNs on the unit and this is something that maybe nursing would be able to tell you better. But when a patient is going home, like, a day, say that only RNs can do the suicide risk assessment tool with the patient, not the LPNs.

Q. Mm-hmm.

A. So there is a little bit of a difference somehow. I don't know what LPNs can do, but LPNs, they are the ones ... any staff member will be the ones who will do suicide screening or suicide risk.

Q. Okay, but my ...

A. And I think that would be something that when we are working in a multi-disciplinary team ...

Q. Yes.

A. ... and interacting with patients all the time at whatever level of contact, if there's any indication of any thoughts of harming oneself or harming others, that it's ... in mental health professions it is part of the discussion. It's always in the back of your mind if that risk is there or not.

Q. I appreciate that.

A. So they are somewhat trained in that and I think they know what to ask.

Q. But that is the heart of my question in terms of this document.

A. Yeah.

Q. And my question being, is there another document that identifies what the results of the suicide screening should be, like what material should be covered. So if you look at ...

A. Mm-hmm.

Q. ... 2.1.2 ...

A. Yeah.

Q. ... there's an onus on any staff member to document in the health record the results of the suicide screening.

A. Yeah, yeah.

Q. Is there a tool, is there a form or is this something that just is done in practice and is intuitive to an individual?

A. I'm not aware of that.

Q. You're not aware of that, okay.

A. Cannot answer this question, yeah.

Q. When it does get to a stage where a suicide assessment is to be done, and that is what my friend reviewed with you, would be restricted to licensed health care providers of mental health training, I understand from this document there's two components to that. There's this suicide risk assessment and intervention tool which is the final page that we looked at, the checklist.

A. Yeah.

Q. But there's also a form. Is that correct? There's a more detailed form that's being worked on? I wasn't sure if I understood your evidence on that point, Dr. Rahman.

A. More detailed form?

Q. Yeah.

A. Okay, yeah.

Q. And so just to help orient you, if we go back to Exhibit P67, and this is the three-page crisis response service mental health risk assessment form at page 7 to 9. That three-page document, which we understand was in place and would've applied in terms of Mr. Desmond's care, on page 9, that includes a suicide risk assessment at the very bottom, the bottom third, but it's a detailed form that obtains collateral information in advance of ...

A. Oh yeah, okay.

Q. That's what I mean.

A. Okay.

Q. Is there another document that goes along with this new policy in addition to the actual tool?

A. Oh, absolutely.

Q. Okay.

A. Yeah, yeah. You mean, you're talking about the whole form.

Q. Correct.

A. Like which the crisis nurses, they use?

Q. Correct.

A. This tool is part of that form at the end.

Q. Yes.

A. But there's a whole, I think, large four or five pages of questions basically that they fill and that has evolved also from that time.

Q. Okay.

A. And that's what the crisis worker doesn't see, and so that form, at the end of the form, if they're referred to a psychiatrist, there's a page where psychiatrists can document also.

Q. Okay. So that form ...

A. So it's a much, much comprehensive form and this is attached to that form.

Q. Okay, but that ...

A. Instead of this small suicide risk assessment.

Q. Thank you. That form, that comprehensive form, we don't see it attached at this Exhibit P105.

A. Oh yeah, yeah. This is just a tool.

Q. This is the tool.

A. This is probably the suicide risk assessment tool, yeah.

DR. FAISAL RAHMAN, Cross-Examination by Ms. Miller

Q. One of the things that struck me on this new tool, Dr. Rahman, when we look at the suicide risk assessment on page 9 of Exhibit P67, there is no reference in, I'll call it the old suicide risk assessment to access to lethal means.

A. Yeah.

Q. There is now reference to that in this new tool that was effective in the summer of 2017, and under "Management Plan", there's also a note, "removal of lethal means".

A. Yes.

Q. So there's two components to this. Identifying if there's access to lethal means which could be a gun or a knife, et cetera, and then there's also a requirement in terms of a management plan to address removal.

A. Yes.

Q. That's new. Correct?

A. Yes.

Q. Okay. I'm going to move off of that.

Yesterday in your evidence, my friend, Mr. Macdonald, asked you what you reviewed in preparation to come and give your evidence here at the Inquiry both recently and then in November when we were initially going to start.

A. Yeah.

DR. FAISAL RAHMAN, Cross-Examination by Ms. Miller

Q. And you said you had reviewed the St. Martha's chart.

A. Yes.

Q. And that's the information that we have at P67.

A. Yes, yeah.

Q. Did you review, or have occasion to review, at any point in preparation for your evidence, Dr. Rahman, any other records? Any medical records from New Brunswick? Any medical records from treatment providers? Did you ever have an opportunity to take a look at any of those other records?

A. No.

Q. Okay. You indicated yesterday that your emergency room chart note following the consult request from Dr. Clark, you said it was longer than it would usually be.

A. Yeah.

Q. You said your two pages of notes was not usual. Why was it longer? Why was it not usual to have that level of detail?

A. I'm not bragging myself, first of all, but it's just that seeing a patient in the emergency room setting is much different than having a full psychiatric assessment.

Q. Yes.

A. It just happened that I started to talk to Mr. Desmond

and there was a flow and we went into a little bit more depth into his presentation and his symptoms and his history in terms of his military service also, so it was a very interesting experience for me. I was able ... he was very personable and we were able to make a rapport and ... so when I ... I was on call. I was not that busy also.

Usually, when they are ... you could see the emergency room care record. The space in the emergency room care record is pretty small where the ER physician writes and sometimes when we are referred from patients who are directly coming from other hospitals, that's the space that we get and we usually do that much of ... you know, information is figured in that area.

So because we were planning to keep him in the hospital and there was a chart and there were more papers and I didn't have to go through the small one, so there was much space and, of course, I would say Mr. Desmond, he had a history that I documented. He had a history but it was not a difficult assessment for me. There were no acute psychiatric symptoms there. He was clearly asking what he needed, a place to say. Otherwise, he was telling his story. I could not see, in the course of the discussion of 30, 40 minutes that there was some acuity in the symptoms. There could be chronic symptoms but

acute and chronic can also happen where people can present acutely. "Acutely" would be sudden and severe whereas "chronic" is longstanding, long-developing syndrome.

Mr. Desmond had a history for about ten years and I was pretty sure that besides the records that we have and I read, he would have a lot of other ten-year records also, but I was seeing him here and then kind of at the time situation, so what I would say that it was not a difficult assessment for me, although any veteran with PTSD can be complex. It's complex. It is complex.

So in that regard, I wanted to cover as much as bases I can in my note. It was almost like a ... not a full psychiatric because I did not do the full symptom profile. I could not ... it would take ... you know, if I go (take time?) to profile each diagnosis, then ... but the diagnosis was already established from reviewing the previous records as well as personally interviewing Mr. Desmond.

So it just happened that I happened to write quite a bit on that note.

Q. Is it also fair to say ... I mean you had said yesterday in your evidence that in your experience with military veterans, they're often treated privately in the community.

A. Yes.

Q. But there are occasions, when they are in crisis, when they show up in hospital.

A. Yes.

Q. And this would certainly, to my review, qualify as that exact situation. We know Lionel was being treated in the community privately, but he had a crisis which landed him in the hospital on his own volition on January 1st. Is that fair to say?

A. Yeah, yeah.

Q. Okay.

A. So ...

Q. So that crisis, is that the same as it being acute or is there a distinction?

A. There's a distinction.

Q. Okay, what is the distinction?

A. Acute psychiatric symptoms would be somebody who's presenting in mania or psychosis, losing touch with reality, having hallucinations. They're aggressive, they're agitated, they're suicidal, their demeanour is ... there's psychomotor agitation. That's a different scenario.

And we get patients ... it's not that we have admitted many

veterans on our unit, including RCMP, that were in crisis and they are treated either in our department, outpatient department, or in the community by a private therapist and we have admitted them. We have to the point of involuntarily invoking **Involuntary Psychiatric Treatment Act.**

Q. Yes.

A. Crisis is something which is, you know, there's a definition, as much as I can explain to you, is a situation where a normal or usual coping strategies of a person are overt thereby needing or them requiring urgent support.

So there's a difference. That's a crisis ... situational crisis. That's what actually the Honourable Judge had asked in the past, that crisis. So my definition of "crisis" is ...

Q. Is that, yeah.

A. ... that, whereas acute psychiatric presentation would be substance-induced psychosis.

Q. Fair enough. And that was not the case.

A. Although it's not ... no, it was not the case.

Q. No.

A. But we end up certifying people who have lost touch with reality, with no psychiatric history, no suicidal ideations, but they're completely out of it.

Q. So with the crisis definition you've provided, you'd agree with me that Lionel had gotten to a situation where his usual coping strategies were over and he needed more support and that would've brought him into the hospital.

A. Absolutely.

Q. Is that fair? Okay.

We reviewed yesterday your notes in your chart. You indicated that it was never intended to be a verbatim capture of the conversation you had ...

A. Yeah, yeah.

Q. ... with Corporal Desmond which you said took place over 30 to 40 minutes. There were a number of items, they were reviewed yesterday, that were not captured in any way in your chart.

A. Yes.

Q. The fact that Corporal Desmond reported his guns being taken away from him.

A. Mm-hmm.

Q. There was a discussion about his wife working apparently on the third floor and you perceived him trying to protect her from the gossip which would be related to him being admitted there.

You also had a conversation with him about asking if you could call his wife and he said no.

A. Yes, yeah.

Q. None of that was captured.

A. Yes, yeah.

Q. After January 1st and 2nd and the deaths, Dr. Rahman, did you ever prepare a more detailed recollection of what had happened, while fresh in your mind, to capture and preserve your memory?

A. Okay, yeah. So I understand this is almost three, more than three years, but, personally, I will tell you that on the day this happened, I've been reliving this for three years.

Q. I appreciate that.

A. And so I remember. I almost ... it's a constant recollection about our discussion and meeting and that's how I remember these things.

Q. So my question was did you ever prepare a more detailed recollection in writing? I appreciate that, you know, this would've impacted you as well.

A. Yeah, yeah.

Q. And that you've been reliving it, but did you ever take time to sit down in any shape or form and make more

detailed notes about what had happened?

MR. HAYNE: Your Honour, if I just may, I just want to make the clarification, "other than discussions with counsel".

THE COURT: Other than during your discussions with counsel and particularly for the purpose of informing counsel as to what your recollections are.

MS. MILLER: Thank you.

THE COURT: Okay.

MS. MILLER: So do you understand the distinction? If you were asked by counsel to prepare notes, we don't want to hear about that. What I'm asking, Dr. Rahman, is if you, on your own initiative, sat down, without being told by your counsel to do so, did you ever prepare any, even if they were brief, did you ever put pen to paper, fingers to a keyboard, to prepare any detailed notes that captured more detail than what was in your chart?

A. No.

Q. Okay, thank you.

I'm going to move now to training. We have your CV and certainly we heard yesterday that you've had the benefit of some Veterans Affairs work during your externship and then after your fellowship in 2004 ...

A. Yes.

Q. ... in Minneapolis. During that period of time, Dr. Rahman, did you ever have any familiarity or experience with a drug called mefloquine?

A. Well, mefloquine, I don't have any recollection, but I know mefloquine is an anti-malarial which is used for treatment in prophylaxis of malaria.

Q. Okay.

A. And I think that that can be used in veterans or probably I might have used it when I go to Pakistan or some tropical place where there's malaria.

Q. It's a vaccine?

A. It's a vaccine.

Q. Yeah. Which was commonly used, the peak of its use, I think, was in around 2003.

A. I see, okay.

Q. So you have a general sense of what it was?

A. Yes, yes.

Q. But in terms of your contacts in those veterans hospital and with military veterans, particularly in the US, up until 2004, did you ever have any cases that you worked on where there would have been a suggestion that the impact, the use of

mefloquine would have created some mental health issues?

A. No, I really don't have any recollection, except Agent Orange.

Q. Okay.

A. I remember that in great numbers, Agent Orange, and I don't have much ...

Q. Yeah, but that's not the same as mefloquine?

A. ... much recollection of that also now, but, but I don't have any.

Q. Okay. And then since 2004 when you would have left Minneapolis and arrived in Nova Scotia ...

A. Yeah.

Q. ... to 2017, other than your on-the-job work, day in, your inpatient, outpatient, have you, yourself, had any more recent formalized training on military veterans and PTSD?

A. No, not specially, but we are involved in Continuing Medical Education. I attend either American Psychiatric Association meetings or Canadian Psychiatric Association meetings every, you know, every year.

Q. Yes.

A. Sometimes both, sometimes one, definitely one. And I have attended some workshops and some kind of CMEs there.

Q. Okay. Have any of them specifically ..

A. But I have not had any ... Yeah.

Q. That was my question. I appreciate that you would have participated in Continuing Medical Education.

A. Yes, yeah.

Q. That's dictated by the College.

A. Yeah.

Q. And you would have participated in that. But had any of it focused on military veterans and PTSD and I believe your answer is no.

A. Yes, not specifically.

Q. Okay. And a similar question - any specialized training focusing on military veterans and suicide risk from 2004 to 2017?

A. No, not specific.

Q. Moving now, I want to just touch upon Lionel's admission.

A. Yeah.

Q. My understanding from your evidence is that when Dr. Clark called you, he wanted to know if he, Dr. Clark, could take a bed on the inpatient unit. Those were your words yesterday in evidence, is that correct?

A. I, yes, I have the recollection.

Q. Okay. An inpatient unit would have been the third floor?

A. Yes, Psychiatry, third floor.

Q. Third floor.

A. That's why he was calling me, yes.

Q. Yeah. So at that point in time he had met with Corporal Desmond, he hadn't identified any issues with admission on the inpatient unit ...

A. No.

Q. ... that he conveyed to you, correct?

A. Yes, correct.

Q. Okay. And it was only through the course of your conversation with Corporal Desmond that it became apparent that Corporal Desmond's wife ...

A. Yeah.

Q. ... was working on the Mental Health Unit?

A. Correct, yeah.

Q. Okay. What is the acronym P-C-U, PCU, where is that in the hospital?

A. Progressive Care Unit. PCU ...

Q. Okay, yes.

A. ... is Progressive Care Unit. That's a medical, acute medical unit.

Q. Yes.

A. It's a stepdown unit from Intensive Care Unit, ICU.

Q. Yes.

A. So it's a medical unit.

Q. Medical unit. And where is that located?

A. That's on the main floor of the hospital, near the ICU, and patients are, it's a stepdown from ICU, it's connected to ICU.

Q. And if somebody was working on the Progressive Care Unit, is it, the way the hospital staffing goes, is that where they would be assigned and they would work there exclusively or would they ever be moved over to cover care on the Psychiatric floor?

A. Oh, there is possibility.

Q. Okay.

A. There are float nurses. I think ... I don't know the exact lingo but I think it's float nurses.

Q. Okay.

A. They can go wherever the need is.

Q. Um-hmm.

A. So that would be my answer, yeah. It's not necessarily that one is assigned to one unit until ... There are some nurses who do rotate around different units.

Q. Okay. And if I understood your evidence correctly yesterday, Dr. Rahman, you, yourself, had, when Corporal Desmond told you about his wife working on the inpatient third floor ...

A. Yeah.

Q. ... you, yourself, had a recollection of the individual, Shanna Desmond, who actually worked there?

A. Yes, yeah.

Q. Okay. So you recall Shanna Desmond working on the inpatient floor in the Psych/Mental Health Addictions Unit?

A. Correct.

Q. I'm going to move now to the discharge. As I understand your evidence and the record, you received a phone call on the morning of January 2nd from someone you thought was an Emergency Room doctor but turned out to be Maggie MacDonald?

A. Yes.

Q. A nurse.

A. Yeah.

Q. And you provided over the phone, basically, authorization, once you were assured there were no concerns, you

provided authorization that Lionel could be discharged, correct?

A. Yes, yeah.

Q. Okay. And that's charted in the nurses' notes as, I think, "telephone order for discharge".

A. Absolutely, yeah.

Q. We looked at that yesterday.

A. Yeah.

Q. Yeah. So based on that, my understanding is that you did not need to see Lionel after you had provided those discharge instructions, is that fair to say?

A. That is fair to say, yeah. I mean, I could have ...

Q. But you did go to see to him?

A. Yes, yes, yeah.

Q. Why did you go to see him after you had given those instructions for discharge? Was there something about Corporal Desmond, his presentation, the case, that caused you concern?

A. Okay, yeah. So I was on call, I was in the hospital, basically, so it's just that my interaction with him, being a spouse of a staff member, it's not only that, but I had a connection with him.

Q. Okay.

A. I did have a connection with him. So I just came

down to ... I wasn't even sure whether he's still there or not.

Q. Right. Because you were in the hospital already doing rounds?

A. Yes, yes, yeah.

Q. What time would you have arrived to start your rounds that day?

A. I don't remember, 10:30, 10. I don't remember exact timing ...

Q. Okay. But you went down ...

A. ... on that day.

Q. If I can understand your evidence, you just had a personal connection with him.

A. Yes, yeah.

Q. The fact that his spouse worked in the hospital?

A. Yeah.

Q. You did ...

A. And usually ... There have been situations in the ER when patients are there ... I try to see them, as much as I can, before they leave.

Q. Okay.

A. You know. Yeah.

Q. You didn't tell Dr. Howard ... this is who you

thought was Dr. Howard?

A. Yes.

Q. It turns out to be Maggie MacDonald. You didn't tell that person to do a new suicide risk assessment before discharge?

A. No.

Q. No. But yet you did it when you went there. Can you explain why you wouldn't have given that instruction to the person on the phone that you were providing the discharge order to but then you did do it yourself?

A. I just asked her is everything okay, because that plan was already made last night, the night before. It was just a continuation of the assessment the night before.

Q. Yeah.

A. So if there would have been any issue the staff would have informed me about it and I was available throughout the night and any time ...

Q. Yeah.

A. ... prior to discharge. So the information that I got was that there's nothing concerning.

Q. Yeah.

A. So there was nothing concerning to me to begin with.

In case there would have been any concern at the time when I admitted him, then I would have ... This is my thought process. Because I gave him off-unit unaccompanied privileges. I usually don't do that, I confine people to their unit. Somebody who's really suicidal or somebody, any ... if the risk is too much, we don't keep them in the Emergency Room.

Q. Right.

A. We will be certify them, we will take them to the floor. We have many situations where staff members from other hospitals, they call me and they say, Well, their husband or their child or their son or somebody, family member, can you bring them here, because they, they work in that hospital.

Q. Right.

A. So we do all the time that. And sometimes that happens with us also, that we ... I could have called somewhere else for him to be transferred. So basically ... so that was the reason.

Q. So you had been told by your staff who had seen ...

A. Yes.

Q. Or by your medical colleagues who had assessed him through the night, who had charted things ...

A. Yes.

Q. ... that you hadn't had a chance to read, you had been told that there was nothing concerning, you didn't tell them to do a revised suicide assessment but yet you did. And so my question is why? Was there something that was a red flag for you? I mean, you charted that you did that...

A. Okay, yeah.

Q. ... when you coincidentally happened to be there to see him?

A. Yes, yeah. So when I see somebody, that's out of habit also.

Q. Okay.

A. Being a psychiatrist, I will do suicide risk assessment, I will ask these questions, standard, anybody who I see when they're going. But that does not mean that I see everybody, you know. This was a atypical situation because he was in the ER. If the patient is in the inpatient Mental Health, the nurses do their mental health profession and they do automatically suicide risk assessment. Now it's very formal ...

Q. At discharge it has to be ...

A. ... since this document has come out, this document has come out. Now it's very formal. Nobody goes before that.

Q. Right. And the document is the Exhibit P105 that we

looked at.

A. Suicide risk assessment tool, right. So at that time... so the ER staff ... If I would have had concerns, I would have ... our ... we have an involuntary, in **IPTA** we have a form, and I don't remember the whole script now, but it's just that if nurses have concerns, a nurse can hold patient for three hours involuntarily. The nurse has the power ....

Q. Yeah. Okay.

A. ... in Mental Health to hold ...

Q. But in this case, I guess, in answer to my question, Dr. Rahman, there was nothing of concern to you, you did this revised suicide assessment not out of concern but just out of habit?

A. Absolutely.

Q. Okay.

A. Absolutely, yeah.

Q. Thank you. One of the items yesterday you had identified as could be helpful in future for you and for those of you in the mental health field was more domestic violence training.

A. Yeah.

Q. What's your definition of what domestic violence is,

Dr. Rahman?

A. Well, domestic violence, I think that would be anybody treating someone else in an abusive way, in an intimidating way, physically, verbally, emotionally, in an intimate relationship would be abuse.

Q. Okay. So physical, emotional and/or verbal abuse in an intimate relationship?

A. Yes.

Q. Okay.

A. Or financial.

Q. And I ... just to confirm my understanding of your evidence - financial, thank you - your evidence yesterday that when you reviewed with Corporal Desmond the interpersonal conflict with his wife, you restricted your questions to physical, I think, is that fair to say? You didn't explore anything else?

A. Yeah, that would be fair to say.

Q. Okay.

A. Yeah.

Q. You were asked yesterday about, by Mr. Macdonald, about what you've done since the events of January, what has changed for you, and your answer was you're always learning and

that's been a takeaway for you.

A. Mm-hmm.

Q. I'm curious, in your role have you done any research, reading, self-study since then into the correlation between PTSD, military veterans and suicide?

A. No, not particularly.

Q. You were asked yesterday by my friend, Ms. Ward, about the PTSD suicide rate in the general population and I believe your evidence was it's about 10 percent?

A. Yes.

Q. Okay. Do you know what the rate is when it's applied to military members, the ... what the PTSD suicide rate is when applied to military members?

A. I think it's 15 percent. I did read somewhere that suicide attempts are much higher, 20 to 25 percent PTSD veterans, they do have suicide attempts. I think it's, 10, 15 percent is the suicide ... I did a workshop. There's a book, actually I still have it at home, there's American Psychiatric Association, books come where you self-learn.

Q. Okay.

A. And then you do the question and answers. I did that, I think, last year.

Q. Okay.

A. PTSD, it's called PTSD workbook, and that's where I got some information in terms of, that I reported yesterday that 80 percent of PTSD patients are more likely to have ... they meet criteria for another mental, concurrent disorder.

Q. Co-morbidity. Yeah.

A. And that's where I got the information about 48 percent of the combat veterans coming from Afghanistan and Iraq have a concurrent mild traumatic brain injury.

Q. Right.

A. So I remember that but ...

Q. So that is another question I was going to ask you - since 2017 have you done any research, reading, self-study on the association of traumatic brain injury and the risk of suicide with ...

A. That was in that. That was in that.

Q. That was in that.

A. I think ...

Q. That was initiated by you, this training or workshop ...

A. Yes.

Q. ... of the American Psychiatric Association?

A. And I bought that book ... actually not that long ago I bought that book from San Francisco at the American Psychiatric Association meeting.

Q. Okay. Have you had an opportunity since you've been learning, your words yesterday, have you had an opportunity to look at the 2017 report from the Office of the Coroner in Ontario which identifies risk factors for intimate partner deaths arising in Ontario? Have you had a chance to look at those risk factors, that report?

A. No. No.

THE COURT: I'm going to stop you just for a second while I think about it. When you have a discussion about suicide rates - and you used the word military, okay, and I know you used the word "military", and at some point in time the doctor was talking about combat veterans and so when you talk about rates, are you talking about rates in the military, generally? Are you talking about those that have been discharged and are veterans? Are you talking about rates of those that are still in the service?

MS. MILLER: Fair question, yeah.

THE COURT: As I understand, those numbers are tracked, may be tracked differently.

MS. MILLER: My question was a general question about an awareness of an increase in suicide rates with military members and veterans, so I lumped them together. Are you aware of any distinction between whether someone's actively in the military or if they've been discharged and they're military veterans in terms of the suicide rate, with PTSD?

A. I'm not sure. I have not dealt too much in active duty military personnel. It's mostly the vas in US are usually these other types.

Q. Yeah.

A. Veterans.

Q. So that's the extent of what you can comment on the US retired military veterans?

A. Yes, yes.

Q. And is that from the workbook that you looked at ...

A. Yes.

Q. ... through the American Psychiatric Association last year?

A. Yes, that piece, and then I worked at the VA hospital. The first two years of our residency, 1998 to 2000, the first couple of years ...

Q. Um-hmm.

A. ... we had regular rotations in the VA ... VAC. We were doing calls there and we did inpatient work there, we did outpatient work there. So off and on I've been affiliated with that.

Q. Okay.

A. But I am not an ... I don't consider myself an expert in PTSD.

Q. Okay.

A. I don't have a sub-specialized training, I'm not a sub-specialist in PTSD in any way. I've just experienced through my, in my lifetime, but there are more specialized people who work in specialized PTSD clinics.

Q. Fair enough.

A. In these hospitals ... in the military hospitals.

Q. Yeah.

A. And probably in the OSI Clinic also here.

Q. And I believe you said yesterday you're a generalist, if I can use that, as a psychiatrist?

A. Absolutely.

Q. Yeah. But you do have a sense that there is an increased prevalence of suicide in military members and/or veterans who have a diagnosis of PTSD than the regular

population, the general population?

A. Yes, yeah.

Q. Okay.

THE COURT: Ms. Miller, the other point I was going to ask was this, and it will be for all counsel, I know you're going to refer to a report.

MS. MILLER: Yes.

THE COURT: If when you do that, if you could give us the formal name of the report and the details so that if somebody wants to look it up or pursue it, they would be able to do that.

MS. MILLER: Yes.

THE COURT: Okay. Thank you.

MS. MILLER: I had asked you, Dr. Rahman, if you had an opportunity in your learning since 2017 to take a look at the Domestic Violence Death Review Committee 2017 Annual Report, which is produced by the Office of the Chief Coroner in Ontario?

A. No, I have not looked at it.

Q. Okay. And, you know, for clarity, when ... The term domestic violence death is defined in that report and it is defined as "all homicides that involve the death of a person and/or his or her child or children committed by the person's

partner or ex-partner from an intimate relationship". So you've not had an opportunity to take a look at that report?

A. No.

Q. When would you, or would you ever, enlist a neuropsychiatrist, in terms of your practice, either on an inpatient or an outpatient basis?

A. You mean when would I refer somebody to a neuropsychiatrist?

Q. Yeah. Well, let's start with what is a neuropsychiatrist?

A. Yeah. Neuropsychiatrists are ... it's not a sub-specialty. It is if somebody has an interest. It's not, there's no extra fellowship or anything like that by the name of neuropsychiatry. Some psychiatrists might have special interest or they might have done some more courses or has a special ... So a neuropsychiatrist would deal with patients with, of course with neurological ... There's a psychiatric sequela to a lot of neurological diseases and I think brain injury is somewhat considered a neurological diagnosis and there could be psychiatric sequela.

Q. Okay.

A. Like, dementia is a neuro ... is a medical diagnosis,

a neurological diagnosis, and it has a psychiatric sequela. Parkinson's Disease is a neurological that has a... So there are a lot of neurological ... you know, ALS.

Q. Okay.

A. So those ...

Q. But traumatic brain injury being one.

A. Traumatic brain injury will be one. So there are people that do some special work. So Mr. Desmond was treated at Ste. Anne's Center and that's the PTSD rehabilitation unit.

Q. Okay.

A. Which does, I believe, which does encompass ... it does cover all this treatment.

Q. Neuropsychiatric treatment?

A. Neuropsychiatric also.

Q. Okay. Yeah.

A. And he was there for three months and so forth so ...

Q. Do you know that he would have been assessed by a neuropsychiatrist there or you just assume?

A. I assume. We don't ... didn't have any records but he just told me that he was there for three months.

Q. Okay.

A. But I ... we didn't have any records.

Q. If you had to refer someone to a neuropsychiatrist is there one in the eastern district?

A. No.

Q. Okay. Where would you have to refer them to?

A. Probably I'd have to take a look at in Halifax.

Q. Okay. Okay. I'm almost done.

A. Okay.

Q. It's clear to me from your evidence yesterday that the psychiatric practice doesn't have the benefit of an objective record to confirm a diagnosis. So, for example, you don't get an x-ray that shows a broken bone ...

A. No.

Q. ... like you would if you were an orthopedic surgeon?

A. Correct.

Q. You don't get a blood test that confirms the presence or absence of some sort of relevant marker. As you've said, you have to rely on your interview and, you know, your clinical judgment when you're making a diagnosis and assessing sort of a management plan. Is that a fair characterization?

A. And the patient's participation and engagement in the therapeutic process also.

Q. Absolutely. A lot of that information that you have

to rely on comes directly from the patient?

A. Yes.

Q. And so it's from ... we all have a sense of the, we know what happened, we know that based on your interview with Lionel it appears he either under-reported or incorrectly reported things to you. So, for example, we know his guns were taken away, he told you that, but we also know he got his guns back.

A. Mm-hmm.

Q. But he didn't share that with you, correct?

A. I believe so, if that's the case.

Q. Yeah. We also know that he was seeing a Veterans Affairs counselor, you know that?

A. Yes.

Q. He told you he did not have any suicidal ideation, he wasn't thinking about harming himself, but we also know that her records show that he had frequent suicidal ideation in that month. But you didn't know that because he didn't tell you that?

A. Yeah.

Q. Is that fair to say?

A. If that's the case, yeah.

Q. He wouldn't allow you to call his wife to get any collateral information to help you confirm any of the information. So the sense I get is that you were left with your clinical judgment, the information that was provided from Lionel ...

A. Um-hmm.

Q. ... and you did the best you could with that?

A. Um-hmm.

Q. You know, as we move forward, and the purpose of this Inquiry, Dr. Rahman, is to find ways to make sure we build as robust a system as possible to prevent this.

A. Yeah, yeah.

Q. And I appreciate that there are medical things that have been done from your perspective - you described them yesterday - and we went over again this clinical tool that came into play in the summer of 2017. But it strikes me that, you know, there are ways that if you had access to additional information, access to being allowed to call Shanna Desmond, access to being allowed to call or someone in your clinic being allowed to call the Veterans Affairs counselor, someone who could call the police to check or to check about the presence of firearms, that all of that would have helped you build a more

accurate picture of what was going on with Mr. Desmond, is that fair to say?

A. Any additional information could be helpful.

Q. Right. And you had barriers and you have barriers to accessing additional information because of certain legislative privacy requirements, for example?

A. Yeah, yeah.

Q. At the time, you wanted to call Shanna Desmond is my understanding.

A. Yes, yeah.

Q. But Corporal Desmond wouldn't allow that, but you felt it was ... you felt there was a need to talk to her, right? So you were hampered ... is it fair to say you were hampered by the system, it wouldn't allow you to call her, is that correct?

A. Yeah. I mean, I asked him, but he would not allow me. Yes, yeah, no, absolutely, yeah.

Q. If you were able to have called the Veterans ... Again, I'm not suggesting you, necessarily, but somebody who would have had contact with Corporal Desmond that night who could have gathered additional collateral information to ensure that the information you had was as robust as possible. If someone had been able to contact the Veterans Affairs counselor,

knowing what we know, that would have been helpful, too, in terms of you making a disposition plan?

A. But I had some information also in terms of Dr. Slayter's notes, which did have a lot of information.

Q. Yes.

A. Any ... again, any information would be helpful.

Q. Yeah, and this is a forward-looking question.

A. But ... Yeah. So in the course of my interview, asking him about ... I'll tell you, this is ... Can I elaborate, give a perspective?

Q. Absolutely.

A. If some veteran like Mr. Desmond comes to the ER himself, not brought in by police, things change, and is not endorsing any acute psychotic or psychiatric symptoms, would ask, one, that, you know, that's what happened and I need a place to stay, in terms of ... And he tells you that police have been involved many times, but there's no record that ever police had brought him to the hospital here in St. Martha's.

Q. Um-hmm.

A. And you ask him if there's any legal history, he tells you ... I don't know, now you would know better whether this is true or not, he did not have any ... We get patients

all the time having restraining orders, peace bonds, charges, drug use. He was not using any drugs, police had been involved, but police has taken away guns but, usually, if that's the case, police does bring them to the hospital. So these are all safety factors also. In my view, if a police ... This regularly happens that police brings in patient. Oh, well, taking away guns and not bringing to the hospital, that does not happen often. So there is some assessment from the RCMP standpoint that had been done in the past, right, not to a point where ... He's seen by Dr. Slayter with all these symptoms, and he was seen previously also, so there was no other intervention. You know, he would have presented maybe relatively worse than what he was presenting this time.

Q. Yeah.

A. But he was still being managed as an outpatient.

Q. I appreciate that.

A. So ...

Q. So my question is more forward-thinking. I appreciate that what you had at that time was what you could do, but as we look forward as a province in terms of building as robust a system as possible, you know, with different components - police, firearms, the medical, you frontline treatment

providers - it strikes me that there would have been value in you being able to access collateral information to confirm some or all of the information that would have been relevant that Corporal Desmond had shared with you.

A. Oh, no, absolutely. We need patient ... If somebody doesn't tell us the truth, our hands are tied.

Q. Right. Because you ... and won't give permission ...

A. If we don't have a collateral ... Yes.

Q. ... to speak to a spouse, your hands are tied?

A. Yes, yeah.

Q. Even though you may believe, as you did in this case, that there would have been value in that?

A. Absolutely. But in his case, according to my assessment, the safety of the person, it did not trump his personal health information.

Q. Fair enough. Okay. Thank you, Dr. Rahman. I appreciate your time.

A. Okay. Thank you.

THE COURT: Mr. Rodgers?

CROSS-EXAMINATION BY MR. RODGERS

MR. RODGERS: Thank you, Your Honour. Dr. Rahman, I'm Adam Rodgers, I'm counsel to the personal representative of Corporal Lionel Desmond.

A. Hello.

Q. I want to pick up close to where my friend, Ms. Miller, left off and I want to ask you, Doctor, about your knowledge or familiarity with the operational stress injury facilities, Ste. Anne's, the Veterans Affairs programs. You've had some background in that area from the United Status but I guess in your role as Chief of Psychiatry for the eastern region or perhaps in your clinical practice, is it often the case where, or is it ever the case, where you come into contact with military veterans and need to interact somehow with the federal health system if I can put it that way?

A. Yes, that happens.

Q. So you mentioned Ste. Anne's facility in a way that told me you had some familiarity with it, is that fair to say that you do?

A. I had minimal familiarity, like I don't know what level of programs they offer but I know it's a PTSD

rehabilitation unit funded by the veterans and there are some patients who do quality and meet the criteria and go there for inpatient services.

Q. Okay. And just anecdotally from your perspective, have you sent patients there and then seen them afterwards, like do you have any sense of the effectiveness of the programs that they offer?

A. We had, you know, once they are discharged it depends where they will be followed up.

Q. Yes.

A. Either in the community or with a private therapist or they are sometimes followed with the OSI clinics.

Q. Yes.

A. I don't have much experience in terms of too many patients who have gone in that program and come back and being followed up. They are still ... they are usually followed up by specialized services.

Q. Okay. And what about, so would that be the case again for the OSI clinic, the OSI clinic in Nova Scotia or elsewhere?

A. Yeah.

Q. Okay. What about, Doctor, in terms of accessing information and I'm not talking specifically about Corporal

Desmond's case but in any veteran's case. Have you had occasion to seek out medical records from Veterans Affairs or from the federal government?

A. I have and it's not easy to (unclear) federal VA records. When I look at, I know OSI, even if we request records from OSI and patient consents, there's a limitation even on patient consent that my understanding is that there's a limitation how much records we can access or they will be able to send us.

Q. Yes.

A. There's some classified records that even the patient consents, they are not released. I have that much of an understanding.

Q. Would you ...

A. And one more thing, OSI is not ... it's new also.

Q. Yes.

A. I think OSI Clinic in Halifax, I don't remember what year it was that there was a contract signed between them but OSI is part of Nova Scotia Health Authority now, they are subcontracted or it's part of that through the VA so it's a new program.

Q. Yes. Are you aware whether that's going to change

anything when it comes to accessing records? I mean, we're talking about this One Patient One Record thing. Would it be your understanding, and you may not know, but whether OSI would be included in that?

A. Well, I don't know but that is my hope and that was one of my recommendations also the other day that, you know, some simplified or centralized system to access records no matter where the patient has had treatment, other provinces, other departments, other governments, that could really help us but at the same time, I work in inpatient and I can get records from other provinces and we call, we get records regularly, but VA records are not as easily accessible.

Q. It seems, and I wanted to make that comparison, Doctor, I'm glad you raised it because we heard Dr. Clark say as an emergency room physician, that if he needs records from another province sometimes it's just a matter of faxing and requesting them and they arrive, you know, in a relatively short timeframe.

A. Yeah.

Q. Would it seem to make sense to you that emergency room physicians and psychiatrists and maybe others should have better access to those kinds of records?

A. Yeah, they should. I'll give an example. At VA where I used to work, the whole VA system in US at the time, they were all computerized and connected to each other so there was paperless charts in late 1990s. All VAS in US were centralized on one computer system. Not public, like they weren't ... it wouldn't be public, it's within the VA.

Q. And certainly there's going to be some information that may disclose an operation or something else that must remain secret but the diagnosis and some of the key information should certainly be available, would you agree?

A. Absolutely, yeah.

Q. It seems strange, I mean, not everything is comparable but, you know, justice records are run by each province and yet we get a criminal record printout for each person that's going to court if it's relevant. So it seems strange that that would not be available on the health record side but that's interesting, more than 20 years ago that they were available in the United States that way.

A. Yeah.

Q. Do you ever get referrals, like I was asking you I guess, do you send people to Veterans Affairs OSI clinics?

A. Yes, yeah.

Q. And do you ever receive referrals from Veterans Affairs, like so if such as the case like Corporal Desmond's, you know, he's been discharged or was moved to the area, do you ever receive referrals from Veterans Affairs?

A. Yes.

Q. Okay. And can you talk about that process a little bit and how it works, if it works well?

A. I think in Corporal Desmond's situation, I just saw him once in the ER, you know, Dr. Slayter would be the one who saw him and he would have a better knowledge about accessing records in this particular case.

Q. Sure.

A. But I know that when we get referrals from the Veterans and OSI clinics for people to be followed up in the community through the public psychiatry so we have patients referred from them and we refer to them also patients who are, when we get referrals they're either being followed by our own department in the outpatient mental health. That's how Dr. Slayter got involved, he got a referral.

Q. Yes.

A. He had a family doctor also, I think family doctor referred him, but initially I think there was some role of

Veterans also that the referral came from and so these veterans are being followed up by either private therapists in rural Nova Scotia.

Q. Yes.

A. They are in the public system also and some of them are attached to the OSI Clinic. Some people don't prefer to go all the way to Halifax so they are here, they're subcontracted, and then there's a tele-psychiatry also now, we're offering tele-psychiatry which is also new and that's great that OSI Clinic is offering that too.

Q. When they send ... when they refer someone to you and I know I think in this case it was Dr. Ranjini who had sent ...

A. Yes. Yeah, family physician.

Q. ... Corporal Desmond to see Dr. Slayter but if Veterans Affairs sends ... refers somebody, or secondarily refers somebody, would they include the records they have or some relevant records with that referral or do you still then need to see the patient, identify that you need some records, and then request them?

A. I think it's case-by-case and there could be one letter coming in but they're not detailed medical records, we don't get that. That's why Dr. Slayter was ... he had asked

Corporal Desmond to ...

Q. Yes, and we'll talk about whether that's a good way to obtain records.

A. Yeah.

Q. I presume your view would be or maybe I'll ask you, what would your view be on a good way to have those records received by yourself or by one of the psychiatrists?

A. That could be the simple way, the best way that either we can request it or the patient can request it and they should be sent to us promptly. That could be the best case scenario but I think there are some ... that needs to be looked at, there are some limitations as to ...

Q. In your experience, it strikes me that there may be a difference between somebody who's looking for records, you know, for a bad back as opposed to a mental health issue because the issue itself may prevent them or impede them in making the request, you know what I mean? So would it be your ... is it your understanding that the patient needs to agree that these records ... they need to sign a release so that the records get transferred?

A. Yes.

Q. And in a case of a mental health patient, certainly a

mental health crisis, would it be your view that that consent is not essential or should not be required?

A. Well again, the simple and direct way would be helpful. I cannot say that, I don't know what are the ... there's a **Personal Health Information Act** and there's a confidentiality piece and there's a patient preference piece and that is something that needs to be dealt with, it needs to be brainstormed and maybe in legislation.

Q. Sure, that's fair enough. Okay. So, Doctor, a slightly different question now. In Veterans Affairs when somebody's discharged from the military, there is some effort, and we'll talk to other witnesses about that effort, to set up services for veterans that are in need of such services. Is it ever the case that ... are you aware or are you part of that contact that, you know, we're discharging a veteran, this person's been treated for so many years by OSI in our mental health system, they're moving to your area.

A. Yeah.

Q. Now we're not telling you that they've got anything or they need to see you next week but we're just letting you know they're there. Does that ever happen that you're just simply made aware of a veteran that's moved to your area that has a

mental health history?

A. Yes, that happens.

Q. Do you appreciate getting that information or ...

A. About veterans, I cannot answer that. We get referrals from Veterans Affairs. Usually if somebody is followed by ... in OSI clinics, let's say Corporal Desmond's case, he was followed up in Fredericton, they would refer them to an OSI clinic here. I don't know really about the process, to what extent the referral was made, but I'm aware that we got the referral from Dr. Ranjini.

Q. Yes, okay. So would you see a system and I'm asking you to imagine how this might work ...

A. Yeah.

Q. ... would you see benefits of having that connection between the provincial medical psychiatric system and Veterans Affairs where a veteran's been discharged or a soldier's been discharged, moving to the area, that some awareness is identified?

A. Oh, absolutely. Background about any patient deserves to be served where they live, nearby, a nearby facility, whether it be background or it could be public psychiatry so that would be helpful to incorporate them to the nearest professional

available but, of course, there has to be a smooth flow of records also along with that where the patient has been, has agreed or would be followed up in the long run.

Q. You were asked by my friend, Ms. Miller, about the ... anything that you've identified and read yourself on these topics that we're covering but is there, as far as you're aware, anything provided for continuing education on mental health as it pertains particularly to military veterans? Is there anything like that provided to psychiatrists through the provincial system, any formal education or materials or training?

A. I'm not aware of any.

Q. Okay, thank you, Doctor, for those.

I'm going to switch topics and ask you, you identified that Corporal Desmond had at one point been prescribed marijuana, medical marijuana for his PTSD?

A. Yes.

Q. I know that wasn't something that was current when you met with him but we're going to hear from a doctor who prescribed the medical marijuana to Corporal Desmond. I just want to know from you in your 20-plus years of experience and working with veterans and working with those with PTSD, if

you've explored that topic, that use of marijuana for that condition, and what your views might be.

A. Well, I'm not an expert in marijuana. I don't have a ... I don't prescribe marijuana but as a generalist I can tell you that marijuana, it does cause psychiatric symptoms, it does cause psychosis, it all depends on person to person, how much one is using, what kind one is using, what is the THC content or the CBD content, in what form they are using. So it just, it depends, case-by-case basis but we regularly see patients in our inpatient unit and in our emergency rooms who present with psychosis in context of marijuana. We have seen, marijuana was very common, it has been around for a number of years. Since it has become more readily available now, we have noticed some increase in the presentation with people in psychosis caused by marijuana.

Q. Have you noticed anyone ...

A. I don't understand marijuana. I attended the CMEs and marijuana does, to some family doctors who prescribe it, it has some therapeutic advantages in terms of treating pain and PTSD symptoms also but I have limited experience in this field.

Q. Okay. Given your profession I wanted to see what your views were as we'll hear some other witnesses on that topic,

thank you.

So, Dr. Rahman, it may have surprised some people to hear that in the course of a week you're encountering maybe 10 to 15 people that are identifying as with suicidal ideations.

A. Mm-hmm.

Q. That seems like a high number and it seemed like a high number to have at any point two or three individuals referred through the **Involuntary Psychiatric Treatment Act** at any time but that is your experience on a weekly basis?

A. Yes, one or two involuntary and ...

Q. Sure. But that still seems like a lot of people coming in each week that you've got to deal with and talk to that are expressing suicidal ideations?

A. Oh absolutely, we are a very busy service.

Q. It's not a fair question, I'm not going to ask it, Dr. Rahman, but it's a question that's sort of implicit in a lot of what we're asking you here is, you know, how come you didn't see this coming, that's the question and it's not, like I say, it's not a question I'm asking and we're not here to assign a blame so I don't want to have that discussion. But a few people saw Corporal Desmond before he did these things and you're a psychiatrist so if anybody was going to see it coming, perhaps

you had the best chance under the right circumstances.

So I want to talk about what those circumstances might be or might have been and we do, of course, want to try to foresee these and prevent them. So Ms. Miller's already asked you about the potential to contact collateral contacts and the desire that you had to do that. You did wish to contact other people that might have informed your views more but there were barriers to that, legal barriers and perhaps availability barriers, we don't know, because you weren't able to make the efforts but certainly Catherine Chambers who was identified in Dr. Slayter's report as his mental health clinician and Shanna Desmond, Corporal Desmond's wife, maybe others.

So there were barriers there and we can identify whether we want to look at those but do you see, just when it comes to collateral contacts, do you see other barriers besides the privacy and legal barriers that we've talked about? And certainly if you were ... I was thinking if you were overburdened in terms of time that perhaps you wouldn't be calling two or three collateral contacts for every patient you deal with.

A. We do that anyways, we try to do that if we get the permission, depending on the circumstances. Collateral

information is very important in the field of psychiatry so we do understand that. Again, (slow flow?) of medical records and availability and there are confidentiality issues.

Q. Yes.

A. I mean a private therapist, whether they will give us information, if the patient will consent or not.

Q. Yes.

A. There are different points of care which needs to be integrated and to minimize the risk. That is ... that's part of ... that's what we are here for. That's the purpose of the inquiry also and we will be very open to look at what the recommendations are, the options are, and we want to serve the people ...

Q. Sure, no, that's ...

A. ... in a safe environment.

Q. ... that's apparent, Doctor, thank you.

Another potential barrier and I think you've addressed this indirectly but are there enough psychiatrists to deal with the workload that you have on a regular basis at St. Martha's?

A. St. Martha's, I think we are in good position. We have enough resources at St. Martha's but if we talk about all over Nova Scotia, we have a dearth of psychiatry services in

Cape Breton right now ...

Q. Yes.

A. ... and some other places but as far as St. Martha's is concerned, we have full complement of three adult psychiatrists and one child psychiatrist and, you know, so but additional resources would always be welcome. It's a busy service but we are managing, we are coping.

Q. So time is always precious. Is time a frequent barrier to full treatment of a patient when they come in to see you?

A. It depends on different settings so it does not ... we do have time, we spend time with the patients, it's not a barrier.

Q. And access to records is certainly another circumstance, I guess ...

A. Yes.

Q. ... if we frame it that way that if you had more ready access to records and I'm thinking some sort of instantaneous access to records, would that be the standard you wish to reach?

A. Absolutely and we are moving towards that direction in terms of medical records but that's within the NSHA but we also have to look at getting records from ...

Q. Other provinces and from the federal government?

A. Yeah.

Q. Okay. I'll jump around a couple of questions, Doctor. The triage level was identified by a triage nurse as a level two and then you reassessed Corporal Desmond when you met with him. When you change the triage level on a patient, does that require a discussion with the triage nurse to say, Listen, was there something you saw and you didn't write down in your notes that I should know before I change the triage level?

MR. HAYNE: Your Honour, just again just to be clear, I don't think Dr. Rahman's evidence was that he changed the triage level so just a minor ...

A. I can answer.

MR. RODGERS: You didn't change it on the form?

A. No, that's not my job.

Q. Yes.

A. The triage level is done by the triage nurse and the level I spoke yesterday, that only affects the interval for the patient to be seen by the ER doctor.

Q. Okay.

A. I have nothing to do with the triage levels.

Q. Okay. But you don't automatically, when you say,

Well, that doesn't seem quite right, do you routinely or ever go back to the triage nurse to say, Well, what did you see, you know, I think is is a four or a five, you put it as a two?

A. No, I don't do that, I have not done that.

Q. You just make your own assessment, okay.

A. Yeah.

Q. Trazodone, Dr. Rahman, an antidepressant and was prescribed to Corporal Desmond. We don't have evidence of exactly what the concentration was at the time but we sense that he was on ... he was taking trazodone. Are there risks to that medication? When I see the potential side effects, it looks like for those that have major depressive disorder that there's an increased risk of suicidal thinking and behaviour at least in younger people?

A. Yeah.

Q. Was that something of which you were aware or were cautious or considered when it was prescribed to Corporal Desmond?

A. I did not prescribe and he had already been on.

Q. Or sorry, he had ... yes.

A. He had already been on for I don't know how long.

Q. Yes.

A. Trazodone in children and adolescents there is always increased risk of any antidepressant can increase the risk of suicide, that is true for many antidepressants. But in his case I think trazodone was being given for his sleep, Dr. Slayter had prescribed it, 100 milligrams, and it's an antidepressant at very high doses, not at 50 to 100 milligrams. You need to be on a very high dose for it to have a antidepressant effect. So it is not commonly used nowadays as an antidepressant but it's an off-label, evidence-based usage as a sleep aid.

Q. Okay. That didn't ... it didn't concern you, I guess, when you saw it on his chart?

A. No, no.

Q. Now, Doctor, it appeared that Corporal Desmond wasn't quite forthcoming with you on a number of occasions. Ms. Miller has gone over a few of them. He told you he slept well, the nurses' records show that he probably didn't sleep that well. He was looking at guns online that day, I appreciate you weren't aware of this and weren't aware of much of what I'm about to tell you, I guess, but yet he presents well to you?

A. Mm-hmm.

Q. He's looking at guns online then he comes in and he presents fairly well to you as a doctor. He left the hospital

the next day and we have records that he went to Canadian Tire and bought a big knife and then, of course, the next day, bought a gun.

A. Mm-hmm.

Q. Is that ... well, I guess you don't always know, Doctor, if somebody is not presenting in a completely forthright manner but is that unusual for somebody to come in seeking help and then not be forthcoming?

A. That is unusual.

Q. Yeah.

A. People come to seek help, to get help, and they are forthcoming. They are there to get help.

Q. And part of the evidence that we heard from the investigators was that Corporal Desmond went into the woods and went through a pathway to get to the house before he committed the incident. That's only two days later too. Does that suggest some sort of dissociation to you?

This is what I'm asking, I guess, Doctor, if you considered whether this might be some sort of dissociative disorder that Corporal Desmond had at the time?

A. Counsel, I cannot comment on this. I have ... I was ... I didn't see him at the time.

Q. Yeah.

A. I still feel his status changed in the intervening period. That is something that, you know, the assessment of status of mind when he was doing all that would be something that a forensic psychiatrist would be better equipped to answer. They are the ones who do the criminal responsibility and stuff like that. Risk assessment, in their term, the state of mind at the time. I am not an expert in this what was state of mind after he left us.

Q. But if you were treating the patient for an extended period of time and had the time to get to know them well enough, you could diagnose somebody with a dissociative disorder. You are familiar with the diagnosis at least. Correct?

A. Yes. Yeah.

Q. So some of the things such as depression and mood swings, suicidal tendencies, sleep issues, anxiety, panic attacks, compulsions, these sorts of things that seem to be part of a dissociative disorder diagnosis, may have been present with Corporal Desmond. But I guess would you agree with those symptoms being somewhat present?

A. Again, at the time I saw him, I did not see any dissociative symptoms.

Q. Sure.

A. But they are part of the PTSD diagnosis. There are some dissociative symptomatology as part of diagnosis of PTSD.

Q. Okay. And I don't want you to go beyond what you're comfortable opining on, Dr. Rahman, but where somebody is able to present in a normal way or a way that persuades a doctor that they're okay, and yet is able to go off and do these other things in relatively short timeframes thereafter - purchase weapons and then go off and do the actions that follow - does that suggest some sort of dissociation to you?

A. Cannot comment on that, what happened afterwards, in the next 25 to 30 hours.

Q. So when Corporal Desmond comes to see you, I guess the question is why would he come to seek help and then not really seek the help?

MR. HAYNE: Sorry, Your Honour, just the framing of that question is really to the state of mind of ... or what Mr. Desmond was thinking, and although Dr. Rahman is a psychiatrist, I think it may be offside.

THE COURT: Let me hear the question again.

MR. RODGERS: The question is why would Corporal Desmond go to the hospital to seek help and then ... well, the way I put

it was, and then not seek help.

THE COURT: And not seek help.

MR. RODGERS: Yes.

THE COURT: Well, it presupposes that when he went to the hospital that he was not going for the purpose of seeking help.

MR. RODGERS: Yeah, but I guess the ...

THE COURT: Okay. Versus, you know, he went to the hospital to seek help, and at some point in time when he was there, and for whatever reason he may have recalculated what his plan might be without disclosing it.

You know he was looking at websites when he was at the hospital, leaves the next day, and you know he goes to Canadian Tire and eventually you know he goes to Leaves & Limbs.

MR. RODGERS: Yeah.

THE COURT: This means he had that formulated in his mind the night he went to the hospital because his web searches occurred while he was there.

MR. RODGERS: Mmm.

THE COURT: So you've just got a bit of a problem with the premise.

MR. RODGERS: That's right. I agree.

So, Doctor, I guess the question is whether ... can you think of what Corporal Desmond's motivations might've been? And, again, that's a difficult question to answer but ...

THE COURT: Motivations in relation to?

MR. RODGERS: Motivations in not being completely forthcoming with his answers or his account to you, as it appears that he wasn't.

MR. HAYNE: And, Your Honour, my objection still stands. I mean I understand Dr. Rahman can give his views as a psychiatrist and what he observed with respect to Mr. Desmond, but I think probing into Mr. Desmond's motivations may be offside in this case.

THE COURT: Well, he may be able to ask the question if you accept that the information that Mr. Desmond gave him wasn't whole and was not complete, particularly in the context of what he already was aware of through looking at Dr. Slayter's report. Did that have any significance to him in terms of how he would look at or assess Mr. Desmond on that particular evening? Perhaps ask it that way.

MR. RODGERS: Well, the question I want to ask, Your Honour, is, you know, what else might Corporal Desmond have been ... looking back on it now, what does he think Corporal Desmond

might've been doing there?

THE COURT: That's really pretty speculative and I think that's the objection, too, is that I think you can ask the doctor how he might view something himself in terms of the differences in the information and how that might affect his assessment, but I think you're going too far to ask him to try and read in motivation.

At the end of the day, if you think about it, one of the most difficult tasks that this Inquiry will ever have is trying to actually determine what thought processes were, if that's even possible.

MR. RODGERS: If it's even ...

THE COURT: Possible.

MR. RODGERS: If it's even possible, Dr. Rahman might be one of the people in the best position to opine on it.

THE COURT: Now we would be doing, at the end of the Inquiry, after we've heard all of the evidence. And what we're going to get exposed to in terms of evidence, in effect, is going to be a lot different than what the doctor has available to him right now.

MR. RODGERS: Mmm.

THE COURT: So I might just leave it to you to speculate

as to what the thought process was in your summation at the end when all the evidence is in.

MR. RODGERS: No. That's ...

THE COURT: You know, it's a little bit like having Staff Sergeant Maccallum speculate what the trigger was.

MR. RODGERS: Yeah.

THE COURT: Right? That would be an opinion that was developed by the RCMP and the people that he was dealing with, but whether that would constitute a trigger and whether or not a forensic psychiatrist might view it that way, I don't know.

So we should be careful about how much of that speculative opinion creeps in because I don't think it's helpful.

MR. RODGERS: Okay, that's fine. And those are all the questions I have for you, Dr. Rahman, thank you.

A. Thank you.

THE COURT: Mr. Hayne?

CROSS-EXAMINATION BY MR. HAYNE

MR. HAYNE: Thank you, Your Honour. Dr. Rahman, I just have some key points for clarification and then some other areas I wish to ask you some questions about. Firstly, just to be

clear, Mr. Macdonald asked you yesterday whether you discussed your evidence with anyone in advance of presenting here yesterday and your answer was no but you did have a discussion ... although I was present, you did have a discussion with Inquiry counsel, Mr. Murray and Mr. Russell prior to attending yesterday. Correct?

A. Yes. Yeah.

Q. Mr. Macdonald asked you - and, again, I'm paraphrasing - about your clinical judgment and asked you about the various chart information checklists, nursing information, patient information, possibility of collateral information, and he first used the word "trump" but then changed his question to say something along the lines of whether your clinical judgment was the most important factor. And my question is, isn't it true that your clinical judgment doesn't replace or override those other things that I mentioned, but rather, your clinical judgment represents the culmination of your consideration and analysis of all those factors. Is that right?

A. That's correct.

Q. You were also asked why you didn't call Dr. Slayter and your answer was that's not what you do as you were the physician on call, but isn't it also fair to say that you would

expect that all of the pertinent information that Dr. Slayter would've had would've already been written and encompassed in his consultation report that you had already seen? Is that right?

A. Correct. I will elaborate a little bit on that. Being medical professionals, physicians, especially, we are the ones who know what it's like being on call and not being on call. It does have ... affects the quality of life and that's how the medical system works.

Q. Okay.

A. The person on call is the one responsible. We see many patients who have seen many clinicians and we can make a case, people can make a case, on calling each and every physician each time a patient shows up. The on-call person is the one that's not indi- ... it's not ... it does not happen in the medical profession.

Q. Right. And Mr. Desmond was in front of you at the time. You were doing the assessment.

A. Yes. Yeah.

Q. You were also asked about your experience with respect to veterans in the United States from the Afghanistan War and I believe your response was that you had seen some, but not many,

or something along that lines?

A. Yeah. Afghanistan War was not ... by the time I was done there, they were just a couple of years into non-conflict and they were trickling in, few of them. I have not seen too Afghan veterans. Mostly from Iraq conflict, Vietnam, Korean conflict, and so forth, but Vietnam was the major share.

Q. Yes, no, but certainly some from the Iraq War as well.

A. Yes. Yes.

Q. Yeah. And is it fair to say that from a psychiatric perspective that the particular theatre of war is not necessarily the most significant factor? It's rather the patient's presentation and perhaps the fact that they had seen combat?

A. Yes, absolutely. Like these are the questions that we ask, you know, and not everybody suffers from PTSD in having a military background. It depends upon one's coping skills. Some veterans have experienced more exposure to trauma and active theatre and they can manage whereas some cannot.

Q. Right.

A. So it just depends. Each case is different.

Q. So I just want to switch gears a little bit now just to get through some basic information just to make sure that the

Inquiry has the basic background information because you talked about inpatients and outpatients, and just for clarity, outpatients are patients who come to the hospital periodically to meet with a psychiatrist in this context. But, otherwise, they go home and live in the community. Is that right?

A. Correct.

Q. Yeah. And inpatients are those who stay and effectively are living out of a hospital, at least for a period of time, as compared to outpatients who go home at the end of the day.

A. Correct.

Q. Or after their visit, to be more specific.

A. Yes.

Q. Okay. And with respect to inpatients, there's two classes. Is it fair to say that there's a class of people who are admitted who can benefit from the inpatient care and they're there voluntarily? That's one class.

A. Yes. Correct.

Q. And then there's the second class of those patients - and we've gone through the requirements under **IPTA** - but they're the second class who are there as inpatients who are there involuntarily, against their will.

A. Yes.

Q. Okay. And you were aware of the **IPTA** and its provisions when you saw Mr. Desmond. Correct?

A. Absolutely.

Q. And you had used **IPTA** to involuntarily admit other patients prior to your encounter with Mr. Desmond. Correct?

A. All the time.

Q. Yeah. And I think there was discussions about the numbers of one ... you may use it one to two times per week, but at any one time there may be two or three patients in St. Martha's under **IPTA**. Correct?

A. Correct.

Q. And is it fair to say that you would not have hesitated to apply or invoke **IPTA** in the case of Mr. Desmond if you believed that it was indicated. Correct?

A. That's correct.

Q. Your assessment was that it was not indicated. Correct?

A. Absolutely.

Q. Okay.

A. Correct.

Q. Just want, again, a little bit of background

information, talk a little bit about PTSD. PTSD is a recognized psychiatric disorder. Correct?

A. Correct.

Q. It's recognized in the DSM-5. That's the manual of psychiatric disorders?

A. Yes, Diagnostic and Statistical Manual of ...

Q. And in general ... and appreciating that every patient is unique. But, in general, the treatment of PTSD may be a combination of medication and therapy. Correct?

A. Correct.

Q. And this may be called sort of a biopsychosocial approach?

A. Yes. That's what we ... the modern training of psychiatry is treating people with this model.

Q. Okay. And so the "bio" may refer to the medication and ...

A. Yes.

Q. ... that component. "Psychosocial" may be the therapy component.

A. Yes. That's the ... the "psycho" is the therapy, which is dealt with the psychotherapist, and the "social" piece is also integrated in that.

Q. Okay. So in that ...

A. Yeah.

Q. ... treatment plan, if I can call it that, the role of a psychiatrist is to provide the diagnosis but not necessarily to conduct the therapy. Correct?

A. That's usually the case.

Q. Right. The therapy would usually be provided by a psychologist or therapist or other ... some other form of regulated health professional.

A. Correct.

Q. Okay. And in the case of veterans, for example, in the Antigonish area, that may be provided through an OSI-appointed therapist or some local therapist in the Antigonish area. That's right?

A. Yes.

Q. And once that's underway, the role of the psychiatrist ... or in the case of ... if not followed by a psychiatrist, the role of a family doctor is to manage prescriptions and monitor their mental health. Is that fair?

A. Correct.

Q. And just in terms of patients and ... who have ... we heard about the prevalence of suicidal ideation in your

practice. In terms of patients and ... sorry. We also heard about the levels low, moderate, severe. In terms of patients who have a low level of suicidal ideation ... again, every patient is different, but it may be appropriate from a psychiatric point of view to have those types of patients live in the community and be seen on an outpatient basis.

A. Absolutely. Psychiatry is mostly community based ...

Q. Right. Okay.

A. ... and all these patients are managed as an outpatient.

Q. And the same may be true for patients with a moderate level of suicidal ideation and could still be ... could possibly still be appropriate from a psychiatric point of view to have them live in the community and be seen on an outpatient basis.

A. Correct.

Q. And I just want to go through and put some of the record to you to see if you agree.

The triage nurse recorded that Mr. Desmond was calm and speaking quietly. And do you agree with that from your assessment? That was fitting when you saw Mr. Desmond?

A. That was my impression, as well.

Q. And Dr. Clark ... and I think we've gone through this

but I just want to confirm. Dr. Clark wrote, "No suicidal ideation, no homicidal ideation." And that was your assessment, as well?

A. Yes.

Q. And Dr. Clark wrote, "No evidence of psychosis." That was your assessment, as well?

A. Absolutely.

Q. As part of your psychiatric assessment, is it true that you try to develop a therapeutic or a psychiatric rapport with a patient?

A. That is our goal.

Q. Yeah.

A. And I think I was able to achieve that.

Q. And, in fact, with Mr. Desmond, earlier you used the word ... you said that you had a connection with him.

A. Yes.

Q. And in your experience with the VA Medical Centre in the United States, is it fair to say that you got to ... I think the word you used earlier, that you became familiar with the lingo that veterans may use.

A. Yes.

Q. And so is it fair to say that you were able to apply

that in the case of Mr. Desmond and that helped you build the therapeutic rapport with him?

A. I think that was really helpful.

Q. Yes. And in that rapport, you found him to be engaging and forthcoming. Correct?

A. Yes.

Q. And that's one of the reasons why your note in this particular instance, as you said was a little bit maybe longer than normal.

A. Yes.

Q. Your assessment was that his thought process appeared to be logical and goal oriented?

A. Correct.

Q. And he was future looking?

A. Correct.

Q. He was coherent and logical and he comprehended you?

A. Yes.

Q. When you're asked about the prescriptions that ... or, rather, the medications that were provided for Mr. Desmond, and some you had struck out with a line, I believe your evidence was that he ... you mentioned the medication to him and he suggested that he tried it before and it didn't agree with him. That was

his subjective report back to you. Correct?

A. Yes. And we ... and usually in terms of medication, we do depend and take this into regard, the subjectiveness of what worked in the past for a patient, what does not. So their recollection of ... that he had been on these and it didn't agree ...

Q. Right. And so ...

A. ... and wanted to be ... yeah.

Q. Yeah. And I think you answered my question, but it's part of your psychiatric practice when providing medications to a patient, you rely at least in part on their subjective report to you as to the impact of those medications.

A. Correct.

Q. Just in terms of the discharge or when he left hospital, and we discussed how that was a plan that had been put in place the night before and ... Mr. Desmond indicated to you that he was going to follow up with Dr. Slayter. Correct?

A. I asked him that.

Q. Right. And we know that he ... or ... take that back. And did you also ask him regarding follow up with a therapist?

A. Yes.

Q. Mr. Macdonald asked you yesterday about steps that you

could have done. But in not meeting the requirements of **IPTA,** which was your evidence, is it your understanding that you had no legal means, as you understand it, to restrain Mr. Desmond or to keep him against his will? Correct?

A. Correct.

Q. And, regardless, you didn't think that was indicated. Correct?

A. Correct.

Q. And there was also a question about your contact potentially with collateral sources of information, including Shanna Desmond. And you understood that with his refusal of consent, and I think your evidence was that safety didn't override that in this case, you had no other means to reach out to Shanna Desmond. Correct?

A. That would be correct.

Q. Okay. The last topic to cover with you this morning, Dr. Rahman, is there was some information that you weren't aware of at the time and I just ... and feel free if you can't comment. But I want to put certain information to you to see what your impression was because these things occurred ... at least the first things I'm going to speak to you, they occurred while you were seeing Mr. Desmond, at least that's the

understanding that we were provided with. And they are text messages from Mr. Desmond's phone to Shanna Desmond's phone on January 1st, 2017. So just to put in context, Mr. Desmond ... you saw Mr. Desmond sometime around 7:45 p.m., something like that, for ...

A. Yes.

Q. ... 30 to 40 minutes. That would have been 19:35, in that nomenclature. There's a text from Mr. Desmond's phone to Shanna Desmond's phone at 20:23, so 23 minutes after 8 p.m. It says, "Hey, just wanted to say I'm sorry for yelling." I'm going to put some more to you here. There's a text at 20:28, "I am sorry I put my hands up to you. I would never hit you. I am sorry for yelling our business out there. Apologize for Aaliyah to hear me outburst. I'm safe now. Good night. XOXO. Love you Shanna."

And all ... there's two more, but just stop there. From your view as a psychiatrist and having seen Mr. Desmond at or around that same time, do you believe that these texts are consistent with how Mr. Desmond presented in front of you?

A. Yes. It sounds he's remorseful and also regretful of what happened. He did endorse that. And it goes along, I believe, with this text.

Q. And, similarly, there's two more texts, one at 20:34, "Please let me know if I can come home to you. I was out of my mind. I'm calm. I should have stayed calm and I said some hurtful things to you. Please forgive me." Is that also consistent with what Mr. Desmond told you and his presentation in front of you?

A. Yes.

Q. Okay. And, lastly, at 20:39, "Shanna, I'm sorry for my actions. If you have time, text me. I am getting ready to fall asleep." Similar? Consistent with ...

A. Similar. Pretty clear text messages.

Q. And from a psychiatric perspective and feel free, because I was objecting earlier to similar questions, but feel free to ... if you have issues. But from a psychiatric perspective ... and, again, based on what you saw of Mr. Desmond at or around the same time and these text messages, would you ... is it fair to say that these text messages do not demonstrate someone with psychosis? It's correct that these would not ...

A. That's ...

Q. ... reflect psychosis?

A. That's correct. It does not reflect psychosis.

Q. And they don't reflect suicidality?

A. They don't reflect suicidality.

Q. And they don't reflect homicidality?

A. They don't reflect homicidality.

Q. Is it fair to say these texts are consistent with coherent thought?

A. Yes.

Q. They're consistent with forward-looking thought?

A. Yes.

Q. And your evidence earlier was that from your perspective ... and, again, correct me if I mischaracterize this, but that you believe that his status changed after he left hospital and after he saw you. Correct?

A. That's what I believe.

Q. And Mr. Desmond's change of status, according to your belief, could have been brought on by subsequent interactions with other individuals. Is that fair?

A. There is certainly a possibility.

Q. And we have phone calls on January 2nd and is it ... just to get the time right, Mr. Desmond left hospital sometime around 11 a.m.? Is that ...

A. I believe so.

Q. Something like that? There is a phone call from Mr. Desmond's phone to Shanna Desmond's phone at 10:52 which lasted 2 minutes and 13 seconds. But then there's a subsequent call at 12:56. So that would have been after he had left hospital.

A. Probably. Yes.

Q. And that call ... and I think the evidence was ... you weren't here but ...

A. Yeah.

Q. ... we don't know if that was a voice interaction or maybe a voicemail message. But it's listed as being 6 minutes and 42 seconds. And is it possible that there may have been something on that phone call, or some other interaction, like you said, that may have resulted in the change of status that you believe happened?

A. I believe that.

Q. Okay. Those are my questions. Thank you very much.

A. Thank you.

MR. MACDONALD: Your Honour, I had a question arising from Mr. Hayne's questioning, which is new material. I wondered if I might ask it. Relates to the texts.

THE COURT: I'll let you ... just give me a minute, Mr. Macdonald.

MR. MACDONALD: Sure.

EXAMINATION BY THE COURT

THE COURT: Following along with the questions that Mr. Hayne asked you ... okay? So he takes you up to 12:56 on January the 2nd or thereabouts. You were talking to Corporal Desmond about his ... about the plan, he was going to do at least two things. One was to follow up with Dr. Slayter.

A. Yeah.

Q. And the ... because he had missed an appointment with Dr. Slayter.

A. Correct.

Q. And I think you've become aware that on January the 3rd, sometime proximate to noon, I'm going to use that as the time, that he had gone to the outpatient mental health clinic and, in fact, had rescheduled the appointment that he'd missed with Dr. Slayter in December and had it rescheduled for January the 18th.

A. Correct.

Q. Okay. So that was him following through on that part of the plan that he said he would follow through on.

A. Absolutely.

Q. Okay. One of the other things that he said he would do is he said he would follow through with his therapist.

A. Yes.

Q. Okay.

A. Yes.

Q. And I think we'll eventually hear some evidence, and I'm going to suggest to you that this is correct that, in fact, also on January 3rd, in the afternoon, he did, in fact, call his therapist and had a conversation ... a lengthy conversation for perhaps over 20 minutes with his therapist that day. So that would ... he was also following through with his plan ...

A. Yes.

Q. ... and the plan that he had agreed to.

A. Absolutely.

Q. So would those be the same kind of events that would suggest to you that he was still forward thinking?

A. Forward thinking and forthcoming also. He did follow through.

Q. Okay. We have a video of Mr. ... Corporal Desmond in the ... in a retail shop called Leaves & Limbs sometime proximate to 4 o'clock on January the 3rd. Have you ever seen

that video?

A. No. I've not seen the video.

Q. All right. Thank you.

THE COURT: So I'm just going to leave that for a moment. Mr. Macdonald ...

MR. MACDONALD: Oh, thank you very much, Your Honour.

THE COURT: ... what's your question? Okay.

CROSS-EXAMINATION BY MR. MACDONALD

MR. MACDONALD: Good morning again, Dr. Rahman.

A. Yes.

Q. I won't be very long. So Mr. Hayne took you through texts that Mr. Desmond was sending, while he was at St. Martha's, to his wife. And it's the one about ... as I understand the quote ... I've seen it. I've read it before. "I'm sorry I put my hands up to you. I would never hit you." If you had known about that text being sent and those words being used when you interacted with him, would that have given you any more pause for concern in terms of the domestic violence potential?

A. Yes.

Q. Thank you.

THE COURT: Thank you. Before I turn to Mr. Murray and Mr. Russell, anyone else have any additional questions? No? Thank you. Mr. Murray, Mr. Russell?

MR. MURRAY: Was Your Honour planning on taking a lunch break?

THE COURT: So it's 12:30. I know that I mentioned to counsel the other day that we were going to have to break early because it's a Wednesday and there's a council meeting today. And I was advised that there's actually a meeting before council meeting. So we realistically have to break at 2:30 today. So I think we're going to take a break for lunch. Take an hour. Come back at 1:30.

Mr. Murray may have some questions for Dr. Rahman. I have a few questions for Dr. Rahman and, in fact, I'll tell counsel, in case you want to have a look at it in the interim, is the video from Leaves & Limbs, I'm going to make arrangements to have that played in court this afternoon while we have Dr. Rahman here and let him have an opportunity to review it. And then I might have a couple questions for him and if counsel have any questions follow up to that. And then we will be out of here for 2:30 at that point in time. So I expect we'll take up

DISCUSSION

the rest of the afternoon dealing with that bit of evidence.

So if there are witnesses here that were expecting to testify this afternoon, I think they can be released and plan on having them here tomorrow morning, subject to whatever discussions we have about tomorrow and what the weather might bring. We'll adjourn until 1:30. Thank you, Doctor. Thank you.

COURT RECESSED (12:36 HRS)

COURT RESUMED (13:36 HRS)

THE COURT: What's the exhibit number on this?

THE CLERK: What exhibit number? It hasn't been entered, Your Honour, as an exhibit but it's Inquiry number 68.

THE COURT: Right. This is Inquiry document number 68. It's going to be entered as the next numbered exhibit. We'll get that updated. I wanted Dr. Rahman to see it.

EXHIBIT P-000112 - INQUIRY DOCUMENT 68 - SECURITY VIDEO FROM LEAVES & LIMBS - JANUARY 3, 2017

EXAMINATION BY THE COURT

THE COURT: Dr. Rahman, I'm just going to give you a little background on this. This is a security video from an

DISCUSSION

establishment called Leaves & Limbs. It was obtained following theses events. And you'll see that the date on the time of the ... the date is January 1st and the time is 4 o'clock. We'll blow that up in a minute.

A. Yeah. Sure. Yeah.

Q. All right. I can tell you that the ...

MR. MURRAY: Your Honour, you may have said January 1st. It's January 3rd.

THE COURT: Sorry. January 3rd.

MR. MURRAY: 3rd. Yeah.

THE COURT: Right. Thank you, Sorry. It was January 3rd. This is the location at which Corporal Desmond purchased the firearm that was used later that day. We know, I think generally, from the documents that have been provided, some of the other evidence called, was received by the RCMP, a 9-1-1 call, some time proximate to 6 o'clock that same day. So from 4 o'clock to 6 o'clock, we're probably two hours out from the event. And this is after ... later in that day when we know that Corporal Desmond had also rescheduled his mental health appointment for January the 18th and had spoken to his therapist that afternoon as well.

And, generally, we have him in the store and you'll see his

... there's no audio. This is all video. So I was just going to ask you to have a look at it and I'm interested in whether you have any observations to make about the way he moves, his apparent demeanour in the context of whether or not you could offer any opinion as to whether or not he was exhibiting, just from his behaviour that you could see, anything that might suggest either psychosis or agitation, because it's so close in time to the shootings.

I can tell you that our expectation is, as well, that the person that's seen behind the counter will testify and has provided information to suggest that his interaction with Corporal Desmond at that time was not other than he would expect of somebody in that situation, looking at firearms and buying firearms and having discussions and engaging in discussions about firearms. He appeared to be knowledgeable about what he was talking about. We'd expect that, given the nature of his training. All right? So we'll let you watch it. We'll play it through. If you want to see it a second time or if there's some reason to stop it, just let us know.

A. Sure.

Q. All right?

A. Okay.

Q. So that's the purpose of it ...

A. Okay.

Q. ... at this time. All right. Thank you. So if we could play the video and maybe bring it into full screen.

VIDEO COMMENCED (13:41 HRS)

Q. It's about 15 or 16 minutes long.

VIDEO PLAYING

Q. Thank you. You can stop it there.

VIDEO CONCLUDED (14:03 HRS)

Q. I realize that that's the first time you've seen that and it's ... I thought it was 15 minutes. It's more like 20 minutes but ...

A. Yes.

Q. ... it would give you an opportunity to have watched some of Corporal Desmond's actions on that day at that time.

A. Yes, Your Honour.

Q. What do you see there?

A. So my general mental status without interacting with him, just watching him on the video, would be that he appeared to be calm and composed. He appeared to be engaging with the business owner. He was able to concentrate and decisive also in terms of selecting ... in terms of, first of all, browsing and

looking around. He picked about four guns and then he came back to the third gun that he had picked. So that clearly shows that he was coherent. He was decisive. He was not in a haste. He was not in a hurry. He made sure that the business owner was able to engage with him enough that he looked as a serious buyer.

There was no psychomotor agitation or retardation. Initially, he was ... his hands were in his pocket. He would take it out. He would walk. He would browse. In terms of selection, the ammunition, he again looked around two or three different kind of ammunition packets and was able to make a decision and select one of them, so decisive.

Q. After he was looking at the ammunition, it appears like they have a discussion about a case for the rifle.

A. Yes. Yeah. So the case piece would be again in the same line. Looked around couple of cases but eventually did not buy a case. Wrapped around in that ... the ...

Q. It's almost like ...

A. So then ...

Q. ... a shrink wrap.

A. Yeah. And ... but, at the same time, he was cognizant enough that he had the owner to put the gun case back into the

plastic bag and put it back where it came from. So it takes a lot of coordination, articulateness, and able to complete a financial deal there, purchasing a firearm with the ammunition. He had probably enough knowledge of what he was doing. New guns ... he looked at the new guns initially, first, I believe, and then there were used guns. He went on to the used guns section, that was a decision also.

His wallet was lying ... he gave, I think, the license or whatever he gave and then his wallet was lying. He was attentive enough to go back and pick up his wallet and put it back in his pocket. He didn't forget it. Again, no psychomotor agitation/retardation, not in a hurry. The dealing that it appeared to be with the business owner seemed to be that he was cognitively intact to proceed with his decision and make this transaction happen.

So I cannot comment on his speech or other thought processes at the time, but it appeared to be a normal buy, buying a gun, in the right state of mind. There was somebody else in the shop initially. That gentleman left and there's another one who came in. It did not bother him. He was pretty ... remained pretty calm and composed and was able to continue with the interaction with the business owner. It did not

distract him. He took his time. That would be my assessment.

Q. All right. Thank you.

THE COURT: Does anyone have any questions? No? Thank you. Mr. Murray or Mr. Russell, you may have had some questions of Dr. Rahman other than the video, so go ahead.

RE-DIRECT EXAMINATION

MR. MURRAY: Just a couple of points on your earlier cross-examination. Just for clarification for my own benefit, you had said in answer to a question that you believed that Lionel Desmond's status, that was the word you used, had changed between his release ... or his discharge, I should say, on January 2nd and the events of January 3rd. When you use that term "status", are you referring to a mental health status and a mental health diagnosis? Is that the way I understand that term or is it more general or something different?

A. I think I used the word status change in the intervening period.

Q. Yes.

A. And so I cannot say for sure in terms of ... I think it's a mixture of mental status and his actions. In my view,

"status" also would be how I saw him and perceived him, how the ER doctor saw him/perceived him, how the staff saw him and perceived him. That status was different than what eventually ... ultimately what happened. I cannot comment on his state of mind and status at the time but that status that we saw was not the status that somebody would proceed to engage in these actions.

Q. No. No, that's fair. I guess I wanted to understand how you were using the term "status", just to understand.

A. Yeah.

Q. So it's more than just mental health diagnosis. You're talking about his whole presentation when you use the term "status"?

A. Yes. Yes.

Q. Okay.

A. And, again, I would add here this would be something that a forensic psychiatrist who has an expertise in capacity to stand trial and criminal responsibility and they are very trained to know and understand what might have been going on in his thought process at the time. I think ... I don't ... I'm not that experienced or don't have that expertise.

Q. Yes.

A. I have never worked in the forensic system.

Q. Yes.

A. This is almost like a forensic situation. I think I would not be able to comment.

Q. And a forensic psychiatrist may be able to express those types of ...

A. I hope so.

Q. Just in terms of what you saw in the video, just in terms of demeanour and the way that Lionel Desmond was acting and moving, how did that compare to when you saw him on January 1st and 2nd?

A. This was a different situation. This was ...

Q. Understood.

A. ... a different environment. When I saw him, he was in a room with a comfortable couch and so forth. He was sitting. He was ... but his affect here was ... it was relatively flat as compared to how I saw him and perceived him. He was more reactive at the time.

Q. Okay.

A. But he appeared ... his face appeared to be ... there were not too many expressions.

Q. Yes. On the video.

A. On the video.

Q. So at least something of an assessment of someone's affect, you could get without actually hearing him talk, just like looking ...

A. Yes.

Q. ... at his face?

A. Yeah.

Q. Okay.

A. Because when he turned around, I looked at his face and tried to make an assessment as much as I could.

Q. All right. I just have a couple of other general questions just before we conclude. The ... when Lionel Desmond attended at hospital, it was obviously after hours and it would be, well, a holiday as well.

A. Yeah.

Q. Had it been a weekday and through the day and he had been seen by the crisis team, is it your understanding that they would have completed a risk assessment tool when they saw him or would they have ... like physically completed the paper, do you think or ...

A. Yes.

Q. Okay.

A. And that had happened on ...

Q. Understood.

A. ... October 21st that ...

Q. Right. It happened on October 24th.

A. It would have been the same procedure.

Q. And it would have been done again.

A. Yes.

Q. Okay.

A. Absolutely.

Q. If a person attends at one of the other smaller hospitals in this region ...

A. Yeah.

Q. ... they wouldn't have access to the mental health crisis team.

A. No.

Q. Okay. Would they have access to the mental health crisis team at St. Martha's?

A. Yes.

Q. How would that work? Would they be asked to go there or would the crisis team come to them or how would that work?

A. So it depends how they present in the community hospital like Guysborough or Sherbrooke or Strait Richmond or

Canso, so forth. They are assessed by the ER physician. Triage system is the same, but the ER physician ... they're assessed. And then the ER physician will call during the daytime when the crisis team is on. They will call the crisis team. Or they can talk to the psychiatrist directly also. So that is an option. It depends upon how one presents in the community hospital. They can be either transported with the family or mostly it is via EHS.

Q. Okay.

A. Because they are ... there's enough ... if they meet the criteria in terms of suicidality or agitation or there are a lot of overdoses and stuff like that, then they're transported by EHS and they are brought to the ER at St. Martha's Regional Hospital daytime until 5, 6 o'clock ... it's until 6 o'clock, but by 5 o'clock the crisis team stops to see ... take new patients. They're done at 6.

So during the daytime they will be assessed by the crisis and then a psychiatrist will be get involved, bypassing the ER physician at St. Martha's because they're already seen by ER physician at the community hospital. If it's ... this is during their daytime hours and if it's a weekend or holidays or after hours, the physician will directly contact the on-call

psychiatrist.

Q. Yes.

A. And they would then decide, the on-call psychiatrist, whether the patient would come to the ER at St. Martha's and they will be assessed there as a consult service, or if there's enough evidence or if we know somebody then there's an option of directly admitting patient from the Strait Richmond via psychiatrist to the inpatient mental health unit and the psychiatrist assesses them on the unit.

Q. So it is very much a case-by-case ...

A. Case-by-case. If it's too ... we have our 24/7 service, but if it's too late at night and the patient is stable, then there's a possibility it's more of a direct admission to the inpatient unit and the psychiatrist can give orders on the phone at night and will see them the next day. And ... but they do go through all the nursing assessment on the unit.

Q. Right.

A. If the nurse feels that they need psychiatrist at any hour, then the psychiatrist ... or the on-call person from Psychiatry is available to come to the hospital.

Q. Okay. You had said ... I think there have been some

questions about ... we've talked about the suicide risk assessment tool and that there isn't really a homicide risk assessment tool or no tool to assess the risk of homicidality, if that's the correct word.

A. Yeah.

Q. You're not aware of any such tool being developed or any ...

A. I'm not aware.

Q. All right.

A. It's very rare that we come across patients but ... the tool is not there but the crisis team and the psychiatrist, we are trained to ask those kind of questions. And if there's any risk that they would meet the criteria of involuntary hospitalization also and they are admitted and ... so there is ... so that's how ...

Q. Right.

A. ... we would conduct business.

Q. And just one last question.

A. Yeah.

Q. The ... there were some questions about the use of cannabis and I understand that ...

A. Yeah.

Q. ... you're not an expert in that or you don't prescribe it yourself. If you're able to answer this, Can the use of cannabis either as medical marijuana or else ... or not, can that interfere with other forms of psychiatric treatment like psychotherapy or cognitive behavioural therapy if someone is using ... actively using marijuana?

A. Absolutely.

Q. If someone comes to you and is a candidate for psychotherapy, let's say, and you know that they are a consumer of cannabis, would you prefer that they stop or would you give them any advice in that regard?

A. We would advise them to refrain from smoking marijuana. It's up to the patient.

Q. And is that also true of a product that was low in THC and perhaps higher in CBD or ...

A. It's person to person. It depends how one is reacting.

Q. Yes.

A. So it just depends.

Q. Right.

A. And different people respond differently, and amount they are smoking, the frequency they are smoking. And it's not

only marijuana. It could be polysubstance abuse also.

Q. Yes.

A. Alcohol inclusive.

Q. Yes.

A. We ... our message to the patients is that their brains are vulnerable. They cannot tolerate these illicit drugs or legal drugs or alcohol and we advise them to refrain from it. However, marijuana use is very common. We don't restrict their access to our services, even if they're in therapy and patients are using, but they're managing themselves. They can manage in the community. It's not affecting their occupational or social or any other important area of functioning. We don't put any restrictions, but our advice is always that ... to minimize or refrain. They also interfere with the psychiatric medications also.

Q. It can?

A. It can.

Q. Yes.

A. It can. And so that is usually our advice.

Q. Okay. All right. Thank you, Dr. Rahman.

A. Thank you.

THE COURT: All right. Thank you, Dr. Rahman. I think

we're finished with your evidence. Appreciate your time. Thank you very much and you're free to go for now.

DR. RAHMAN: Thank you, Your Honour.

THE COURT: Thank you.

WITNESS WITHDRAWS (14:22 HRS)

THE COURT: This is the evidence ... that's the end of the evidence for the day. I think we're going to adjourn for a few minutes. I'm going to ask counsel to have a discussion about a start time tomorrow. I understand there's been some discussion whether we start at 9:30 tomorrow. I know there's some weather expected. I don't know how that impacts on everyone in the room. So you should have a discussion. I'm prepared to consider whatever the consensus position is in terms of starting. We'll adjourn for maybe ten minutes. You can have a discussion and we'll decide. Thank you.

COURT RECESSED (14:23 HRS)

COURT RESUMED (14:29 HRS)

THE COURT: Thank you. I understand that counsel had an opportunity to have a discussion with regard to continuation of these proceedings tomorrow and there would be a consensus that, in all the circumstances given counsel's travel and what the expectations for weather are, particularly for tomorrow, that

DISCUSSION

we're going to adjourn today and we will resume on Monday morning at 9:30. All right? Thank you.

COURT ADJOURNED (14:30 HRS)

CERTIFICATE OF COURT TRANSCRIBER

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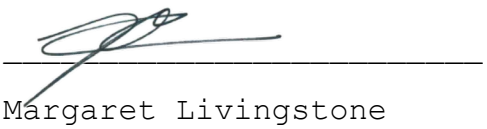

Margaret Livingstone

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