

CANADA

PROVINCE OF NOVA SCOTIA

IN THE MATTER OF THE  
*FATALITY INVESTIGATIONS ACT*  
S.N.S. 2001, c. 31

**THE DESMOND FATALITY INQUIRY**

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**TRANSCRIPT**

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**HEARD BEFORE:** The Honourable Judge Warren K. Zimmer

**PLACE HEARD:** Guysborough, Nova Scotia

**DATE HEARD:** February 10, 2020

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**HEATHER WHEATON**

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1           February 10, 2020

2           COURT OPENED    (09:39 HRS.)

3

4           THE COURT:        Good morning.

5           COUNSEL:        Good morning, Your Honour.

6           THE COURT:        Mr. Murray or Mr. Russell?

7           MR. MURRAY:        Yes, Your Honour, the first witness for this  
8 morning is Dr. Ian Slayter.

9           THE COURT:        Thank you. Good morning, Dr. Slayter.  
10 Perhaps you'd just come over and just stand there for a moment  
11 at the witness stand, please. Thank you.

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1 **DR. IAN SLAYTER**, affirmed, testified:

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3

**DIRECT EXAMINATION**

4

5 **MR. MURRAY**: Can you state your name for the record,  
6 please?

7 **A.** Ian Slayter.

8 **Q.** And how do you spell your last name?

9 **A.** S-L-A-Y-T-E-R.

10 **Q.** And how are you employed, Dr. Slayter?

11 **A.** I'm a self-employed psychiatrist working at St.  
12 Martha's Regional Hospital.

13 **Q.** All right. And I'd like to bring up an exhibit, which  
14 is your *curriculum vitae* which you've provided to us, which I  
15 think is Exhibit 70.

16 **A.** Is that in here?

17 **Q.** Yes. So in Volume 1 of the exhibits it will be  
18 number 70.

19 **A.** Okay.

20 **EXHIBIT P-000070 - CURRICULUM VITAE OF DR. IAN SLAYTER**

21 **Q.** All right. So Dr. Slayter, you're currently working  
22 as a psychiatrist and that's exclusively at St. Martha's

1 Regional Hospital?

2 **A.** Yes.

3 **Q.** All right. And what's the nature of your  
4 relationship with the hospital? You said you were ... How did  
5 you describe it?

6 **A.** I'm self-employed.

7 **Q.** Yes.

8 **A.** We have an implicit contract with the hospital to be  
9 there and provide services.

10 **Q.** Okay. And do you maintain a private practice, as  
11 well, or ...

12 **A.** No.

13 **Q.** All of your practice is at St. Martha's?

14 **A.** It's all there.

15 **Q.** Okay. And so do you deal with inpatient services at  
16 St. Martha's and outpatients?

17 **A.** Yes. My main role is working in the Outpatient  
18 Department doing consultations and follow-up. I also, two days  
19 a week, I cover psychiatric needs in the Emergency Department,  
20 when I'm called down.

21 **Q.** Yes.

22 **A.** And I'm on an on-call schedule for nights and

**DR. IAN SLAYTER, Direct Examination**

1 weekends. I just did the weekend. And I, we do, we share, we  
2 rotate through Medical and Surgical units when there are  
3 consultations needed, and I cover inpatients when one of the  
4 inpatient psychiatrists is away.

5 Q. Okay. And we've heard some evidence from Dr. Rahman  
6 earlier about the complement of psychiatrists at St. Martha's.  
7 I believe there are three adult psychiatrists and one child  
8 psychiatrist, is that correct?

9 A. We have an approved complement of four, and there are  
10 three adult psychiatrists now, and the child psychiatrist will  
11 be an additional complement, and I think he's part-time.

12 Q. Okay. And you had mentioned that you are sometimes  
13 on call and again we've heard about that. There's always, I  
14 believe, a psychiatrist on call in St. Martha's, is that  
15 correct?

16 A. There is always someone on call on the psychiatry  
17 schedule 24/7. There are six of us on - three of us are  
18 psychiatrists, three are family physicians who have been doing  
19 it for a long time.

20 Q. Right. Okay. And you're, I note, as well, and you  
21 can comment on this, you're also working as an Assistant  
22 Professor in the Department of Psychiatry at Dalhousie?



**DR. IAN SLAYTER, Direct Examination**

1           **A.**    Yes.

2           **Q.**    And you teach there or is it more taking students at  
3 the hospital and ...

4           **A.**    I have a family medicine resident with me one day a  
5 week.

6           **Q.**    Yes.

7           **A.**    We do clinical teaching.

8           **Q.**    Okay. And you're also the co-Chair of the Eastern  
9 Zone Mental Health Quality Council?

10          **A.**    Yes.

11          **Q.**    Okay. All right. And Dr. Slayter, your CV is  
12 extensive. You've worked in the area of psychiatry for,  
13 obviously, a number of years. Do you have a specialty or would  
14 you consider yourself a general adult psychiatrist? How would  
15 I describe you?

16          **A.**    General adult psychiatrist.

17          **Q.**    Okay. There are areas of specialty in psychiatry,  
18 are there?

19          **A.**    Yes.

20          **Q.**    Okay. In a community like Antigonish it's more  
21 common, I guess, to have a general adult psychiatrist?

22          **A.**    We do have a child and adolescent psychiatrist who

**DR. IAN SLAYTER, Direct Examination**

1 would be regarded as a specialty, so they do children and  
2 adolescents, which I don't do.

3       **Q.**     Right. And so in the Outpatient Clinic, perhaps you  
4 can just give us a bit of an understanding of how that normally  
5 works, how would you see a patient, for what period of time and  
6 what would normally happen.

7       **A.**     So the way I do my practice, and different  
8 psychiatrists are somewhat different, is a patient is referred.  
9 I most often see someone who's referred by a family doctor.  
10 Some are self-referred but, generally - or referred by one of  
11 our therapists - but generally they're family doctor referred.  
12 And so I do an assessment or consultation, I would call it.  
13 Typically, I would ... It varies how long I spend with them but,  
14 on average, it would be about an hour and 10 minutes, I would  
15 say. Most ... three-quarters of the people that I see in  
16 consultation I see only once and I send them back to their  
17 family doctor for medication, follow-up, and to a therapist, if  
18 they need therapy.

19       **Q.**     And on some occasions you will see someone for  
20 follow-up, will you?

21       **A.**     Some people who are more complex, that I think can't  
22 be so well managed by their family doctor, I will follow for a

**DR. IAN SLAYTER, Direct Examination**

1 while, and when I think they can be followed by their family  
2 doctor I will send them back. And that's a way of dealing with  
3 the demand for services, so ... I can't see everybody forever,  
4 so I try to see the ones most in need and most in need of my  
5 services.

6 **Q.** Okay. And the typical case, then, would be referred  
7 back to their family doctor with your recommendations for  
8 follow-up?

9 **A.** Yes.

10 **Q.** Okay. Your Outpatient Clinic, that is, you do that  
11 at St. Martha's Hospital?

12 **A.** Yes.

13 **Q.** Okay. That typical hour or so first visit with  
14 someone in the Outpatient Clinic, that would typically involve  
15 what, it's an interview or a discussion?

16 **A.** It would be an interview. I'd go out to the waiting  
17 room, meet the person and take them, and if they have a family  
18 member with them, I usually take the family member with me, as  
19 well, and we go back to my office down the hall and sit down and  
20 ask some questions, they tell me their story, and I make some  
21 conclusions and ...

22 **Q.** Um-hmm. Okay. When people come to Outpatient Clinic

**DR. IAN SLAYTER, Direct Examination**

1 meetings with you, do they typically have ... Well, let me ask  
2 you this first. You may have a referral from the family doctor.  
3 Do you have, generally, other information or is it a little hit  
4 or miss that way?

5 **A.** If they ... It varies. If they've been to our clinic  
6 before, then I would have their old records, generally, and I  
7 would look at those beforehand, go through them. I would ... If  
8 they've been - I don't always check; it depends - but often we  
9 have on our electronic medical record called MEDITECH if they've  
10 been seen before. If, for example, they've had admission to our  
11 Inpatient Unit, there would be some information on there and so  
12 I would go through that if I think they've been seen before.

13 **Q.** All right. And if, for example, they are currently  
14 prescribed some medication, is there a way to easily determine  
15 what they are prescribed?

16 **A.** Generally, I go by what they tell me. When it's not  
17 clear I'll sometimes call the pharmacy to find out directly.

18 **Q.** Okay. And let me ... In just reviewing your CV, Dr.  
19 Slayter, you've worked in a number of different places during  
20 your career. I wanted to ask you, prior to your current work  
21 at St. Martha's, which was from August '11 to the present day,  
22 you were about eight years at Capital District Health Authority?

**DR. IAN SLAYTER, Direct Examination**

1           **A.**     Yes.

2           **Q.**     And your work there or your title was Clinical  
3 Director of General Psychiatric Services?

4           **A.**     Yes.

5           **Q.**     And what did that entail?

6           **A.**     For most of that time it entailed overseeing from a  
7 psychiatric point of view six inpatient units, two psychiatric  
8 services and two emergency departments, five outpatient clinics,  
9 and the on-call service.

10          **Q.**     In your *CV* you made reference to some of the areas  
11 that you were able to achieve some improvement, I think, while  
12 you were Clinical Director at CDHA, including acute inpatient  
13 care, emergency care, community mental health care, and quality  
14 improvement. I wanted to ask you about one of those, in  
15 particular. In the area of acute inpatient care you make  
16 reference to suicide risk assessment and monitoring. You did  
17 some work in that area, did you?

18          **A.**     I did. If I can go back a little further?

19          **Q.**     Sure.

20          **A.**     I did spend four years in the unit one time.

21          **Q.**     Yes.

22          **A.**     I was Chief of the Department there.

**DR. IAN SLAYTER, Direct Examination**

1           **Q.**     Yes.

2           **A.**     And I was interested in suicide risk, because we had  
3 to review whenever there was a suicide attempt, that sort of  
4 thing, and I did, along with the Director of Nursing, we did a  
5 study of 21 attempted suicides in the hospital over a 10-year  
6 period and reported on how they compared to a control group, in  
7 terms of what seemed to put them at risk and what to watch for.  
8 And I gave a talk on suicide and I began recommending at that  
9 time, for example, that every time we see someone we should  
10 record the suicide risk, in terms of whether it was low, medium  
11 or high. I've had trouble getting people to accept that, but I  
12 got interested at that time and in Capital Health, now Central  
13 Zone, I did a major talk with a review of a lot of papers in  
14 2005, looking at what was important to look at. And in, I  
15 think, 2010, Accreditation Canada came out with an ROP, which, I  
16 think, means Required Organizational Practice, and they wanted  
17 something across Canada that everyone would have a protocol for  
18 assessing suicide risk and what to do when they found it. So I  
19 put together a group in 2010 to develop a protocol, a process,  
20 which ended up in our current form that you have.

21           **Q.**     Okay. So the output, I guess, from that work was a  
22 suicide risk assessment tool?

**DR. IAN SLAYTER, Direct Examination**

1           **A.**     Yes.

2           **Q.**     All right.  And in ...

3           **A.**     At that time it was part of Capital Health, but when  
4 the new Health Authority came it had merged into that.

5           **A.**     And this was developed both from your own clinical  
6 experience then and also from an extensive review of the  
7 literature?

8           **A.**     Yes, we had a committee put together and we looked at  
9 references from a number of journal articles and books, and we  
10 went through and identified risk factors in all the different  
11 articles and chapters, put them in a list.  I found that some  
12 were the same thing using different words, so we collapsed them  
13 and we put them into sub-groups, and it eventually came down  
14 from 120-some different factors to approximately 25 or 30 of  
15 them.

16          **Q.**     Apart from the fact that some were perhaps  
17 duplicative of others, did you find that some were more  
18 statistically significant than others or were they all relevant  
19 in that consideration?

20          **A.**     I don't think anyone's ever done a statistical study  
21 where they said this one's present so many percent of the time.  
22 It would be very hard to do that anyway.

**DR. IAN SLAYTER, Direct Examination**

1           **Q.**     Okay.  But these are all factors that, in your  
2 experience and again in your review, were useful in predicting  
3 suicide risk?

4           **A.**     Yes.

5           **Q.**     And so that tool, that suicide risk assessment tool  
6 was ... when was that completed or when was that put into  
7 practice?

8           **A.**     Well, in Capital Health we came out with it as a  
9 policy in 2011, several months before I left there, and it's  
10 been, you know, evolved since then a little bit.  It's not  
11 greatly different.

12          **Q.**     All right.  When you came to St. Martha's to, I guess,  
13 what was then GASHA, you began to use the tool there, as well?

14          **A.**     No, because we weren't part of Capital Health.  We  
15 didn't have a tool then ...

16          **Q.**     Okay.  Did you ...

17          **A.**     ... that was broadly used.

18          **Q.**     Okay.  We have seen reference, though, to a suicide  
19 risk assessment tool being used in this case.  When was that,  
20 when did that come into use?

21          **A.**     I don't recall what was used.  I guess it was an  
22 early version, when I think about it, the one that I saw our



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1 Crisis nurse use, yes. So that was an early version.

2 Q. Okay. And perhaps I can just get you to reference  
3 Exhibit 67 in your binder. And there's pages or page numbers at  
4 the top there. I think if you go up to page 9 ...

5 A. Right.

6 Q. ... you'll see the suicide risk assessment tool  
7 there, the one that Heather Wheaton completed in this case.

8 A. Yes.

9 Q. Is that similar to the one developed in Capital  
10 District Health?

11 A. It's similar. The current form is a whole page long  
12 now.

13 Q. Yes.

14 A. This is a shortened version but the idea behind  
15 suicide risk assessment is that you take a patient's history,  
16 their story, their symptoms, so on, their situation. One  
17 considers factors that are thought to be associated with risk of  
18 suicide, and this is a list of such factors, and then one  
19 subjectively makes a judgment as to whether this is a low risk,  
20 a high risk, or somewhere in between, which would be a moderate  
21 risk. That's basically what happens. So this is a list of some  
22 of the factors to consider. I know some people refer to this as

**DR. IAN SLAYTER, Direct Examination**

1 a checklist. It's not to be a checklist that you count them and  
2 give them weights; it's just to help jog your memory as to what  
3 to consider and then each one, its weight, depends on the  
4 particular situation and you come to a judgment. We used to  
5 have a fourth ... This one, I don't think, has on it levels of  
6 risk - at least, I can't see it. So we judge the three - low,  
7 moderate, and high. At one time there was one called "no risk"  
8 but decided that everyone is, theoretically, at risk, so we  
9 dropped that and just have low risk.

10 **Q.** I think actually on the one that was used there, the  
11 category under Suicide Risk Management of "None" is still there.  
12 Are you on page 9 there?

13 **A.** Oh, on the right, yes, Low, None.

14 **Q.** Okay. Right. So you say in the newer tool the  
15 category of None has been removed?

16 **A.** Is gone, yes.

17 **Q.** Why is that, again?

18 **A.** Some people would argue that you can never say  
19 there's no risk, so if you said it's absolutely zero, that would  
20 be wrong. But we used to say no used to mean we would not have  
21 to think about it at all. Low risk meant ... At one time the  
22 way I defined it meant that they needed treatment but you didn't

**DR. IAN SLAYTER, Direct Examination**

1 have to follow the risk as long as you were doing the treatment,  
2 whereas moderate risk implies that they run a risk. Most  
3 importantly, it means one has to monitor the risk to assess  
4 whether it's getting worse or not and address that as needed.

5 Q. Okay. So the tool that was used, and we'll talk more  
6 about this in a bit, but the tool that was used here is an  
7 earlier version of the tool that's used now?

8 A. Yes.

9 Q. The tool that's used now has been expanded somewhat?

10 A. It has, it's easier to read.

11 Q. That's always helpful.

12 A. Yes. So, essentially, it's the same. I think it's a  
13 similar list. The items on the list haven't changed much over  
14 the last 10 years. One or two or three have changed, that kind  
15 of thing. The space used to say Mild, Moderate, or Severe has  
16 changed and the space to write in your comments has changed.

17 Q. And maybe just briefly we can bring up Exhibit 105.  
18 I think we may have, at the end of that document, the new ...  
19 Just the last page, I think, of that document.

20 A. Yeah, so it's, essentially, similar.

21 Q. All right. So you say some of the factors on that  
22 have been modified somewhat and ...

**DR. IAN SLAYTER, Direct Examination**

1           **A.**     I'd have to go through and compare them to tell you  
2 which ones but they're, essentially, the same.

3           **Q.**     Okay. All right. And that tool is still in use?

4           **A.**     The one that's on the screen is what's in use right  
5 now, I believe.

6           **Q.**     Exhibit 105. Okay. So if I may also ask you,  
7 Doctor, in your practice now in this area, do you have occasion  
8 to see patients who have been diagnosed with post-traumatic  
9 stress disorder?

10          **A.**     Yes.

11          **Q.**     And how often do you see patients with that  
12 particular diagnosis?

13          **A.**     PTSD covers a wide range of different people. In one  
14 sense, I probably see it a couple of times a month. Some of  
15 those, a lot of them, the majority of them relate to women  
16 who've been sexually assaulted at some point in the past or as  
17 children.        At the other, I call it end of the spectrum, but  
18 it's not that, in principle, not different, I see first  
19 responders, like, paramedics who have PTSD relating to the kind  
20 of situations they have witnessed. I see fishermen who have  
21 been involved with drownings and situation like that, people  
22 they know or near-drownings themselves. I see police officers

**DR. IAN SLAYTER, Direct Examination**

1 and retired police officers. I tend not to see very often  
2 veterans from the Canadian Forces but I do see sometimes.

3 Q. Is that a function perhaps of where we are in the  
4 province as much as anything?

5 A. It's a function of I don't think there are any  
6 veterans who've had active service around us, yeah.

7 Q. In this area?

8 A. Yeah.

9 Q. Okay.

10 A. That's a speculation but ...

11 Q. And to your knowledge individuals who have been  
12 diagnosed with post-traumatic stress disorder, there are  
13 therapists, I think, in the area that do work with those  
14 patients, as well?

15 A. We have therapists who do.

16 Q. Okay. There isn't a sub-specialty that deals  
17 specifically with post-traumatic stress disorder, though, is  
18 there?

19 A. I have two answers for that. First of all, with  
20 therapy, there are different kinds of therapy, but it is  
21 evolving into a sub-specialty. So a trauma therapist tends to  
22 do primarily PTSD cases, and they've developed special skills.

**DR. IAN SLAYTER, Direct Examination**

1 Sort of ordinary cognitive behavioural therapy, which is often  
2 used, in general, by itself isn't that effective in PTSD, so  
3 they've developed therapies and skills that are particularly  
4 helpful and there are different approaches. So we have, for  
5 example, in Antigonish two people who - I think it's two - who  
6 do that. We have other resources - the Antigonish Women's  
7 Resource Center in Antigonish had someone who does trauma  
8 therapy. I think in Port Hawkesbury there's one. So those would  
9 be our resources, some private therapists who may or may not do  
10 trauma therapy.

11 The other part I was going to answer ...

12 **Q.** Sure.

13 **A.** To go back to my role, ordinarily, with PTSD - I said  
14 that I'd see most people once and only follow people who were  
15 complex - I generally see patients with PTSD once, I make the  
16 diagnosis, I'm able to make the diagnosis, and I recommend  
17 medications, if needed, and medications, essentially, are not  
18 specific to PTSD but to some of their symptoms. If they're  
19 depressed, then we would treat their depression; if they're  
20 anxious, there's anxiety; if they're an insomniac, then  
21 something for insomnia. I make those recommendations and then  
22 send them back to their family doctor for follow-up of the

**DR. IAN SLAYTER, Direct Examination**

1 medication piece and if they don't have a therapist, put them on  
2 a waiting list for a trauma therapist.

3       **Q.**     Okay. And to the extent - and I appreciate you said  
4 you've not seen as many soldiers or veterans who have suffered  
5 or are suffering with PTSD, in part because of our geographic  
6 location - but to the extent that you have any knowledge of  
7 that, is their presentation any different perhaps than other  
8 patients who are suffering with post-traumatic stress disorder?

9       **A.**     The main thing I've come across, and I saw a little  
10 bit of this when I was working in the US, is that soldiers  
11 who've been in combat and have their PTSD relating to combat can  
12 have very violent nightmares and sometimes sort of wake up sort  
13 of under fire or being bombed, and if there's partners next to  
14 them, they can get hit until the person wakes up. That has  
15 stood out to me on a couple of occasions.

16       **Q.**     Yes.

17       **A.**     Sometimes soldiers are a little more sort of  
18 regimented in their presentation.

19       **Q.**     And when you say they're "more regimented", what do  
20 you mean by that?

21       **A.**     Well, they're used to, you know, following orders and  
22 ... In my role people sometimes present to me a little

**DR. IAN SLAYTER, Direct Examination**

1 differently than they do to somebody else; for example, my  
2 secretary or crisis workers will say, you know, They were like  
3 this when I saw them, but, with you, they were calm and  
4 respectful and polite, that kind of thing.

5 **Q.** Um-hmm.

6 **A.** So that it's ... I have to get past that to assess  
7 what's going on.

8 **Q.** Okay. And do you have any experience or have you  
9 treated individuals who have attended at the OSI, or  
10 Occupational Stress Injury Clinic, in the province or in any  
11 other province?

12 **A.** Yes.

13 **Q.** Okay. All right. And I meant to ask you as well,  
14 Doctor, just with respect to St. Martha's, there is a mental  
15 health crisis team at the hospital, is there?

16 **A.** Yes.

17 **Q.** And how is that made up presently?

18 **A.** It has three people in it. One's off on sick leave  
19 right now, so leaving two. They cover our ... they work in our  
20 Emergency ... As Crisis staff, they work in our Emergency  
21 Department from - I'm not quite sure of the exact hours - but,  
22 say, 8:30 to 6, I think, Monday to Friday, so on regular days.



**DR. IAN SLAYTER, Direct Examination**

1 They're not there at nights or on weekends. They also are ...  
2 we now have what we call an Urgent Care Clinic for short-term  
3 follow-up of people they've seen in Crisis or who've just been  
4 discharged from Inpatients and they follow them for a short time  
5 if needed.

6 Q. And the makeup, the professionals that are on the  
7 Crisis Team are a mental health nurse, a social worker, I  
8 believe, and ...

9 A. Yes, two mental health nurses and one social worker.

10 Q. When you see a patient in the Outpatient Clinic,  
11 would any member of the Crisis Team be involved in that?

12 A. Only if they were already involved.

13 Q. Yes.

14 A. And they would only be following short-term through  
15 Urgent Care, because Crisis is a one visit phenomenon.

16 Q. Right.

17 A. And Urgent Care might be two or three or five or six.

18 Q. The Urgent Care Clinic, then, is as many as up to  
19 five or six visits?

20 A. I forget the upper limit, but something like that.

21 Q. Okay. And what type of service would be provided, to  
22 your knowledge, in the Urgent Care Clinic?

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1           **A.**     They would see someone, according to need, let's say,  
2 weekly for a short time.

3           **Q.**     Yes. Okay. With some therapeutic involvement or  
4 more social ...

5           **A.**     They would be providing supportive counseling and  
6 whatever else kind of help seems to be needed that they're able  
7 to provide.

8           **Q.**     All right. Okay. Dr. Slayter, I'm going to refer you  
9 to Exhibit 67.

10          **A.**     Okay.

11          **Q.**     And page ...

12          **A.**     Actually it is easier to read on the screen.

13          **Q.**     Okay. Perhaps we can start with page 6.

14          **A.**     Can you magnify that a little bit?

15          **Q.**     So from a review of the records, Dr. Slayter, it  
16 would appear that you did have some involvement with or  
17 interaction with Lionel Desmond at St. Martha's Hospital, is  
18 that correct?

19          **A.**     Yes.

20          **Q.**     And the first time that that occurred was on October  
21 24th, 2016?

22          **A.**     Yes.

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1           **Q.**     Did you know Lionel Desmond prior to that, had you  
2 ever met him, to your knowledge?

3           **A.**     No.

4           **Q.**     Okay. And you'd never treated him?

5           **A.**     No.

6           **Q.**     Okay. So on October 24th, 2016, Lionel Desmond  
7 attended at St. Martha's, it would appear, and the page that we  
8 currently have up is the Emergency triage record. That's a  
9 document that would be completed by the triage nurse in  
10 Outpatients, is that correct?

11          **A.**     Yes.

12          **Q.**     All right.

13          **A.**     In the ER, to be specific.

14          **Q.**     Sorry. I have to be clear in my terminology. ER,  
15 okay. And I appreciate that you didn't complete this document  
16 and it's not your document but, to your knowledge ... We've  
17 heard some evidence about the description that patients who  
18 present at the Emergency Department, how their conditions are  
19 sometimes described. In this case, the triage nurse used the  
20 term "situational crisis". I appreciate that's a triage term.  
21 Does it mean anything to you, from your perspective, or does  
22 that tell you anything about how Lionel Desmond presented that

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1 day?

2           **A.**     Well, if you're asking me about the term, it means to  
3 me that someone is in a situation they're finding difficult and  
4 they're experiencing distress in some form.

5           **Q.**     Right.

6           **A.**     I would expect to see someone with some sort of acute  
7 emotional symptoms and something going on in their situation.  
8 He, when I met with him later - he saw the triage nurse first  
9 and then our Crisis nurse, Heather Wheaton, and then saw me -  
10 the complaint was that he couldn't sleep because of nightmares.

11          **Q.**     Okay. So this document indicates that he attended for  
12 triage at 12:40, I believe, in the upper left-hand corner there,  
13 and the triage nurse also used a numerical triage level. In  
14 this case, it would appear to be a "3", and I think you had said  
15 to us that the triage level, the numerical triage level, is not  
16 something that's particularly relevant to your consideration of  
17 a patient in Emergency?

18          **A.**     Most of the time, I don't see or don't look at the  
19 triage note and that's simply because someone else will have ...  
20 I don't see anyone till they've seen either our Crisis nurse or  
21 the ER physician and who will have written much more extensive  
22 notes, so it's usually those notes that I look at before I see

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1 the patient.

2 Q. Okay. So in this case, given that Lionel Desmond  
3 appeared at the hospital at 12:40, which I take to be p.m.,  
4 during the day, the Crisis team was available to meet with him  
5 that day?

6 A. Our process has evolved over time. At one time, we  
7 would sometimes intercede when we knew there was someone who had  
8 been to triage and was waiting with a mental health concern and  
9 our Crisis nurse would see them before the ER physician.

10 Currently, the process is they have to wait until the ER  
11 physician has seen them, which is often a considerable wait, and  
12 so I don't remember what we were doing at that point in time.

13 Q. Okay. The triage record, so when you did see him,  
14 that would be something that would be available to you, would  
15 it?

16 A. I'm sorry. Would you repeat the question?

17 Q. Sure. This Emergency triage record, when you did see  
18 Lionel Desmond that day, you would have that document?

19 A. It would have been available. I have no recall  
20 whether I saw it or not but it would have been available.

21 Q. Okay. All right.

22 A. I do recall that I had the Crisis note available and I

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1 probably read that and didn't look at the triage note.

2 Q. Okay. So if we go over one more page to page 7, so  
3 this is the Crisis note that you're referring to, or the Crisis  
4 ...

5 A. Yes.

6 Q. I guess it's entitled "Crisis Response Service Mental  
7 Health Risk Assessment". This is the document that would've  
8 been completed by Heather Wheaton?

9 A. Yes.

10 Q. Heather Wheaton is a mental health nurse, is she, at  
11 St. Martha's?

12 A. Yes.

13 Q. And was at the time?

14 A. Yes.

15 Q. So would Heather Wheaton had seen Lionel Desmond prior  
16 to you seeing him?

17 A. Yes.

18 Q. And would she have completed this document before you  
19 saw him?

20 A. Not necessarily, and I don't recall ... sometimes  
21 there will be ... she will have, or whoever is doing that role,  
22 will have completed the note before I see them. Sometimes they

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1 won't have started it and sometimes it's partly done and they  
2 finish it after they've seen me. It partly depends on when they  
3 call me and when I'm available to come down and see the patient,  
4 so it varies a little bit.

5 Q. Okay. And in this case, do you recall how much of the  
6 risk assessment tool would have been completed?

7 A. No, I don't.

8 Q. Okay. Whatever was completed, you would've had at  
9 your access, though?

10 A. Yes.

11 Q. Okay. When you see patients - and I'll ask generally  
12 first - in a circumstance such as this, does the mental health  
13 nurse work with you or do they see the person separately from  
14 you?

15 A. They see them first by themselves. More often than  
16 not, when I come down on her floor, when I come down and see  
17 them, usually, they sit in with me and we do a joint reinterview  
18 or at least a new one for me.

19 Q. Okay. In this case ...

20 A. She was present when I saw him.

21 Q. Heather Wheaton was present?

22 A. Yes.

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1           **Q.**    Okay.  And do you have a recollection of how long she  
2 would've been with him prior to you coming down to see him on  
3 that day?

4           **A.**    No.

5           **Q.**    Okay.  I assume you would have an opportunity to speak  
6 to the mental health nurse before seeing the patients?

7           **A.**    Yes.

8           **Q.**    And get their impressions of the person?

9           **A.**    Yeah.

10          **Q.**    Okay.  Typically, a mental health nurse will complete  
11 a document.  Now this is the one that was in place in 2016, but  
12 this will be a guide for their use?

13          **A.**    It's likely she had it all completed or most of it  
14 completed.

15          **Q.**    Okay.

16          **A.**    But I don't remember.

17          **Q.**    Now when you saw Lionel Desmond on the 24th of October  
18 - and perhaps we can go back to page 4 - this is the chart that  
19 you would have completed when you saw him?

20          **A.**    Yes.

21          **Q.**    All right.  And the handwriting on this document is  
22 yours.



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1           **A.**    Pretty ... obviously I ...

2           **Q.**    All right, and so again, just if you could review for  
3 us again, what was the nature of the information that you  
4 obtained and the nature of the concern that Lionel Desmond  
5 presented with on October 24th?

6           **A.**    What I remember of that time, and I remember left more  
7 of an impression than anything, his wife did most of the talking  
8 and they were both somewhat emotional.

9           His complaint was that he was having trouble sleeping  
10 because of nightmares and wanted some help with that. Along the  
11 way came the story that he was having PTSD-types of symptoms  
12 such as flashbacks and the nightmares and so on.

13           It was quite clear that there was a lot of arguing going on  
14 between them. There was some - a little bit, I think - in the  
15 interview itself and they were talking about years of that going  
16 on. I could go into that a bit more.

17           He also, or she - I don't know who - it came up that his  
18 nightmares would sometimes relate to his military experiences  
19 but, at that time, more of them related to nightmares that his  
20 wife was cheating on him and he would wake up angry or whatever  
21 about that and distressed. And she was annoyed with him because  
22 he was often away when she expected he would be home from

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1 military deployments.

2 And so we talked a bit about that, I think, but the  
3 underlying reason he was there was to get something done about  
4 his sleep so I increased the medication that might, or usually,  
5 helps nightmares and PTSD. I gave him something to help him  
6 sleep.

7 Q. The interview you had with Lionel Desmond and his  
8 wife, that was in an interview-type room, was it, in the  
9 Emergency Department?

10 A. I don't think so. As I remember it, I think it was in  
11 one of the regular ER rooms that medical patients go to with  
12 curtains around. I'm not sure about that but I think so. I  
13 vaguely remember sunlight coming in which would've come in  
14 through one of those rooms.

15 Q. Did you know Shanna Desmond at that time?

16 A. I don't think so. She, somewhere around that time or  
17 shortly after, joined our nursing staff in the Inpatient Unit,  
18 but I think I saw her there once. I have no idea when that was.

19 Q. Okay. So not sure if she had started ...

20 A. I didn't really know her. I don't normally work in  
21 Inpatients and she was new around that time or shortly after.

22 Q. Okay. And it was just the two of them then that were

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1 present?

2 **A.** And Heather.

3 **Q.** And Heather, okay. The sense you got of the  
4 interpersonal conflict between the two of them, you said you saw  
5 a little of that in the interview, did you?

6 **A.** Yeah. They were ... I think they were ... I vaguely  
7 remember they seemed irritated with each other. They weren't  
8 yelling at each other but he was frustrated with her and she was  
9 frustrated with him.

10 **Q.** To the best of your recollection, did either of them  
11 describe that interpersonal conflict that had been ongoing in  
12 their relationship?

13 **A.** Oh yeah. She took it way back to when he was in  
14 Germany and he got called to Germany to play in the military  
15 band and he had said he'd be home for that week but he got  
16 called away and she'd be disappointed that he wasn't there and  
17 he was frustrated because he couldn't help being told to go  
18 somewhere else. That kind of thing.

19 **Q.** And he said that the nightmares that he was  
20 experiencing at that time were predominantly about their  
21 marriage and his wife's fidelity more so than his ...

22 **A.** Yes.

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1           **Q.**   ... experience in war?

2           **A.**   Mm-hmm.

3           **Q.**   What did you make of that? Anything?

4           **A.**   Clearly, jealousy was one of the problems. Can't say  
5 any more than that at this point. I didn't, at that time, go  
6 into it. I don't know that I did a lot later. It was a  
7 problem. It wasn't ... So that was an issue. I didn't spend a  
8 lot of time going into that. I just noted that that was there.  
9 I didn't note it on here, but I noted it and it's something that  
10 would have to be dealt with later. There were other things I  
11 was more focused on to start with. The PTSD.

12          **Q.**   Do you have a sense of how long you, yourself, were  
13 with Lionel Desmond?

14          **A.**   I don't know. I would guesstimate that it was  
15 somewhere between 15 to 30 minutes. It wasn't an hour, it  
16 wasn't ten minutes.

17          **Q.**   Do you remember anything about his presentation that  
18 day? His mood or affect or demeanour? Any of that?

19          **A.**   I think he seemed ... the word that comes to mind is  
20 subdued.

21          **Q.**   Yes. Right.

22          **A.**   Because she seemed to be doing the majority of the

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1 talking and had a lot to say about things.

2 Q. Okay. So his complaint at that time was the  
3 nightmares and how they interfered with his sleep.

4 A. It also came out that he would get angry at times and  
5 sort of pound tables, maybe throw things, that kind of thing.  
6 But the important thing, I think, for me is that he said and she  
7 said he never hit her or physically was violent toward her and  
8 she said she wasn't afraid of him.

9 Q. Okay. Did that information come ... was that  
10 volunteered by one or the other of them or did that have to be  
11 elicited with questions?

12 A. I think we would've asked whether he hit her. I think  
13 she would've volunteered that she wasn't afraid of him.

14 Q. So his chief complaint was the nightmares and his  
15 inability to sleep because of them. Did you know at that time  
16 whether he was on medication and did you change his medication?

17 A. He was on something we call quetiapine to help him  
18 relax and sleep, and he was on a sleeping pill, zolpidem, and so  
19 I believe those were the two.

20 Q. You said "quetiapine" and "zolpidem"?

21 A. Zolpidem. Uh-huh.

22 Q. Quetiapine is for what?

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1           **A.**    It's used for different things.  In that dosage, it's  
2 used for helping people relax if it's taken during the daytime  
3 and to sleep at nighttime.  At much higher doses, it's used for  
4 psychosis.

5           **Q.**    Okay.  His dosage wasn't being used as an anti-  
6 psychotic drug?

7           **A.**    No.  He was on about 75 milligrams a day.  It would  
8 have to be up around 800 to be an effective anti-psychotic.

9           **Q.**    Okay.  I see reference to another drug.  Prazosin.  
10 What is that?

11          **A.**    That's an alpha-adrenergic.  It's sometimes used for  
12 blood pressure and that kind of thing, but it has been found  
13 often effective for nightmares from PTSD.  It doesn't help any  
14 other kind of nightmares and we don't know why it helps but it  
15 does.

16          **Q.**    Nightmares only from PTSD?

17          **A.**    Yes.

18          **Q.**    Interesting, and we don't know why that is?

19          **A.**    It is interesting but I don't know why.

20          **Q.**    Okay.  And I think when you first started to discuss  
21 that drug, you referenced the category of drug it is.  What was  
22 that again?

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1           **A.**    I believe it's an alpha-adrenergic drug. That just  
2 means that it stimulates receptors, which receptors it  
3 stimulates (on neurons?).

4           **Q.**    Okay. In this case, it would appear that you  
5 increased his dosage of prazosin?

6           **A.**    Yes.

7           **Q.**    So is that from two to four milligrams? Am I reading  
8 that correctly?

9           **A.**    Yes.

10          **Q.**    Okay. Why the increase in the dosage of that  
11 particular drug?

12          **A.**    The dosage that I consider for that purpose is  
13 somewhere between a milligram and five milligrams a day. Most  
14 people respond to two. Sometimes go up to three. He was having  
15 quite a bit of difficulty but had gotten some benefit, so I  
16 thought we'd go up to four.

17          **Q.**    He indicated some benefit from the prazosin?

18          **A.**    Yes.

19          **Q.**    Okay. And given that he indicated he had a diagnosis  
20 of post-traumatic stress disorder, but his nightmares also  
21 related to his marriage situation, was it your opinion that  
22 prazosin might still nonetheless be of assistance to him?

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1           **A.**    I don't recall what I thought about that but he said  
2 it helped his nightmares so I increased it.

3           **Q.**    Okay. And then you started another drug, trazodone.

4           **A.**    Yes.

5           **Q.**    What is trazodone and why did you start that?

6           **A.**    Trazodone is used a lot for sleep, particularly for  
7 people who wake up in the middle of the night and have trouble  
8 going back to sleep. In higher doses of 200 milligrams or more,  
9 it used to be used as an antidepressant, but it made people too  
10 sleepy so we stopped using it. But as a side effect, it does  
11 help people sleep then, so most people are on 50 to 100  
12 milligrams of it to help them sleep and it's particularly  
13 focused more on staying asleep than falling asleep, whereas the  
14 zolpidem is more for falling asleep and not so good at keeping  
15 asleep.

16          **Q.**    Okay. So two different aspects of sleep, I guess  
17 then.

18          **A.**    Yes.

19          **Q.**    And the quetiapine, though, that doesn't assist with  
20 sleep so much?

21          **A.**    That helps with sleep, again with the sort of staying  
22 asleep side of things and it has some advantages like trazodone



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1 that it's not addictive and one doesn't develop tolerance to it,  
2 whereas zolpidem, one can develop some tolerance to it but then  
3 doesn't work quite so well.

4 **Q.** Was your thought or advice to him that some of these  
5 sleeping medications would be taken as needed or would he take  
6 them regularly?

7 **A.** Yes, you can do that. Usually, we would use the  
8 zolpidem that way. The quetiapine and the trazodone less so  
9 because it's harder to tell whether you're going to wake up in  
10 the middle of the night or not, whereas you kind of know better  
11 if you're likely going to fall asleep or not. So it's a bit  
12 subjective.

13 **Q.** Right. Okay. To your recollection or from what you  
14 understood, did he have a family physician at that time?

15 **A.** I'm not clear about that. I know he was later  
16 referred by one of the family doctors here in Guysborough, Dr.  
17 Ranjini Mahendrarajah. I don't recall if he was actively  
18 involved at that time, but they had one practice anyway, so  
19 everyone in this area would, I think, go to that practice, so  
20 I'm not quite clear.

21 **Q.** Okay.

22 **A.** And he had just come back to Nova Scotia from being

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1 away for a long time, so I'm not sure.

2 Q. Right. From the information that either you gleaned  
3 or Heather Wheaton did, you understood that he was a veteran.  
4 Did you have an impression of whether he was, at that time, in  
5 October, obtaining services through Veterans Affairs Canada or  
6 whether he had attended at the OSI Clinic? Anything like that?

7 A. He said that he had been followed in New Brunswick by  
8 OSI Fredericton, as I call it, and I don't know the details of  
9 what that involved, but he had been followed by them and he was  
10 told when he came to Nova Scotia he would be followed by OSI in  
11 Cape Breton, but it hadn't been set up yet, he was told, and so  
12 he had to wait for them to open up before he could get services.  
13 That's what I understood.

14 Q. Okay. And that was from him, to the best of your  
15 recollection?

16 A. That was from him.

17 Q. Okay.

18 A. And his wife, I guess.

19 Q. And his wife. Right.

20 I note in page 8 of the ... this is in Heather Wheaton's  
21 document and, again, I appreciate it's her handwriting, but in  
22 the "Social History" at the bottom, she had written, "He had

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1 trouble navigating Veterans Affairs system. Worries about what  
2 they will offer and what they will cover. Waiting for a  
3 Veterans Affairs case manager in Nova Scotia. Transfer not  
4 complete."

5 Does that accord with your recollection?

6 **A.** That's the same thing, yeah.

7 **Q.** Okay. When Heather Wheaton saw him, she completed the  
8 suicide risk assessment and categorized him as low on that  
9 occasion on October 24th. I don't know whether she would've  
10 completed that particular tool when you met with him or not.  
11 You may not remember that specifically. Did you have an  
12 impression about his suicide risk, if any?

13 **A.** I did. I thought it was low.

14 **Q.** Okay, and why do you say that?

15 **A.** He said he didn't have suicidal thoughts. That's what  
16 I heard. And he didn't have any acute risk factors that I was  
17 aware of. Anyway, he said he wasn't having suicidal thoughts.  
18 He was having trouble sleeping. He was mildly depressed. There  
19 was nothing to indicate that there was an acute risk or a high  
20 risk or moderate risk.

21 **Q.** The suicide tool that was completed indicates suicidal  
22 ideation but no intent or plan.

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1           **A.**    When I was with him, he said he had no suicidal  
2 thoughts, so I can't comment on that part of it.  Though,  
3 looking at the suicide risk tool that you put up there, so he  
4 did have intense emotions and he was depressed.  There was a  
5 history of trauma, but nothing that makes you think this man, in  
6 the near future, is at risk of doing something.

7           **Q.**    Okay.

8           **A.**    We see a lot of people.  Almost everyone I see has ...  
9 when I first see them has some degree of suicidal thoughts,  
10 usually very mild, what we call "passive" suicidal thoughts,  
11 without any intent or plan.  So it's an every morning/afternoon  
12 thing seeing people like this.  And so some people have ... you  
13 know, it could happen but this doesn't look like something we  
14 need to worry about at this time ...

15          **Q.**    Right.

16          **A.**    ... unless things change.

17          **Q.**    I guess one could say everyone in this room has  
18 suicidal ideation right now because we're discussing it.  I  
19 guess ...

20          **A.**    Well not ... Most people will say, Well, I wondered  
21 about it once or twice but ... but most people who say that  
22 never ... and know this, never seriously thought of doing

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1 something, they just think about it but ...

2 Q. The distinction, and it may be clear, but the  
3 distinction between suicidal ideation and actual intent and a  
4 plan, can you just ...

5 A. The only ...

6 Q. ... how do you differentiate those?

7 A. So I've said that the vast majority of people have had  
8 some sort of suicidal thoughts. Very uncommon for me to find  
9 someone who never has when I ask them. A much smaller group  
10 have actual intent and a much smaller group go on to plan it.  
11 So there's a huge spectrum.

12 And we can't ... as some ... one person once said to me,  
13 Why can't you lock him up and keep him there forever? Can't do  
14 that. I can put you in the hospital today and say you might  
15 have had a suicide thought once but that doesn't make any sense.

16 Q. Right. No, understood.

17 There is a reference in the social history, sorry, in the  
18 crisis document in "Substance Use and Addiction History" about  
19 previous medical marijuana. Did you ... at that time in  
20 October, did you discuss that at all with him or did that come  
21 up at all?

22 A. Yes, we talked about it both times I saw him so I

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1 don't know which was which, but he said that he had been put on  
2 medical marijuana by one of his military physicians to treat the  
3 PTSD or to treat the nightmares. He said it helped him sleep  
4 but he also said that, and then it wasn't it wasn't clear to me  
5 now anyway, that the nightmares of his wife cheating on him  
6 either started at that time or became worse at that time.

7 **Q.** Yes.

8 **A.** It's probably they became worse but I'm not sure.

9 **Q.** All right. In your experience, does cannabis, can it  
10 increase or exacerbate paranoid thinking?

11 **A.** Yes.

12 **Q.** In Heather Wheaton's mental status exam, she ...  
13 again, many of the things you've said there are recorded:

14 32-year-old male; black; slightly unkempt;  
15 in sweat clothes; angry outbursts that occur  
16 suddenly and are followed by return to low  
17 mood; anxiety; paranoid thoughts about wife;  
18 general distrust of all people; feeling  
19 tired and overwhelmed and unsure about how  
20 best or how to best get or receive help;  
21 suicidal ideation but no intent or plan;  
22 affect downcast and speech tangential; wants

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1           to talk to about military experiences.

2           A lot of things there but is that the way that you saw him  
3 that day?

4           **A.**    Yeah, that was the impression. Yeah. And I should  
5 say perhaps that when someone comes in and seeing a crisis  
6 worker and we're discharging him home, not admitting them, then  
7 my notes are usually short because I use the crisis note as my  
8 larger record of what's gone on.

9           **Q.**    Sure. Okay, no. And just one small thing there, she  
10 described his affect as downcast. You described him as subdued,  
11 I think. She also said his speech was tangential.

12          **A.**    Yeah.

13          **Q.**    Did you find that or do you recall?

14          **A.**    I don't recall that part of it.

15          **Q.**    Okay. He did want to talk about his military  
16 experiences or ...

17          **A.**    I don't recall that. I see a lot of new people each  
18 week. I don't remember clearly from years ago this ...

19          **Q.**    Sure. No, understood, Doctor, I ...

20          So you had made the changes to his prescription medication  
21 and he was discharged, I guess, to home? Is that the way ...

22          **A.**    Yes.

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1           **Q.**    He was sent home basically?

2           **A.**    Yes.

3           **Q.**    Okay. Was there any discussion of follow-up at that  
4 time?

5           **A.**    I said to him that I thought he needed services and I  
6 was concerned when he said that he was waiting for services to  
7 be set up in Cape Breton my expectations that that was going to  
8 happen soon were pretty poor, so I thought that he should be  
9 followed by somebody. So I said to him that if he ... he was  
10 expecting a phone call or something from them I think a couple  
11 of days later, and I said that if services weren't going to  
12 start very quickly then I would be happy to see him again to dig  
13 deeper into what was going on and look at what we could do to  
14 help him as a cover up, not a cover up, to cover until he was  
15 picked up by OSI, but he would need a referral from his family  
16 doctor. So if nothing was going to come after this phone call  
17 to get a referral and that's what he did.

18          **Q.**    Okay. And the anticipation was that that would be in  
19 the outpatient clinic, is that correct?

20          **A.**    Yes.

21          **Q.**    Okay, all right. So he did, in fact, get the referral  
22 from Dr. Mahendrarajah, which I think is on page 13 of Exhibit



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1 ...

2 **A.** Yes.

3 **Q.** ... 16, and he would then have contacted the clinic to  
4 arrange an appointment. Is that typically how it would work?

5 **A.** No, the letter would have gone to us and we would have  
6 called him.

7 **Q.** Yes, okay. And the individuals who typically do the  
8 scheduling in the outpatient clinics are whom?

9 **A.** It probably would have gone to what was then our  
10 intake nurse. We had a nurse who looked at referrals and ...  
11 called the intake nurse, and she would have either assigned him  
12 to somebody, which was me, or she might have called him to get  
13 some more information, but I expect it just went straight to me.

14 **Q.** I see.

15 **A.** That is to say, to our secretaries to book. Somebody  
16 booked it, she did or administrative staff.

17 **Q.** Understood. So just because you had seen him in  
18 Outpatients, it wasn't necessarily going to be you that he would  
19 see at the appointment at the Outpatients clinic?

20 **A.** No, we ... our rule has been that we assign them to  
21 see whoever seems the most appropriate as well as being  
22 available.

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1 Q. Okay.

2 A. But it made sense that he see me so he saw me.

3 Q. Okay. And that appointment was on December 2nd ...

4 A. Yes.

5 Q. ... 2016? All right.

6 And so what can you tell us and I'll ... maybe just you can  
7 go to page 26.

8 A. Which number is that?

9 Q. Same exhibit, we'll just go over a couple of pages to  
10 your page 26 in Exhibit 67.

11 A. Okay.

12 Q. So this is your note that was created as a result of  
13 your meeting with him on December 2nd, 2016?

14 A. Yes.

15 Q. All right. So when you saw him on December 2nd, 2016  
16 at the outpatients clinic, where would you see him? How would  
17 that be set up? And can you just describe the physical layout?

18 A. I ... we're at one end of the hospital on the third  
19 floor. We have a waiting room, a front office where the  
20 clerical staff are. And I would have gone out to the waiting  
21 room and found him and then walked him down the hallway to my  
22 office at the other end of that section. And I would have sat

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1 down in my office and I would have sat in my chair and we would  
2 have had an interview, he came by himself.

3 Q. Okay. Now you see, I assume, a number of patients,  
4 new patients, in the outpatient clinic on a regular basis ...

5 A. Yes.

6 Q. ... do you? Like how many, for example, in a week  
7 might you see?

8 A. I ... when ... on days that I'm not covering the ER  
9 when I have to allow a little extra space I see two new people,  
10 one in the morning, one in the afternoon ...

11 Q. Okay.

12 A. ... and then follow-ups after each of those.

13 Q. And you had said earlier that the appointments are  
14 usually an hour or a bit more?

15 A. I schedule two hours. The length varies, but I would  
16 say that most people take about an hour and 10, 15 minutes ...

17 Q. And ...

18 A. ... that I'm with them.

19 Q. Right. And during the time that ...

20 A. He was probably longer.

21 Q. This particular one was longer you said?

22 A. I'm thinking from what I've written in here he would

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1 have taken longer than that.

2 Q. Okay. The information that you obtained on December  
3 2nd compared to what you might in some other appointments leads  
4 you to think that this appointment was longer?

5 A. He was quite complex in terms of a number of different  
6 problems. Each problem takes a certain amount of time to kind  
7 of get into and so there was quite a lot going on and I didn't  
8 really get it all done.

9 Q. Okay. So, in general, when a person comes to an  
10 appointment like that, they will have ... you said earlier you  
11 would have access to the records if they were seen in hospital.  
12 Do they come with other material or generally not?

13 A. Well, the patient themselves walks in and doesn't  
14 usually have anything.

15 Q. Mm-hmm.

16 A. Sometimes they've written notes to ... they want to  
17 pass over to me but generally they come with nothing.

18 And if they have hospital records from our own hospital, I  
19 can get those quite easily. If they come from somewhere else in  
20 the province I would sometimes ... not always but quite often  
21 request through our secretary that the health records department  
22 of that hospital and now the Health Authority, that they send

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1 certain records that I would identify that I want.

2 Q. Okay. And you might or might not know that those  
3 records exist prior to the appointment, I take it?

4 A. I wouldn't. Unless the referral has indicated or I  
5 ... something in the referral has indicated they might have been  
6 in a hospital recently which makes me look at MEDITECH then I  
7 wouldn't know until they tell me.

8 Q. Right. So when someone comes in for an appointment in  
9 the outpatients clinic, if you know in advance that, for  
10 example, they've seen a psychiatrist in another province ...  
11 well, I guess there's really nothing you can do until they come  
12 in.

13 A. Usually, I ... if I did know that I wouldn't get the  
14 records beforehand. I wouldn't know usually what province or  
15 what psychiatrist or what ... more importantly what hospital and  
16 ... or how it would fit into things. So I see them and then if  
17 I need records I go looking for them.

18 Q. Okay. And again, speaking generally, when a person  
19 comes for an appointment at the Outpatients Clinic, how do you  
20 approach the interaction with them to begin? What types of  
21 questions do you ask them and how do you get them to begin to  
22 describe their problem to you?

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1           **A.**    Okay, walk in. I walk in first because they don't  
2 know which door to go in, and I point to the office and say,  
3 Have a seat. We sit down. I might say I understand such and  
4 such from the referral letter, usually I will do that.  
5 Sometimes I'll ask them for ... you know, what brings you here  
6 or what are you wanting, but usually it's I just do a short  
7 summary to show I've actually paid attention to what I've gotten  
8 already and I'm very broad and vague because I want to hear what  
9 their perspective is.

10           And then the first while is predominantly focused on  
11 listening, encourage them to tell their story, whatever has been  
12 going on, and then ... because it's important to me that people  
13 come to see me with a story or context. It's not just about,  
14 say, symptoms or illness, so I want to know in particular what's  
15 contributing to, triggering, what's helping, that kind of thing.  
16 So I try to get them to talk to me for a while and then I start  
17 getting more specific with my questions.

18           **Q.**    All right.

19           **A.**    Something like that.

20           **Q.**    On this particular day when Lionel Desmond attended at  
21 Outpatients, at the clinic, was he alone or with someone?

22           **A.**    He was by himself.

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1           **Q.**   And ...

2           **A.**   I also should say I absolutely do not remember the  
3 interview, so all I have is this consult.

4           **Q.**   You have your notes which appear comprehensive. They  
5 assist you in ...

6           **A.**   I ... I can tell from the way I write them whether ...  
7 what I meant by ... because I sort of have standard ways and  
8 when I differ from that that tells me something.

9           **Q.**   So, again, having reviewed your ... the note that you  
10 created on December 2nd, what do you recall of Lionel Desmond's  
11 presentation when he came in, his ... and how he appeared to  
12 you?

13          **A.**   Well, I essentially have to go to mental status  
14 examination on the second page which said that he presented as  
15 pleasant; depressed; he was calm and appropriate; rapport was  
16 fair. That would be the usual way I would record that for most  
17 people. His affect was depressed. His speech was articulate  
18 and normal in rate and amount. Most people with more severe  
19 depression I would say the amount was shortened but I didn't  
20 here so that to ...

21          **Q.**   Sorry, I just didn't hear that. What was that?

22          **A.**   I'll say that again. His demeanour, his affect was to

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1 somewhat depressed ...

2 **Q.** Yes.

3 **A.** ... that can vary a lot in severity. I did note ... I  
4 usually talk about whether someone is articulate, and when they  
5 speak if I can make out what they're saying, for example. I  
6 talk sometimes about how fast they're speaking or how softly,  
7 and whether they talk a lot or very little or kind of the normal  
8 amount and I've got him down here as normal amount.

9 Most people with a significant depression I have found I  
10 record them as speaking a small amount, a reduced amount. They  
11 don't talk a lot.

12 **Q.** That's typical of patients who present with major  
13 depression?

14 **A.** Severe ... more severe. Well, major depression  
15 covers a wide range; a very mild depression despite the name up  
16 to very severe.

17 **Q.** Okay.

18 **A.** But if it's more severe people tend to talk less.  
19 They give very short answers.

20 **Q.** You found him, though, more willing to speak and  
21 express himself?

22 **A.** Yes.



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1           **Q.** All right. And ... go ahead.

2           **A.** Well, as I just said, so his ... I say his thought  
3 process coherent and rational. In other words, he's not  
4 tangential as we heard in the ER visit in October, so he's  
5 speaking logically, that sort of thing, not psychotically.

6           He did report jealousy again. We see people with ... who  
7 are jealous in our practices. That ranges very widely from sort  
8 of a little bit to a lot and I judged his thoughts of jealousy  
9 to be what we call overvalued.

10          It's hard to explain, but some people would have a thought  
11 of something that is more a little irrational and held more  
12 strongly than the average person would have and so to a certain  
13 point we call that overvalued, so you might say it means over-  
14 emphasized. And so I thought his thoughts of jealousy were like  
15 that and I don't know if I said it here.

16          I said bordering on delusional. I wasn't writing that for  
17 the Inquiry. What I meant ... mean by that is not that he ...  
18 he does not have ... did not have delusions in my mind.  
19 Delusions is a fixed belief that doesn't change and persists and  
20 is unrealistic. So his weren't within that circle that we would  
21 call delusions, it was outside the circle, but it was  
22 approaching the circle moreso than someone with very minor

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1 thoughts of being ... just lack of confidence that their partner  
2 was being faithful.

3 Q. So a delusion is a firmly-held but false belief?  
4 Something that's ...

5 A. Yes.

6 Q. ... unshakable in the patient?

7 A. Yes.

8 Q. His thoughts of jealousy and concerns about his wife's  
9 fidelity were not in that category you say or not to that  
10 extent?

11 A. No.

12 Q. But you thought that they were overvalued. So the  
13 impression you had was that they were not based in fact but not  
14 held as ... with the same degree of force or regularity. Am I  
15 putting that correctly?

16 A. I thought he got more concerned and anxious about the  
17 possibility of her being unfaithful than was probably warranted.

18 You have ... the problem with jealousy you never actually  
19 know what the truth is, whether the other person is, and one has  
20 to make a kind of a ... sometimes it's hard to say. I've had  
21 people where you know, maybe she's right, I don't know. But in  
22 this case it was my sense that that probably wasn't true, but he

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1 was more concerned about it than that he had any evidence for  
2 it. It was based on nightmares for the evidence, where his  
3 imagination presumably was going. And yet once ... after the  
4 nightmare passed for a while he was able to let that go and see  
5 that that wasn't true.

6 **Q.** Okay. Did you have the impression that he had those  
7 thoughts while awake or was it solely when he was having  
8 nightmares?

9 **A.** No, he would have them for a while when he was awake  
10 otherwise it wouldn't matter if he was asleep when he had them.  
11 But they would last ... I don't have down how long, but I think  
12 it was a number of hours. I don't know how many hours but for a  
13 while. After he'd wake up he'd have them for a little bit and  
14 then they would gradually go away.

15 **Q.** Yes.

16 **A.** Something like that.

17 **Q.** Okay.

18 **A.** I don't remember specifically but that was the  
19 impression I had.

20 **Q.** Was this something that he talked about a lot, I mean  
21 ...

22 **A.** He talked about it and his wife talked about it as

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1 well when I saw them in October.

2 Q. She was aware of it in October?

3 A. Oh yes, yeah.

4 Q. All right.

5 A. They could both talk about it.

6 Q. So there ... I think you've described his presentation  
7 or his various conditions as complex or a number of different  
8 conditions ...

9 A. Yes.

10 Q. ... going on at the same time. And I assume there's  
11 some inter-relationship or ...

12 A. Well, yes.

13 Q. ... overlapping, I guess, of those various ...

14 A. And ...

15 Q. ... conditions?

16 A. ... that, I think, is the problem. Why I later say he  
17 needed a higher level of service. Any one of those things by  
18 themselves would be one thing but all of them together are a big  
19 problem.

20 Q. So one of the things that he had discussed with you  
21 and had previously been diagnosed for was the post-traumatic  
22 stress disorder.

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1           **A.**    Yes.

2           **Q.**    To the extent that you do ... was he willing to talk  
3 about the genesis of that, I guess, and his war experiences and  
4 ...

5           **A.**    Oh yes.

6           **Q.**    All right. So the symptoms that he endorsed, they  
7 were consistent with post-traumatic stress disorder?

8           **A.**    Yes.

9           **Q.**    Okay. He had a variety of those symptoms beyond ...

10          **A.**    It was quite clear-cut. So he described he spent  
11 seven months in Afghanistan, I think, in 2007 and he described  
12 his main role was retrieving bodies, which to me sounds pretty  
13 awful. And so he would be ... they would be going out on  
14 patrols at night. He seemed to emphasize they would be looking  
15 for land mines in front of them, they would have gunfire going  
16 overhead he described, or they would be in a little building  
17 with gunfire going on. So he was often under fire, watching out  
18 for land mines, couldn't see very well, and retrieving, you  
19 know, blown-up bodies. That was his job. And he'd be firing  
20 back too, I'm not quite sure about how that worked. And though  
21 he had a lot of horrific memories of that, that's basically what  
22 I got about that.

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1           **Q.**   And you had made a note of the various symptoms:  
2   flashbacks, nightmares, anxiety, high alert, depression,  
3   difficulty coping with noise and avoidance.  Are those all  
4   symptoms that ...

5           **A.**   Yes.

6           **Q.**   ... are consistent with that ...

7           **A.**   Yes.

8           **Q.**   ... diagnosis and with his experience?

9           **A.**   Yes.

10          **Q.**   All right.  To the extent that you could, were you  
11   able to form an opinion on whether that diagnosis of PTSD was an  
12   accurate one?

13          **A.**   He had clear-cut PTSD.  I would add, though, that he  
14   described his symptoms as improving to some extent from what  
15   they used to be earlier closer to the war.  So he said the  
16   flashbacks and nightmares were less frequent ...

17          **Q.**   All right.

18          **A.**   ... but he still had all of those symptoms.

19          **Q.**   When he saw you on October 24th, I think you said  
20   earlier, that those symptoms were lessening and his thoughts of  
21   perhaps jealousy with his wife were increasing or ...

22          **A.**   So the nightmares were less often about combat

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1 experiences and more often about his jealousy. I didn't ask him  
2 what exactly he imagined or had experienced in the nightmares  
3 for jealousy but that's what he said they were about,  
4 infidelity.

5 Q. There are a number of symptoms, I would assume,  
6 consistent with a post-traumatic stress disorder diagnosis, is  
7 paranoia one of them?

8 A. Yes. It's not a specific symptom of PTSD but PTSD is  
9 essentially kind of a severe fear, reaction to a traumatic event  
10 ...

11 Q. Yeah.

12 A. ... that persists and doesn't go away. You don't lose  
13 the memories and you tend to avoid things that cue recall of  
14 those experiences. The flashbacks are memories but it's not  
15 just a memory but you relive the experience as though you're  
16 right there.

17 The nightmares are remembering the experiences or similar  
18 types of experiences and so you avoid situations that will  
19 trigger that, that re-experiencing type of thing. Along with  
20 that, this ... you can have quite a wide variety of other kinds  
21 of that I call negative symptoms in a sense of like depression  
22 or anxiety or paranoia or withdrawal from people, things like

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1 that.

2       **Q.** The paranoid thinking with respect to his wife, did  
3 you get a sense whether there was a relationship with his post-  
4 traumatic stress disorder or were they more distinct?

5       **A.** I didn't get into quite where that related. I made a  
6 note of that I think somewhere in there. I suspected that it  
7 was a response to different things going on. What I didn't have  
8 a good handle on was to what extent he might or might not have  
9 had that beforehand. It's possible that there was some degree  
10 of being a little bit unsure of his wife before that, not that  
11 there was any evidence but I didn't know if there was or there  
12 wasn't. But a lot of people at his age that felt their wife was  
13 being unfaithful would have been like that at age 20 as well, so  
14 I ... there was so much to cover that day I didn't ... the  
15 jealousy part I didn't get into in detail.

16       **Q.** All right. I had asked you earlier about your  
17 recollection either on October 24th or December 2nd about his  
18 history of substance use and abuse, if any. He had a history of  
19 medical marijuana. Did he discuss that with you or did you get  
20 into that with him?

21       **A.** He said that he had been started on it for ... I  
22 think, for the nightmares, the PTSD, and he had stopped it



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1 because he found it might have helped his sleep, I think, but it  
2 made him feel worse and the jealousy was worse so he had stopped  
3 using it. He might have started ... I'm not clear, I think he  
4 ... I have something about early 2016, and I think he started a  
5 bit and by the time he saw me in October he had stopped it.

6 **Q.** Okay. And do you have a recollection of how long he  
7 had stopped using?

8 **A.** No, I don't.

9 **Q.** Had he stopped earlier in the year, I think there's  
10 actually a note in your ... a reference in your note to him  
11 having stopped early in 2016. Would his previous use of  
12 marijuana ...

13 **A.** Okay, I'm getting the dates then mixed up. I thought  
14 he started in ... anyway, he had stopped it before we saw him.

15 **Q.** Yes. If it had been a number of months prior to his  
16 seeing you, would that still be having an impact on him?

17 **A.** I wouldn't expect it to be, no. So we see a fair  
18 number of cases each year of people who become psychotic on  
19 cannabis ...

20 **Q.** Yes.

21 **A.** ... and we admit them. Most people can use cannabis  
22 without problems but some people become psychotic on it. We

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1 would usually expect that to settle down over several weeks at  
2 most and then it'd be back to kind of normal after, assuming  
3 they stop using. A few people it might trigger an underlying  
4 psychosis which would continue on but we would usually expect  
5 the symptoms of cannabis use to go away.

6 **Q.** Okay. And did you see an underlying psychotic  
7 disorder in Lionel Desmond?

8 **A.** No. No.

9 **Q.** If, on the issue of his paranoid or jealous thinking  
10 regarding his wife, had she accompanied him that day would you  
11 have had a collateral interview with her?

12 **A.** Yes, I probably would have. If I had continued to  
13 follow him or if he had continued to come back, I would expect  
14 that I would have. If she didn't come in with him I would have  
15 asked for her to come in because I would usually do that.

16 **Q.** All right. There were other medical issues that he  
17 presented with. He had difficulty noting information processing  
18 and what was that related to in your opinion?

19 **A.** I was quite concerned about that. He described having  
20 three falls while he was in service/on service, and I wrote ...  
21 described two of them and the third I didn't ask or I forgot.  
22 But anyway, he had three falls with head injuries that were

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1 probably of the nature of concussions. There was nothing more  
2 than that. And he described some symptoms that I associate with  
3 people who have had head injuries. I'll explain what I mean by  
4 that.

5 I'm not an expert in head injuries but at one time when I  
6 was practicing in New Glasgow I had several young men, four  
7 young men, who all had been in motor vehicle accidents, all had  
8 had head injuries and all had, curious to me, the same kind of  
9 symptoms from that. And they all had difficulties like I've  
10 described here: difficulty processing information, their  
11 emotions were labile meaning they were reactive to situations  
12 and so on, and they all were struggling with this and secondary  
13 depression.

14 And at that time, I had a group where they attended once a  
15 week so I ... (I mean?) once a month where I tried to help them.  
16 At that time there were no services in Nova Scotia to help them  
17 so that's what we did. Anyway, he had that kind. And I've seen  
18 this in other people since. So he had difficulty processing  
19 information.

20 For example, if you would give him multiple instructions,  
21 you know, do this and then go do that, then go do that he would  
22 not be able to remember them all. The example I often use is if

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1 you have to assemble a barbeque, and I have trouble assembling  
2 barbeques, and have lots of directions and sub-steps within  
3 steps and somebody like this would be totally baffled by that.

4 He described having difficulty with conversations. If  
5 there was another stimulus such as a television or radio playing  
6 then it would be hard to follow the person. If the person  
7 talked fast he would have trouble processing and remembering it  
8 or if it was a long conversation so he would lose it. He said  
9 that most of what I said that day he couldn't remember.

10 So you can imagine someone with those kind of difficulties  
11 that ... well, as people ... his wife is talking to him fast or  
12 upset or somebody else is, that he's losing a lot, not picking  
13 it all up and we don't know what he's processing, but it's only  
14 bits of it. And if he's emotional at the same time, it gets  
15 harder to deal with those things.

16 **Q.** And the difficulties, were those primarily from him  
17 describing them to you or were they also observable just in your  
18 interactions with him?

19 **A.** I don't recall that. But sometimes I will see people  
20 who seem to not be following me is what I would pick up.

21 **Q.** Okay.

22 **A.** I remember one person, not him but the same kind of

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1 thing, who would say when he would drive into town, he would get  
2 very rattled because his wife would be talking to him when he  
3 came to heavy traffic or a red light. We don't have any lights  
4 in Antigonish either. He would not be able to track what was  
5 going on in traffic and track his wife's conversation. So he  
6 would really have trouble and start getting irritable and angry  
7 because he had to pay attention to the traffic but couldn't  
8 because there was this conversation going on. So he would be  
9 sort of like that, I think.

10 **Q.** All right. The deficits, I guess, that he described  
11 to you or that you observed, or both, I guess you can't say with  
12 certainty but those quite possibly were related to the  
13 concussions that he suffered in combat?

14 **A.** I would suspect they were from concussions.  
15 Concussions in my ... most concussions don't do that over a long  
16 period of time. They clear up over days, weeks, or months. But  
17 some people seem to have deficits like this long term, in my  
18 experience.

19 **Q.** Okay. You, I think, ultimately used the term post-  
20 traumatic brain disorder. Is that the term that you used to  
21 describe what you saw?

22 **A.** That's a term that I came up in the 1980s to explain

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1 what was going on with these patients that I had because there  
2 wasn't much I could ... we didn't have internet then. I  
3 couldn't find much on it other than the word "concussion" or  
4 "head injury". So I called it that because it seemed to  
5 describe what was going on. Nowadays, it would be a subset of  
6 traumatic brain injury, sort of a post-concussion type of  
7 symptom. But I ... as I say, I've seen it ... see it sometimes  
8 in people who are post-concussion, but I see it when all the  
9 other symptoms have gone away.

10 Q. So traumatic brain injury or post-concussion syndrome  
11 are similar terms to ...

12 A. I would see post-concussion syndrome as a subset of  
13 TBI.

14 Q. Okay. And your term "post-traumatic brain injury",  
15 would also be a subset of traumatic ...

16 A. Yes.

17 Q. ... brain injury?

18 A. Yeah.

19 Q. Okay. Because obviously ...

20 A. And I'm just describing a dysfunctional thing in terms  
21 of their information and emotional processing.

22 Q. All right. And I think you said in your document

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1 that, ultimately, a neurocognitive assessment would be  
2 beneficial for him?

3 **A.** I thought so.

4 **Q.** What was it ... what is a "neurocognitive assessment"?

5 **A.** So there's such a thing as a neuropsychologist and  
6 they specialize in people who have neurocognitive problems.  
7 They have trouble processing information as a result of a brain  
8 disorder or an inherited or acquired disorder and this is  
9 something that can take one or two days to do. It takes a long  
10 time and then they read it and put it together, it helps  
11 understand very specifically what specific cognitive tasks a  
12 person can do and which ones they have difficulty with. And  
13 then you use that to try and put together a rehabilitation  
14 program which help them use the strengths that they have and  
15 work around the deficits that they have; in some cases, perhaps  
16 to improve their deficit area.

17 **Q.** Okay. And, to your knowledge, in this area, are  
18 neurocognitive assessments available?

19 **A.** No.

20 **Q.** And I guess ...

21 **A.** We don't have that in rural Nova Scotia. So in  
22 Halifax and ... the last time I ... I haven't tried for five

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1 years. The last time I tried looking for one, I was told, Well,  
2 you know, we're only doing them within what was then the Capital  
3 Health zone because we don't have enough of them. There's too  
4 much of a demand. And private ones, I think, are ... well, it  
5 used to be \$2000 to get them and people like him don't have that  
6 kind of money.

7 Q. So privately you may be able to access it more quickly  
8 but there's a significant expense.

9 A. Yeah. It's still quite a few months, but you can get  
10 it.

11 Q. All right. His PTSD symptoms and is there an  
12 interrelationship with those and his traumatic brain injury or  
13 traumatic brain disorder?

14 A. I'm not clear about that but there ... PTSD can,  
15 through anxiety and other factors, interfere with some  
16 information processing, so there's probably ... I don't know,  
17 probably a little bit of overlap. But certainly ...

18 He also described having some difficulty in school, what he  
19 called "stumbling". I didn't have time to get into that but he  
20 also described difficulty paying attention through his life, so  
21 there were hints that he might have attention deficit disorder.  
22 And that would clearly overlap with ... that's separate from



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1 what I'm describing, but it would ... the two would not work  
2 well together.

3 Q. And since you raised it, in your documents you had ...  
4 you make reference in the assessment to attention deficit  
5 disorder and you have the initials "R.O.". I assume that's  
6 "rule out," is it or ...

7 A. Yes.

8 Q. Okay.

9 A. I didn't know that he had it, but he certainly was  
10 suspicious that he might have it, so it needed to be ... I ...  
11 when I have something that I haven't ruled out and I'm  
12 considering might ... there's a possibility, I put them on my  
13 list of diagnoses in the parking lot as an R.O. or "rule out" so  
14 that I don't forget to look into it a little more.

15 Q. The suspicion you had about a possible ADD diagnosis,  
16 that was from the oral history he gave you and, in particular,  
17 his education experience or ...

18 A. That he said he stumbled in school and always had  
19 trouble paying attention. And I was ... labeled it may be  
20 possible, check it later.

21 Q. Okay. Had you seen him again, he would have been  
22 tested for it?

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1           **A.**    Would eventually have ... The jealousy and the ADD  
2 were down my list in the sense that my immediate focus that day  
3 was on his PTSD, the depression, and the apparent cognitive  
4 problems.

5           **Q.**    All right. You also diagnosed him with major  
6 depression.

7           **A.**    Yes.

8           **Q.**    And tell us, first of all, what is "major depression"  
9 and then tell us how you diagnose depression.

10          **A.**    So depression means a syndrome or collection of  
11 symptoms. It's not "a" symptom. And so we define depression as  
12 being a set of symptoms or collection of symptoms. DSM,  
13 Diagnostic Statistical Manual, has a number of symptoms listed.  
14 The World Health Organization, ICD, has another set of symptoms  
15 as in a different paper suggesting various symptoms.

16          So, anyway, there's sets of symptoms. And the ones I use  
17 are probably listed in the note here. But it ... for me, it  
18 means that a person's mood is low. Usually, their appetite is  
19 affected. Usually, it's low and they lose weight. Some people  
20 have what we call an atypical symptom and their appetite is  
21 increased and they gain weight. Sleep is usually reduced and so  
22 they have trouble sleeping. Again, some people have an atypical

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1 hypersomnia where they sleep more. Their energy is generally  
2 reduced. They can't enjoy things. They don't take an interest  
3 in things. Their libido is reduced. Their concentration is  
4 poor. Their memory is poor. They have suicidal thoughts.  
5 Their self-esteem is low. They feel guilty. Those would be the  
6 things I would usually consider.

7 **Q.** All right. And Lionel Desmond exhibited some of those  
8 characteristics?

9 **A.** Most of those. Yeah.

10 **Q.** All right. And I think on the first page, actually,  
11 of your note, in the third paragraph, you said ... near the very  
12 bottom you said: "He reports low mood, low appetite with weight  
13 loss, poor sleep, low energy, low enjoyment, low libido, and  
14 poor concentration." So a number of those particular  
15 characteristics?

16 **A.** Yes.

17 **Q.** What distinguishes depression from a major depression  
18 or a major ...

19 **A.** So a major depression means that you have the majority  
20 of the symptoms on the list. It has ... the major has got  
21 nothing to do with the severity of it. A lot of discussions in  
22 the past about what to call it, but it just means that you have

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1 a depression marked by a number of depressive symptoms. And  
2 some people are very mild and some people are very severe.

3 Q. I take it then that the diagnosis of depression in his  
4 case was more easily made? Is that ...

5 A. Yes. Because he was able to describe those symptoms.  
6 Well, the PTSD was easy. He described ... they were all fairly  
7 straightforward.

8 Q. Okay. And when he presented, obviously he had  
9 previously had the PTSD diagnosis. Did he indicate to you, to  
10 your recollection, other diagnoses or did he just talk about  
11 symptoms or how he was feeling?

12 A. I don't recall. I think PTSD was either the only one  
13 or the only one that he emphasized. He did say he had been on  
14 antidepressants before, which implied that someone must have  
15 treated him for depression.

16 Q. All right. You were ... you expressed a concern in  
17 your note that he was not taking an antidepressant at that time  
18 or you found it ... I think "striking" may have been the word  
19 you used.

20 A. "Concern" would be the wrong word. I thought that if  
21 he had been treated for depression, he likely would still be on  
22 an antidepressant. It wouldn't necessarily be appropriate that

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1 he would be, but I thought he likely would be. And so, to me, I  
2 had to ask myself, What does that mean if they don't work, as he  
3 said they didn't, or that they're not treating him for it or ...  
4 it was something where I would have expected someone with a  
5 history of depression, with the kind of level of service he had,  
6 most times would be still on one.

7 **Q.** If a person has a diagnosis of depression and they try  
8 an antidepressant without success, is it typical that they will  
9 try other varieties of drugs?

10 **A.** Usually, one will ... there are, I don't know, 20-odd  
11 antidepressants available in Canada. Research would say that if  
12 someone presents with a moderate major depression, that the  
13 chances of responding to an antidepressant the first time is  
14 about 60 percent.

15 **Q.** 6-0, you said?

16 **A.** 6-0.

17 **Q.** Yeah.

18 **A.** That's not very good. And if you try and switch to  
19 another one and maybe another one, by the time you've gotten to  
20 two or three of them, it might get up to 70, possibly 75  
21 percent, if you're really lucky. And it doesn't go much above  
22 that if you keep trying other ones later. So, in other words,

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1 some people respond and some people don't, to them. And he may  
2 have been someone who they weren't going to help anyway. But,  
3 usually, people would try other ones since a tendency to keep  
4 trying people on things.

5 Q. And it was your understanding he had been previously  
6 on two antidepressants?

7 A. He said he'd been on antidepressants and he thought he  
8 remembered two, that he could name. But I thought there might  
9 be others that he ... it sounded like he'd been on others but he  
10 couldn't remember the names. That's how I think I saw it.

11 Q. Just on the second page of your note, under "Past  
12 Psychiatric Medications", you said: "He says he tried several  
13 antidepressants but cannot clearly remember which ones he  
14 tried."

15 A. Yeah. So the way I've ...

16 Q. Fluoxetine and ...

17 A. ... written that ... the way I've written that, he  
18 thought he had been on fluoxetine and sertraline, but that was a  
19 subset of a larger set that ... was my impression.

20 Q. I see. All right. And those ... the names of those  
21 two medications, were those suggested to him or did he actually  
22 remember those names?

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1           **A.**    I can't remember. But when I ... what I do is I ask  
2 people, Can you remember what you've taken, and see what they  
3 tell me. And if they think ... some people don't remember.  
4 I'll just starting running off the list of names and if they  
5 say, I think that one I tried, then I put that on the list.

6           **Q.**    Okay. All right. And ...

7           **A.**    That's why I say "may" have been included because I  
8 probably did that.

9           **Q.**    Understood. He had a history of having seen two  
10 psychiatrists in the past. You say: "While in military service  
11 and/or while attending the OSI Fredericton clinic but he did not  
12 know or remember the names of those psychiatrists."

13          **A.**    Probably didn't ask.

14          **Q.**    You may not ...

15          **A.**    I probably didn't ask because I wouldn't have known  
16 who they were.

17          **Q.**    Okay. All right. So the diagnoses or assessment, I  
18 guess ... I don't know whether it's appropriate to call these  
19 all diagnoses at that time but the assessments were major  
20 depression, post-traumatic stress disorder, post-traumatic brain  
21 disorder, borderline delusions regarding his wife, and the  
22 possibility of ADD. If you had had access to other records at

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1 that time, would any of those diagnoses or would those  
2 assessments have been easier to make or would they have been  
3 clearer or ...

4 **A.** It would have been clearer. Sometimes additional  
5 information is confusing because somebody else might have gotten  
6 a different picture. And then you've got to put them together,  
7 so ... but basically, yes, it would have helped and I would have  
8 liked some past information, because they would have picked up  
9 things that he didn't remember or maybe didn't want to tell me.  
10 And it's always interesting to read reports of what was going on  
11 at the time, because I presume a record written at the time is  
12 fairly accurate, whereas memory ten years later is not.

13 **Q.** Right. At that time you felt his suicide risk  
14 continued to be low?

15 **A.** Yes.

16 **Q.** Okay. And, again, why did you feel it was appropriate  
17 to rate it as low at that time?

18 **A.** I don't recall my thinking then, but there were no red  
19 flags that I saw as red flags to make me think that. I would  
20 have asked him about whether or not he had suicidal thoughts. I  
21 went into depression. Most people who are depressed don't ...  
22 are low risk in terms of suicide.



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1           **Q.**    This is perhaps a bit broad, but when you say there  
2 were no red flags, what type of red flags might you have seen  
3 that would have caused you concern?

4           **A.**    Well, if he said, I tried to hang myself last week,  
5 would be one.  If I ... I think I might do it, would be another.  
6 Very acute distress, high anxiety is ... I didn't used to think  
7 that, but I now think is a very serious red flag.  That would  
8 ... really bad insomnia is another one.  Acute psychosis mixed  
9 in with one of those is a major red flag.  There are lots of  
10 them on the list, but those are the things that I always ... I'm  
11 particularly concerned with.

12          **Q.**    Okay.  Would you have had recourse ... and may not  
13 have needed to because you're familiar, obviously, with the  
14 things on the risk assessment tool.  But would you have had  
15 reference to the risk assessment tool when you met with him or  
16 ...

17          **A.**    No, I wouldn't have.  The way we've taught people to  
18 use that tool is to take a history to find out what the person's  
19 story is, their symptoms and so on.  And those items on that  
20 list should all come up from doing that.  It's not expected that  
21 you will need to specifically ask questions based on that list.  
22 They are all intended to come up from the story.  The list is

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1 simply to jog your memory as you go ... as you think about what  
2 you've just learned from the patient.

3 **Q.** All right. A history of suicide attempts or  
4 threatened suicide attempts, would that have ... if that  
5 existed, would that have had an impact on your opinion regarding  
6 his risk?

7 **A.** Yes. Particularly if we thought there were serious  
8 ones. There are ones we regard as not serious, not ... with no  
9 suicidal intent. If someone took five pills and ... as like I  
10 said, a cry for help kind of thing, no. But if ... a serious  
11 risk ... a serious attempt in the past would make a big  
12 difference.

13 **Q.** Okay. So there was an incident in New Brunswick  
14 approximately a year before this where Lionel Desmond was  
15 visited by police because of a concern about threatening  
16 suicide. That's not something that he disclosed to you.

17 **A.** No.

18 **Q.** And there's no way you would have known it from your  
19 conversations with him, I take it?

20 **A.** Well, he would have to tell me.

21 **Q.** Again, not knowing perhaps how ...

22 **A.** And people usually ... when I say, Do you have

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1 suicidal thoughts or have you had suicidal thoughts? People  
2 will often say, Well, back when I was 16, I did this, or  
3 something like that, so ...

4 **Q.** Okay. If you had known that, though, would that have  
5 impacted on how you assessed his risk?

6 **A.** It would have affected my assessment. What I would  
7 have concluded, I can't tell without more. But, yes, that would  
8 have increased my assessment risk and what I would have ... if  
9 ... and just to be clear, if it had gone ... probably if ... if  
10 all I had was what I've got on the notes here and I had that,  
11 that he'd made a serious attempt ... I forget what you said. A  
12 year or two before? I would probably want to know ... I would  
13 want to know more information of what was going on then, what  
14 triggered it and were those triggers present now or not, and how  
15 was it dealt with, et cetera.

16 But let's just say it seemed like a serious intent and the  
17 situation at present isn't the same as then, then I would  
18 probably raise him to a moderate risk, and a moderate risk that  
19 focus in that is that one is going to monitor the risk. So when  
20 you ... that you're going to follow them and will follow the  
21 risk so that you can address ... do whatever you need, to keep  
22 the risk down. It doesn't necessarily mean that you put them in

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1 hospital. Sometimes you do, but most of the time we don't.

2 High risk would generally mean they're going to go to  
3 hospital. But that would have probably ... given what I had  
4 then, that he seemed like he was managing, not managing happily  
5 or well but managing, with that history I would not have changed  
6 the treatment but I would have elevated him to a moderate risk  
7 and which meant that we would follow him.

8 Q. So even knowing about an earlier incident, you really  
9 need to know more about, as you said, what triggered it ...

10 A. Yeah.

11 Q. ... other information about it ...

12 A. Yes.

13 Q. ... to be able to factor it into your current  
14 assessment.

15 A. Yes.

16 Q. Okay. That type of information though, generally, I  
17 assume would be useful to you when you're doing your  
18 assessments?

19 A. Yes. That's why I asked him for his records.

20 Q. And just on the point you made a moment ago, a person  
21 who is assessed as moderate ... or moderate risk for suicide,  
22 that person is typically not hospitalized either? They're just

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1 monitored in the community? Is that ...

2 **A.** The majority of people that I see with moderate risk  
3 are being followed in the ... as outpatients, yes, in the  
4 community. And we didn't have this as a rule at that time, but  
5 we have it as a rule now that if someone is a moderate risk and  
6 they don't show up for their appointment, then we try to contact  
7 them. If we can't reach them to confirm they're okay and  
8 they're going to come back another day, then we send the ... ask  
9 the RCMP to go out and do a wellness check.

10 **Q.** That's for a person assessed as moderate risk?

11 **A.** Yes.

12 **Q.** Okay.

13 **A.** That's a requirement now of all our staff.

14 **Q.** And where does that requirement come from? Is that  
15 ...

16 **A.** I'm not sure if I'm allowed to say that, Your Honour.

17 **THE COURT:** Can you say there have been reviews that  
18 have taken place and as a result policy is changed?

19 **DR. SLAYTER:** Yes.

20 **MR. MURRAY:** Okay. I guess my question ...

21 **THE COURT:** And leave it at that. I think I know what  
22 the problem is.

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1           **MR. MURRAY**:     Right.

2           **THE COURT**:     Okay?

3           **MR. MURRAY**:     And I do, too.  And I actually ... I guess  
4 what I was inquiring, it's policy now is ...

5           **A.**     Yes.

6           **Q.**     Okay.  That's fine.  And that's ... at the time ...  
7 and, again, I appreciate Lionel Desmond was rated as low in any  
8 event, that policy has come into place since ...

9           **A.**     Yes.

10          **Q.**     Okay.  If a person is rated as a high risk, are they  
11 typically hospitalized?

12          **A.**     Yes.

13          **Q.**     Okay.  Always hospitalized?

14          **A.**     All of mine are.

15          **Q.**     Okay.  And is that ...

16          **A.**     I would expect so, yes.

17          **Q.**     Okay.  All right.  And is that more often under the  
18 **Involuntary Psychiatric Treatment Act** or sometimes just  
19 voluntarily?

20          **A.**     That depends on whether the person is willing to go  
21 into hospital and stay there.  It generally will tend ... if  
22 someone seems willing and seems like you can count on them doing

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1 what they say they're going to do, we would just admit them  
2 voluntarily.

3 Q. All right. You also made reference in your letter to  
4 his concern about financial issues. Does that play into a  
5 person's suicide risk, those concerns about financial pressures?

6 A. Yes. Financial stress plays into it and financial  
7 stress is one of the big ones.

8 Q. All right. So as you meet with an individual such as  
9 Lionel Desmond you begin to, I guess, develop a treatment plan  
10 or a go-forward plan and that involves medication and whether  
11 there's going to be future visits, that type of thing?

12 A. Yes.

13 Q. Okay. Perhaps just generally, first, what are the  
14 types of follow-up that might come from an appointment such as  
15 this? I mean I know you said earlier that you often don't see  
16 the person again, but sometimes will.

17 A. Well, he was complex in terms of having several  
18 different diagnoses going on at the same time and which  
19 interacted with each other. And as I said earlier, I tend to  
20 follow people with complex problems, although I don't normally  
21 follow PTSD. But he didn't ... I'm on a tangent from what  
22 you're asking now.

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1           **Q.**    That's all right.

2           **A.**    Followed him partly because he was complex and needed  
3 help and partly because he had PTSD and needed help for that,  
4 too. And I thought he needed OSI level of service and we'll, I  
5 presume, come back to that. So I was following him until that  
6 could be done.

7           But in terms of what I might do or we might do for follow-  
8 up, so I would look at the ... I generally ... when I talk to  
9 patients, at the end of the interview, I say, There are three  
10 kinds of ways of managing this that we can talk about. One is  
11 medications. I would look at his medications, what we might do  
12 or not do. I would look at therapy and whether that would be  
13 appropriate or not, and it was in his case.

14           And I thought that he needed a trauma therapist. And I'm  
15 not sure if this matters, but I thought ... think it's better  
16 for someone with military experience to have a military trauma  
17 therapist. I've talked with trauma therapists at our own clinic  
18 who would agree that that's different in some ways, not the PTSD  
19 as such, but the character of the people involved, et cetera.  
20 So from someone who treats, you know, women who have been  
21 sexually assaulted as children or adults, there's a different  
22 sort of aspect to it than someone harmed by military combat.



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1 And they probably do better with someone who does that every day  
2 like in an OSI clinic. I'm not sure if I'm being clear. The  
3 ...

4 Q. A military trauma therapist, meaning someone who does  
5 trauma therapy with people who have been in the military? Is  
6 that what you mean?

7 A. Yes.

8 Q. Okay.

9 A. That's what I mean. So you get to know how to work  
10 with people who have a sort of similar background and  
11 experiences. It's just how you work with the person who's got  
12 the PTSD. PTSD is the same, but it's the character of the  
13 person may be different.

14 Q. Yes.

15 A. This is somewhat speculative. And I also talk to  
16 people about what they can do for themselves; hence, he told me  
17 that he found yoga helpful and something else helpful ... the  
18 gym helpful. And I often prescribe exercise for people anyway,  
19 so I said, Well, then you should go and do yoga and go to the  
20 gym regularly.

21 Q. Okay. So with Lionel Desmond you discussed those  
22 general issues; medication, therapy, and ...

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1           **A.**    Self-help, as I call it.

2           **Q.**    ... self-help. Yeah. Okay. And you made  
3 recommendations in all of those?

4           **A.**    Yes.

5           **Q.**    All right. You said that you thought that he would  
6 benefit or need an intensive treatment and rehabilitation  
7 program?

8           **A.**    Yes.

9           **Q.**    What did you conceive that as being? What did you  
10 think he needed?

11          **A.**    Well, I thought he needed more trauma therapy and  
12 needed ... it would ... I felt bad for him. He was, seemed to  
13 me, been let go of what he had been getting and wasn't getting  
14 and he was having a hard time and his wife was having a hard  
15 time. And I thought that he's put his life on the line for  
16 people, that he deserved to get the full service that the  
17 military, the veterans, I get those mixed up, could provide.

18          So I thought he should get a full level of trauma therapy.  
19 He had these other problems. I didn't know if they had been  
20 identified. Well, the depression probably had been identified  
21 because he had been through the antidepressants. The head  
22 injury aspect, I had no idea whether that had come up before but

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1 I thought he needed help with that, which would include the  
2 neuropsychological assessment and some kind of rehab program to  
3 help him learn how to work with that and sort out all the other  
4 issues.

5 Q. Okay. Was it your understanding that that type of an  
6 intensive treatment and rehabilitation program would be  
7 available through the OSI Clinic in the province or ...

8 A. I assumed it would be. I'm gathering from what I hear  
9 on the news it might not be, but I assumed it was.

10 Q. Okay. So fair to say it wasn't clear to you what  
11 resources might even be available to him in the province?

12 A. No. I assumed certain things, that they would be  
13 available if he got reconnected with OSI.

14 Q. Okay. And you said a moment ago that psychotherapy  
15 would be something that he would need and would benefit from?  
16 Did I understand you correctly?

17 A. Yes. Not just with PTSD. The jealousy issues were  
18 the other major thing where that would likely be helpful. And  
19 when I saw him on December 2nd, he told me he had an appointment  
20 in the afternoon with a therapist appointed by Veterans Affairs  
21 or something like that. And she's someone I know of and have  
22 talked to before and I knew that she's done work with people

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1 with PTSD, women with PTSD. I didn't know what her military  
2 experience might or might not be and I thought she would be  
3 helpful in general. I still thought it would be probably  
4 beneficial to work with someone with military PTSD experience.

5 **Q.** Okay. And that was Catherine Chambers?

6 **A.** Yes.

7 **Q.** The therapist that he ...

8 **A.** And she may well do that. I don't ... just don't  
9 know.

10 **Q.** Okay. So the specific treatments for PTSD, and I  
11 appreciate a complex picture, but there are some treatments I  
12 think that may work well and some that ... not so well? Is that  
13 ...

14 **A.** Yes.

15 **Q.** And what treatments would be offered locally and which  
16 might work or not?

17 **A.** At our clinic, our trauma therapists do something  
18 called EMDR, Eye Movement Desensitization and Reprocessing. And  
19 the way I simplistically understand that is that people with  
20 PTSD essentially have difficulty handling their memories of the  
21 trauma, the traumatic event, and that greatly distresses them  
22 and they can't really process them because they're so

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1 frightening that they just back right off dealing with those  
2 feelings.

3       And I think what the ... as I understand it, the people  
4 during these sessions have ... get involved in some sort of eye  
5 movement back and forth. And what the eye movements are doing  
6 is taking their conscious attention away from the memories,  
7 because it's hard to move your eyes without ... I think we're  
8 evolved to pay attention to what our eyes are looking at. And  
9 through constant moving, you're focused your attention on that.  
10 And if a therapist asks you to recall one of your combat  
11 experiences while your eyes are trying to focus on something  
12 moving, you can more easily tolerate the experience and start to  
13 put it into words, which is how we learn to detach from the  
14 memory and our feelings about it and then be able to handle  
15 something like that.

16       **Q.** And that's the EMDR treatment ...

17       **A.** Yes.

18       **Q.** ... and that's available at St. Martha's?

19       **A.** Yes.

20       **Q.** Is there a wait for that?

21       **A.** Yes.

22       **Q.** Is it a significant wait?

**DR. IAN SLAYTER, Direct Examination**

1           **A.**    I'm not sure.  It varies.  I'll say six months.

2           **Q.**    Okay.  And more general psychotherapy would be  
3 available, as well, at ...

4           **A.**    Yes.

5           **Q.**    ... St. Martha's?

6           **A.**    Yes.

7           **Q.**    All right.  Other treatments and ...

8           **A.**    And I should say, too, that most people waiting or in  
9 need of PTSD treatment, because they have trouble tolerating  
10 their memories, before they can get trauma therapy they need  
11 general therapy to help stabilize them so they're a little more  
12 calm and stable, so that they don't start getting into the  
13 history of their trauma and then sort of become extremely  
14 agitated and distressed and can't do anything, go home feeling  
15 worse.

16          **Q.**    Right.

17          **A.**    So there's often a preparatory phase that.

18          **Q.**    Okay.  Of stabilization ...

19          **A.**    Yes.

20          **Q.**    ... before you can actually even begin to ...

21          **A.**    Yes.

22          **Q.**    ... address those issues.

**DR. IAN SLAYTER, Direct Examination**

1           **A.**    So some people will be put into that first and then go  
2 on to trauma therapy.

3           **Q.**    Okay.

4           **THE COURT:**     Mr. Murray?

5           **MR. MURRAY:**    I'm good either way, Your Honour, whether  
6 you want to take a break or keep going.

7           **THE COURT:**     It's 11:30, so let's take a short break,  
8 maybe 15 minutes or thereabouts.

9           **DR. SLAYTER:**    Thank you.

10          **THE COURT:**     All right. Thank you.

11          **COURT RECESSED (11:33 HRS)**

12          **COURT RESUMED (11:52 HRS)**

13          **THE COURT:**     Mr. Murray?

14          **MR. MURRAY:**    Dr. Slayter, before we broke we were  
15 discussing the forms of treatment that might be available for a  
16 PTSD patient in the Antigonish area or at St. Martha's and you  
17 had referenced the EMDR treatments and then more generally  
18 psychotherapy which would be available, including initially  
19 stabilization therapy, is that correct?

20          **A.**    Yes.

21          **Q.**    All right. More comprehensive treatment might be  
22 necessary though elsewhere such as at an OSI clinic?

**DR. IAN SLAYTER, Direct Examination**

1           **A.**    Yes.

2           **Q.**    One of the other things that you said that you ... or  
3 part of the treatment plan or going forward is medication. The  
4 medications are listed in your report. Am I correct that those  
5 are the same as what he was prescribed on October 24th?

6           **A.**    Yes.

7           **Q.**    So he was already taking, when he saw you in October,  
8 the quetiapine and I believe quetiapine XR, is that ... although  
9 it doesn't specifically reference that?

10          **A.**    I presume it was not the XR.

11          **Q.**    Okay, just quetiapine, okay. And so we understand,  
12 again I think we've had these explained to us, but *t.i.d.* is  
13 three times daily, *p.r.n.* is as needed, and *h.s.* is at bedtime?

14          **A.**    Yes.

15          **Q.**    Okay. The prazosin was going to continue at the four  
16 milligrams that you had prescribed on October 24th?

17          **A.**    Yes.

18          **Q.**    The trazodone, the same dosage, zolpidem which he was  
19 already on. We had talked about this before but you noted, I  
20 guess at least, that he was not on an antidepressant, you  
21 weren't prepared to make a prescription for an antidepressant  
22 that day?



**DR. IAN SLAYTER, Direct Examination**

1           **A.**    Yes.

2           **Q.**    What would have been necessary or what was going to  
3 happen going forward for you to determine if an antidepressant  
4 was appropriate and which one?

5           **A.**    I would like to have known what antidepressants he had  
6 taken before, what his response to them was, and that would  
7 guide me as to whether and what I would use so I didn't know.  
8 There's no point in me giving him something today that he's  
9 already been on so ... and there was not ... nothing was urgent  
10 at that time in the sense of acute so we could take time to get  
11 the records and do it properly.

12          **Q.**    That was the intention to get the records of what he  
13 had ... that would include what he had been taking before?

14          **A.**    Yes.

15          **Q.**    Did you feel that he ultimately would be needing an  
16 antidepressant?

17          **A.**    I felt likely he would.

18          **Q.**    Okay. His comment to you was the effect of the drugs  
19 or the benefits of the drugs that he was taking were, I think,  
20 "modest at most" is the phrase you used?

21          **A.**    Yes.

22          **Q.**    Okay. Was there any other pharmaceutical treatment

**DR. IAN SLAYTER, Direct Examination**

1 that you might have contemplated beyond an antidepressant?

2 **A.** That's a very broad question. There are lots of  
3 options but I guess I wanted to see what he'd been on before  
4 that we would try. So some things we'd use for depression that  
5 aren't an antidepressant, *per se*, that might help, for example,  
6 some anti-psychotic agents are helpful for depression, some mood  
7 stabilizers are helpful for depression, some amino acids are  
8 helpful for depression, so there's a wide variety of tools that  
9 we could use.

10 **Q.** For depression?

11 **A.** Yes.

12 **Q.** Anything else about his presentation that might  
13 require a prescription at that time were you considering?

14 **A.** For the PTSD, we would treat just symptoms so we'd be  
15 looking at anxiety in particular. The quetiapine would be a  
16 major player there. There are other things we can use including  
17 antidepressants. Antidepressants are called antidepressants but  
18 they're also anti-anxiety in most cases. For the brain  
19 disorder, as far as I know, medications would not be helpful for  
20 that. If he ADD, stimulants might be helpful for that. There  
21 were a lot of options. I wanted to know what his past treatment  
22 had been, also what problems he'd had before that I identified

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1 with.

2       **Q.** Right, okay. One of the things that you had wanted  
3 him to do and you say in your note: "I had asked him to obtain  
4 his military medical records so that I can review his medication  
5 history before considering medication changes or additions." I  
6 take it from your conversation with him and what he told you of  
7 his history, you thought there might be medical records from his  
8 time in the military?

9       **A.** Yes.

10       **Q.** And you would not have had easy access to those?

11       **A.** I had no idea how to get them so I had a sense I  
12 didn't have easy access.

13       **Q.** All right. With other patients who perhaps have a  
14 military background, I guess was that your experience, you would  
15 ask them to obtain their records?

16       **A.** I'm not sure. I certainly have done that before, I  
17 can't remember every one as to what I did but some people  
18 volunteered their records. I remember someone once gave me a CD  
19 or DVD with 200 pages of notes on it.

20       **Q.** Okay. And just on that point, apart from what we  
21 might describe as military medical records, if you wanted to  
22 obtain a patient's medical records in this set of circumstances

**DR. IAN SLAYTER, Direct Examination**

1 from another province, what would you normally do to do that?

2 **A.** From a regular hospital, not military?

3 **Q.** Yes.

4 **A.** We would get the patient to sign a consent form and  
5 send it to the hospital's medical records department and ask  
6 them to send us x, y and z and they would always send it.

7 **Q.** Since this time, did you become any more familiar or  
8 did you find any easier route to accessing military records or  
9 have you had occasion to do that?

10 **A.** After this incident, we talked about the difficulty  
11 getting records and I understand that the then provincial  
12 director of mental health, Linda Khoury, talked to Veterans  
13 Affairs and I believe we were told that the best way to do it  
14 was to ask the veteran to go get the records themselves.

15 **Q.** That's your understanding is still the process that's  
16 followed?

17 **A.** Yes, I think I've seen something more recently that  
18 says you can phone a certain number but you still have to have  
19 the patient's consent so it still comes down to it's easiest  
20 just to have them call up and do it to get their records. And  
21 they also indicated that they don't have a record, as such, so  
22 I'm not sure what they actually send you but ...

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1           **Q.** All right. You used the phrase in your note that you  
2 felt Lionel Desmond was or seemed to be "falling through the  
3 cracks"?

4           **A.** Yes.

5           **Q.** Falling through the cracks in terms of follow-up by  
6 military and veterans programs. What were you thinking of there  
7 when you said that?

8           **A.** It was my impression that for some period of time he  
9 was being followed by OSI in Fredericton and I assumed getting a  
10 high level of service so he was sort of going along and then all  
11 of a sudden the service stopped when he came to Nova Scotia,  
12 well probably when he went for three months to Ste. Anne's  
13 Hospital outside of Montreal where they do rehab programs for  
14 veterans and disabled police and he went through that program.  
15 So I don't know if he was still part of the Fredericton program  
16 or not but anyway, when he got to Nova Scotia he was no longer  
17 being covered by anything military or veterans related and he  
18 was told to wait until they developed a service, they didn't  
19 even have a service to take him, according to what he was told,  
20 they did in Halifax. So to me he was going along with service  
21 and all of a sudden it stopped and there was some promise of  
22 service later so it was a crack between what he had and he was

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1 going to get.

2       **Q.** And obviously a gap in service is always going to be a  
3 concern with respect to a patient. Was there anything in  
4 particular that caused you concern relating to that gap in  
5 service?

6       **A.** No, just I thought it could have been organized better  
7 and he deserved it, needed it. He would get by and we could  
8 provide him with a level of service that would be helpful but if  
9 they had all the resources I thought they had, it would have  
10 been even better for him.

11       **Q.** You had said as well in your note that you felt  
12 further elucidation of his disorders needs to be done at a  
13 higher level of service. What did you mean by that?

14       **A.** I was particularly thinking of the head injury issues  
15 such as a neuropsychologist getting involved. That was the one  
16 thing that really didn't have anything for him.

17       **Q.** Okay. I think you had said when I asked if he was  
18 forthcoming with his experiences and symptoms that you felt he  
19 was.

20       **A.** Mm-hmm.

21       **Q.** Is there any concern, and again I appreciate you don't  
22 treat a lot of military individuals, but is there a concern

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1 about either soldiers or veterans masking their symptoms or  
2 being unwilling to disclose those symptoms?

3 **A.** There can be. This is based more on what people tell  
4 me and I've read but historically soldiers were taught, I  
5 believe, to kind of suck it up and just ignore all their  
6 symptoms, go back onto the battlefield and I've certainly read  
7 lots of that in the past. That was an issue I think that's  
8 changed a lot in recent years but that was a problem. I was  
9 involved a little bit at the Westray mining disaster and there  
10 there was a problem getting the miners and the firefighters to  
11 talk about their experiences there because they felt it's not  
12 something you talk about. So some people have been sort of  
13 trained not to talk about their experiences.

14 **Q.** All right.

15 **A.** But that didn't seem to be an issue with him, he was  
16 talking about different things. We talked about some which are  
17 uncomfortable topics such as jealousy with his wife and so I  
18 felt he was being, you know, sincere and open.

19 **Q.** Right. Are you able to comment, Dr. Slayter, on the  
20 ... in your experience or from what you've read, is there a link  
21 between post-traumatic stress disorder and family violence?

22 **A.** Not that I'm aware of in terms of something I've read

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1 or learned. I would think that it would be sometimes. The only  
2 part I was particularly aware of was that sometimes people would  
3 have nightmares or hear loud noises or whatever and they would  
4 go into sort of a I'll call it kind of a battle position, ready  
5 to be attacked, and it would take them, if they were wide awake,  
6 a moment or two to realize it's okay and so anyone immediately  
7 around them could get hit or something like that.

8 **Q.** More generally ...

9 **A.** But not in terms of some sort of ongoing violence, no.

10 **Q.** Okay. And more generally, PTSD, well let me ask you  
11 this first. I assume that there can be a risk of suicide with  
12 PTSD or a risk of self-harm?

13 **A.** Yes.

14 **Q.** Is there an increased risk of more generally a violent  
15 behaviour other than to one's self with PTSD that you're aware  
16 of?

17 **A.** Not that I'm aware. Not to say there isn't but I'm  
18 not aware of that, no.

19 **Q.** Okay.

20 **A.** I don't see a reason why there would be unless you  
21 were attacking someone with PTSD.

22 **Q.** Okay. In terms of the self-help piece, he had



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1 mentioned that yoga had been of some assistance to him.

2 **A.** Yes.

3 **Q.** And you recommended that he continue with that and  
4 also that he go to a gym ...

5 **A.** Yes.

6 **Q.** ... to get some physical exercise. Did he express any  
7 concern regarding financial barriers to those things?

8 **A.** Yes, he said he could not afford them so I said I can  
9 write you a note and you can ask Veterans Affairs to pay for it.

10 **Q.** Okay. And I think you did that, did you?

11 **A.** Yes.

12 **Q.** Okay. So those were the three, I guess, general areas  
13 of treatment, kind of the go forward piece.

14 **A.** Yeah.

15 **Q.** You said typically you don't see a patient a second  
16 time but with him you were going to follow up with him?

17 **A.** A patient with PTSD.

18 **Q.** Because of the PTSD?

19 **A.** Because the medications could be easily followed by a  
20 family physician and a therapy could be done by a therapist. I  
21 don't do therapy.

22 **Q.** Okay, all right. So typically a PTSD patient you

**DR. IAN SLAYTER, Direct Examination**

1 wouldn't necessarily do follow up but with him you were?

2       **A.** Yes, because I thought he deserved some kind of follow  
3 up until he got going and because also he had complex problems  
4 which I could help with to some extent.

5       **Q.** So he was going to make another appointment, was he?

6       **A.** I asked him to make another appointment.

7       **Q.** Okay. Did you have an anticipation of when you would  
8 want that to be, within what timeframe?

9       **A.** I don't recall but I think I would have seen him  
10 somewhere between two and three weeks, four weeks later. I  
11 believe he did have an appointment for actually somewhere around  
12 the 18th or 20th which he didn't keep.

13       **Q.** Which he did not keep?

14       **A.** He did not keep.

15       **Q.** All right. I think it may have actually been in the  
16 records, the 21st of December?

17       **A.** Okay.

18       **Q.** And that was ... that appointment was just a no-show  
19 to your knowledge?

20       **A.** It was a no-show.

21       **Q.** Okay. In his case, given the history and given your  
22 interaction with him and what you had learned of him, after his

**DR. IAN SLAYTER, Direct Examination**

1 not showing for an appointment would there have been follow-up?

2 **A.** What I generally do in such a situation is decide  
3 whether the person's at relatively high risk of something like  
4 becoming psychotically ill or suicide and so on or they're not  
5 and if they're not, it's up to them to return if they want to or  
6 don't want to. I was available so he could call back.

7 **Q.** Okay. So in his case given it was not an active  
8 psychotic illness or some other factor that you referenced?

9 **A.** So he seemed to be someone, he could call back if and  
10 when he wanted to.

11 **Q.** Okay.

12 **A.** I did my bit by being available and his was to come  
13 back.

14 **Q.** And then he did make another appointment to your  
15 knowledge?

16 **A.** Yes.

17 **Q.** And when was that?

18 **A.** I think it was the day after he left hospital in early  
19 January, January 3rd.

20 **Q.** Okay. And the person with whom he saw to make that  
21 appointment, do you know who that was?

22 **A.** Joan Hines, one of our secretaries.

**DR. IAN SLAYTER, Direct Examination**

1           **Q.**    Okay.  Joan Hines works in the Outpatient Clinic?

2           **A.**    Yes.

3           **Q.**    And it would be her role, among other things, to make  
4 appointments for outpatients?

5           **A.**    Yes.

6           **Q.**    And it's your understanding and Ms. Hines is going to  
7 testify obviously about this so ...

8           **A.**    Yes.

9           **Q.**    ... I don't expect you to have a perfect memory of it  
10 but it's your understanding that he did attend on the 3rd of  
11 January and make an appointment?

12          **A.**    She told me he did, yeah.

13          **Q.**    All right.  Obviously the appointment that he made on  
14 the 3rd of January he didn't attend for that appointment given  
15 what transpired.

16          **A.**    Yes.

17          **Q.**    Did you have a thought when you learned of the tragedy  
18 that had occurred?

19          **A.**    Sorry, was that a question?

20          **Q.**    Yes.

21          **A.**    Did I have a thought?

22          **Q.**    Well, what was your thought?

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1           **A.**    I was surprised, first of all, and kind of horrified,  
2 that wasn't what I was expecting. Dr. Rahman called me that  
3 evening and told me he had learned that.

4           **Q.**    All right. It may be impossible ... obviously it's  
5 impossible for you to know what may have happened in the  
6 intervening time. Do you have a thought about whether there was  
7 any obvious clinical explanation for what happened based on what  
8 you had seen of him?

9           **A.**    All the things I've heard, I've heard bits and pieces  
10 of the story after he saw me, I can't explain in terms of what I  
11 knew and we knew later, we were not expecting suicide so I have  
12 trouble explaining it that way.

13          **Q.**    Right. Dr. Slayter, perhaps I can ask you, I guess, a  
14 go-forward question. Are there additional resources or supports  
15 that you feel might assist psychiatrists or mental health  
16 professionals, especially in our area in rural Nova Scotia, that  
17 may not be in place?

18          **A.**    In terms of resources, yes, we can always use more  
19 resources. We're not going to get more resources but we could  
20 use more resources in terms of different kinds of staff, things  
21 like neuropsychological assessments. Some of these things could  
22 be done, you know, some other location if we had access to them

**DR. IAN SLAYTER, Direct Examination**

1 and so on. But I think in terms of resources, I think right now  
2 at St. Martha's we're doing relatively well compared to our  
3 neighbours who have less than we do so it's hard.

4 **Q.** In terms of cooperation or information sharing with  
5 any other health care providing agencies or anything that may be  
6 of benefit?

7 **A.** I would like to have an easy way to access OSI  
8 services and Veterans Affairs records and military records, I  
9 think those are separate. So the same way of getting hospital  
10 records, it's very straightforward. If we had a place to go,  
11 we'd just send a consent to, and they would send us something  
12 back the same day or the next day as I expect from hospitals,  
13 even across the country, that would make sense.

14 **Q.** You said that there are therapists available in the  
15 area both at St. Martha's and private therapists. Any thought  
16 on, again, the obvious answer is more is always better, but is  
17 there either training or resources that might be available for  
18 the therapists?

19 **A.** Training is an issue, we don't have enough training in  
20 the province, particularly I think for social workers because I  
21 don't believe that training, clinical therapy is not the focus  
22 at Dalhousie as I understand it, I may be wrong. It's more

**DR. IAN SLAYTER, Cross-Examination by Ms. Grant**

1 difficult to find people to work in a rural area than it is in  
2 an urban area for probably obvious reasons so there are  
3 challenges and probably more could be done to make it more  
4 attractive to work rurally.

5 **EXHIBIT P-000072 - LETTER DATED DECEMBER 2, 2016 FROM DR.**

6 **SLAYTER**

7 **Q.** Okay, all right. Exhibit P72. Is that the letter you  
8 made reference to that you'd given to Lionel Desmond?

9 **A.** Yes.

10 **MR. MURRAY:** Thank you, Dr. Slayter, those are the  
11 questions I have.

12 **A.** Thank you.

13 **THE COURT:** Ms. Grant?

14

15 **CROSS-EXAMINATION BY MS. GRANT**

16

17 **MS. GRANT:** Thank you, Your Honour.

18 Dr. Slayter, my name is Melissa Grant and I represent the  
19 Attorney General of Canada. We represent various federal  
20 entities that are engaged by the Inquiry.

21 Dr. Slayter, I think you said earlier and it's fair to say  
22 that when you wrote your report on December 2nd, you weren't

**DR. IAN SLAYTER, Cross-Examination by Ms. Grant**

1 writing it for a group of lawyers to pick apart so I appreciate  
2 that and just have a couple of questions about, you know, what  
3 you were thinking at the time.

4 So first of all, there's one thing that I wanted to  
5 clarify. That what you were hearing from Lionel Desmond was, as  
6 far as you knew it, you only had his story, you didn't have  
7 records and that sort of thing?

8 **A.** Correct.

9 **Q.** So in your report when you say, it's under "Substance  
10 Abuse History", that he was taking high doses of marijuana as  
11 prescribed in the military and then you said earlier by military  
12 physicians, the evidence that we expect to come out is that it  
13 was not a military physician that was prescribing that it was,  
14 in fact, during his time in Fredericton with a private physician  
15 so you don't have any evidence that that's not the case?

16 **A.** No, I have no trouble with that.

17 **Q.** Okay.

18 **A.** It would have, for me, Veterans Affairs and military  
19 overlap, et cetera and all that.

20 **Q.** Okay.

21 **A.** I didn't know what exactly he had had or what was  
22 available.



**DR. IAN SLAYTER, Cross-Examination by Ms. Grant**

1           **Q.** Fair enough. And there may also be some confusion,  
2 and I'll take a bit of an opportunity to clarify what we can in  
3 this setting, but Veterans Affairs is not a direct service  
4 provider and so direct care to veterans is provided through  
5 provincial and private health authorities. So is that your  
6 understanding as well or do you not have an understanding of  
7 that?

8           **A.** It wasn't my understanding at the time, I thought they  
9 at least contracted. Yeah, I think I thought they provided the  
10 services. And I understand ... I learned later that actually by  
11 that time the Nova Scotia Health Authority was providing or  
12 operating the OSI Clinic in Halifax beginning early in 2015, I  
13 think, but I didn't know that at the time and it's still not  
14 clear to me that is a regular service that we can just phone up  
15 and get records from or if it's different.

16           **Q.** Yeah, and I think that there's maybe an opportunity to  
17 do some ... an education piece and certainly we'll hear later on  
18 from exact witnesses and people that can talk about that but  
19 since VAC is not a service provider, they may have some records  
20 in the normal course, they're not a repository for, say, all of  
21 the records like if I went to St. Martha's, you would have a  
22 record for me at St. Martha's, if I went to an OSI clinic in

**DR. IAN SLAYTER, Cross-Examination by Ms. Grant**

1 Quebec, there would be a record for me in Quebec.

2 **A.** Correct.

3 **Q.** So that's kind of the difference whereas when somebody  
4 is actively serving, when they're a member of the Canadian Armed  
5 Forces, they are seeing doctors and medical professionals on the  
6 base and are getting that direct health care directly from CAF.  
7 So that's just sort of the piece that I feel like is maybe  
8 missing in our discussions but ..

9 **A.** Could I just comment?

10 **Q.** Sure.

11 **A.** It would be good to have something on paper, I  
12 suppose, some clarification how all that works.

13 **Q.** I think that's totally fair.

14 So within that context and you've noted in your report a  
15 couple times that Lionel Desmond was a complex case and had many  
16 overlapping issues and that you felt like he needed a ... I  
17 think you said a higher level of service that you could not  
18 provide for him.

19 **A.** Right.

20 **Q.** So I want to sort of back up and talk a little bit  
21 about where you said you identified a gap in service. In the  
22 background, and I appreciate that you would not have known this

**DR. IAN SLAYTER, Cross-Examination by Ms. Grant**

1 because as we stated earlier, all you know is what Lionel  
2 Desmond was telling you. So we expect to hear evidence from  
3 Lionel Desmond's VAC case manager. So a case manager is  
4 somebody that we'll hear eventually, not every veteran gets a  
5 case manager, it's only those cases that are somewhat  
6 complicated where a case manager is there.

7 So Mr. Desmond had a case manager throughout the life of,  
8 she was his only case manager, and I think that that's important  
9 for you to know for your context because somewhat like you said  
10 earlier, it's generally a policy to see a person once, that you  
11 don't often follow up unless they actually have a complicated  
12 set of needs. This particular case manager, when Mr. Desmond  
13 moved from New Brunswick to Nova Scotia, asked her manager to  
14 keep him on so that, in fact, there would not be a gap, that  
15 there would be a bridging of services until he could get settled  
16 in Nova Scotia. Now that's not in your records so it's clear  
17 that Mr. Desmond didn't inform you of that but we do know from  
18 your testimony earlier that you were aware that Catherine  
19 Chambers had been assigned to Mr. Desmond. So that was part of  
20 the case manager's goals in terms of trying to get Mr. Desmond  
21 settled here in Nova Scotia.

22 One other piece of this is that sometimes if a veteran has

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1 very complicated needs like Mr. Desmond, the case manager can  
2 ask for a clinical case manager to be assigned and while that's  
3 also not reflected in your report, that was also going on in the  
4 background and so we'll see evidence later that Mr. Desmond did  
5 get that clinical care manager, social worker, who could  
6 coordinate things for him.

7 So that's a lot of background to kind of get to the  
8 question that a case manager who's responsible for coordinating  
9 care, approving requests like maybe a gym membership or  
10 something like that, where they're looking for that higher level  
11 of service, they're going to run into, I would suggest to you,  
12 Dr. Slayter, the same kind of problems that you identified in  
13 your report that the services that he needs were not available  
14 in this area. Would you agree with that?

15 **A.** Yes.

16 **Q.** Speaking about the OSI Clinic, for example. So Lionel  
17 Desmond spent time at the OSI Clinic in Fredericton and then he  
18 had an inpatient experience in Quebec. You had noted that he  
19 would benefit from the type of comprehensive treatment that you  
20 would get at an OSI treatment, correct.

21 Did Lionel Desmond say to you that he did not want to  
22 attend an OSI clinic?

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1           **A.**    No, I don't think so.

2           **Q.**    So in the evidence that we expect to hear from the  
3 case manager ...

4           **A.**    Excuse me, something ... he might have been offered  
5 something in Halifax, I can't remember, there's something that  
6 makes me think that's possible and he didn't want to drive to  
7 Halifax but was okay with Cape Breton which is what he told me  
8 he was told he would get anyway.

9           **Q.**    Okay, and that's exactly it, that was exactly my point  
10 because he did, it'll be our anticipation, that he will have  
11 said to his case manager that he thought Halifax was too far and  
12 he didn't want to go there.

13           **THE COURT:**    Excuse me, but that's in the context of him  
14 having some expectation of being advised or told by somebody  
15 that this OSI-type services were ultimately going to be  
16 available to him in Cape Breton?

17           **A.**    That was my understanding is he was waiting for  
18 services in Cape Breton anyway but he had been ... vaguely I  
19 don't ... something about Halifax might have been made available  
20 an alternative or temporary.

21           **THE COURT:**    So I appreciate, Ms. Grant, you're asking  
22 the question but that's the other part of the context his

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1 expectation that if he's saying he's not interested in traveling  
2 and then you say he's not interested in traveling because his  
3 expectation is somehow created that it was going to be available  
4 to him here on some hopefully timely basis, that would be his  
5 expectation in that context? Thank you.

6 **A.** It was my expectation anyway that he should have  
7 something soon.

8 **THE COURT:** Sure, I appreciate that, thank you.

9 **MS. GRANT:** Dr. Slayter, you would agree that Lionel  
10 Desmond did not meet the criteria for involuntary  
11 hospitalization?

12 **A.** Correct.

13 **Q.** Correct. And you had talked about that he had missed  
14 an appointment with you, you had mentioned earlier. Is it fair  
15 to say that if there's somebody who is presenting with the kind  
16 of picture that Lionel Desmond had is not subject to involuntary  
17 hospitalization, is it fair to say you can't force people to  
18 engage with their treatment in circumstances, that there needs  
19 to be some ... that that can be a problem?

20 **A.** I agree, yes, you can't force someone who's capable to  
21 engage in treatment and that can be a problem, yes.

22 **Q.** And did Lionel Desmond talk to you about when he went

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1 to the OSI clinic in Quebec there's some indication that he  
2 didn't complete it and that the noise and the group setting  
3 bothered him, did that come up in the conversation?

4 **A.** I don't recall really discussing it but something  
5 about noise bothering him there sounds familiar and noise  
6 sensitivity was one of his concerns in general with his PTSD and  
7 that's not uncommon.

8 **Q.** And our understanding and this will come up later, but  
9 our understanding that to obtain medical records from CAF as  
10 opposed to VAC but that that can be a form that a doctor  
11 provides or a consent form that they have that can be filled  
12 out, is that not ... has not been your experience?

13 **A.** What's CAF?

14 **Q.** The Canadian Armed Forces.

15 **A.** Okay. Again, I don't really know how to access them.

16 **Q.** So like you said, some education perhaps on that point  
17 would be helpful?

18 **A.** Yes.

19 **MS. GRANT:** Thank you, Dr. Slayter, those are my  
20 questions.

21 **THE COURT:** Provincial Crown, any questions?

22 **MS. LUNN:** No questions from the Attorney General of

**DISCUSSION**

1 Nova Scotia, Your Honour.

2 **THE COURT:** Thank you. Ms. Bennett-Clayton, I  
3 understand ... I'm sorry, Mr. Macdonald.

4 **MR. MACDONALD:** I do have some questions, Your Honour.

5 **THE COURT:** So we're at 25 after 12 and we normally take  
6 a break at 12:30 for lunch so I think we'll take our break now  
7 rather than have you start and stop just so we can control the  
8 timing of this. We'll come back at 1:30 then, thank you.

9 **MR. MACDONALD:** Your Honour, I'm wondering if I'm once again  
10 beating the drum about the caution to the witness about  
11 discussing evidence with anyone during the break. If we could  
12 have it, please?

13 **THE COURT:** Doctor, you've been to court before and  
14 testified previously?

15 **A.** Yes.

16 **THE COURT:** Well, typically there's an instruction  
17 that's given to witnesses that if they're in the middle of their  
18 testimony you're generally directed not to have discussions with  
19 anyone before they return to the stand and that's not to suggest  
20 that witnesses would but might inadvertently wind up engaged in  
21 a conversation that might be better to not engage in. I'll give  
22 you that direction.



**DISCUSSION**

1           **A.**     I understand.

2           **THE COURT:**     Thank you.

3           **A.**     If they think I'm avoiding you, I'm avoiding you, yes.

4           **THE COURT:**     It does not mean you cannot have discussions  
5 with your own counsel but counsel would know the limitations of  
6 what they can discuss with you.

7           All right, thank you.

8           **COURT RECESSED**           **(12:29 HRS)**

9           **COURT RESUMED**           **(13:32 HRS)**

10          **THE COURT:**     While we're waiting for Mr. Rodgers. Ms.  
11 Lunn, with you is Mr. Norton, Adam Norton, do I have that  
12 correct?

13          **MS. LUNN:**        Yes, Your Honour, Adam Norton from the  
14 Attorney General office.

15          **THE COURT:**     Do we know where Mr. Rodgers is?  
16 Counsel, I'll tell you that there is a couple of documents  
17 I'm going to refer to, they've been marked as Exhibits 115 and  
18 116, they'll be pulled up on the monitors. Document 116 would  
19 be CAN001902 for your purposes and Exhibit 115 is going to be  
20 CAN001909. And I may also refer to it would be document CAN and  
21 the last four digits would be 2251, I may also refer to that in  
22 some questions for Dr. Slayter. Thank you.

**DR. IAN SLAYTER, Cross-Examination by Mr. Macdonald**

1 Mr. Macdonald?

2 **MR. MACDONALD:** Thank you, Your Honour. Your Honour, I  
3 should say before I start that Dr. Slayter and I had a very  
4 brief conversation because we both attended the same school  
5 together many years ago and Mr. Hayne was part of that  
6 discussion so ...

7 **THE COURT:** Even after the admonition you were  
8 requesting you still found time to have a discussion with Dr.  
9 Slayter.

10 **MR. MACDONALD:** Absolutely. Full disclosure.

11

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

13

14 **MR. MACDONALD:** Good afternoon, Dr. Slayter, so my name is  
15 Tom Macdonald and I'm counsel for Thelma and Ricky Borden who  
16 are the parents of Shanna Desmond, the grandparents of Aaliyah  
17 Desmond and Sheldon Borden who is ... was Shanna's brother and  
18 Aaliyah's uncle and I share co-representation of Aaliyah's  
19 estate with Tara Miller who is in the front row today.

20 I just wanted to ask you what you would have looked at and  
21 reviewed to prepare before you came to give evidence today? If  
22 you could sort of take me through the materials you would have

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1 ...

2       **A.** I looked at the notes that I made in 2016, that's  
3 primarily it.

4       **Q.** Yes.

5       **A.** I viewed some notes on suicide sort of assessment  
6 system, that's mostly it. I made a point of not looking at any  
7 records following my December 2nd visit so that I wouldn't  
8 colour my memory.

9       **Q.** Okay. That December 2, 2016, I guess we can call it a  
10 note, but the psychiatric assessment ...

11       **A.** Yes.

12       **Q.** ... the one that Mr. Murray was taking you through,  
13 would that have ... I assume you didn't type it yourself. When  
14 would that have been prepared in relation to when you saw Mr.  
15 Desmond?

16       **A.** I would have been done the same day. I dictate into  
17 Dragon to make my notes.

18       **Q.** Okay. I know you said, again it was in response to a  
19 question by Mr. Murray, that you heard the unfortunate news  
20 because Dr. Rahman called you that evening. Other than that,  
21 have you ever had other conversations with Dr. Rahman about this  
22 what I will call the Desmond incident if I can put it that way?

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1           **A.**    We talked quite a bit about it at the time.

2           **Q.**    Okay.  This is after January 3, 2017?

3           **A.**    Yes.

4           **Q.**    Often?  Do you have any idea how many times you may  
5 have spoken to him about it?

6           **A.**    No, just several times.

7           **Q.**    When would the last time have been that you can  
8 remember?  Maybe let me help you, was it in 2019 or 2020?

9           **A.**    2019.

10          **Q.**    Okay.

11          **A.**    I think when the Inquiry was coming up, we talked  
12 about it a little bit ... I think when the Inquiry was coming up  
13 in November before it got canceled.

14          **Q.**    Do you remember where that conversation would have  
15 taken place?  On the phone or in his office?

16          **A.**    It was probably in my office.

17          **Q.**    Pardon me?

18          **A.**    Probably in my office.

19          **Q.**    In your office, okay.  Would he have come to see you  
20 and have the discussion, Dr. Rahman?

21          **A.**    Well, he often comes by in the afternoon and we chat  
22 about whatever's going on.

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1           **Q.**    Okay.  And do you remember any specifics of the 2019  
2 conversation or what would have been said?

3           **A.**    No, I don't think anything new has come up from  
4 before.

5           **Q.**    Okay.  Well, I want to take you to Exhibit 67 and the  
6 portion of it that is your, I'm calling it a report.  Sorry, so  
7 I think it's exhibit actually 71.

8           **EXHIBIT P-000071 - PSYCHIATRIC CONSULTATION REPORT REGARDING**  
9           **PTSD BY DR. SLAYTER**

10          **Q.**    That's your report.  Standalone.

11          **A.**    Yes.

12          **Q.**    Yes.  So I see the assessment and I've read it several  
13 times.  You met with Mr. Desmond and as a result of meeting with  
14 him you prepared this assessment, correct?

15          **A.**    Yes.

16          **Q.**    When you were meeting with him, would you use any kind  
17 of a physical checklist to help remind yourself or tick off  
18 boxes or symptoms?

19          **A.**    I usually have a paper in front of me that has the  
20 different sections as outlined in my notes so that if someone  
21 tells me something that's sort of out of sequence for how I'm  
22 going to record it, I can jot my notes down in the right spot to

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1 sort of pre-organize myself. So I have sections like "PPH"  
2 means past psychiatric history so if somebody says something  
3 about the past while I'm talking about the present, I'll stick  
4 in a note there.

5 Q. Okay. Do you remember whether you ever discussed with  
6 him firearms or his access to firearms or his possession of  
7 firearms?

8 A. I don't think that came up, no.

9 Q. Is it something that, because I know it was part of  
10 the assessment was assessing that his suicide risk was low so  
11 when you're, and please tell me if I am attributing anything to  
12 you that is not the way you said it, but as I understood today,  
13 many people, if not most who come to you, at some time or  
14 another may have had some kind of a suicidal thought?

15 A. Yes.

16 Q. Is it common at all that you would explore with those  
17 individuals specifics in terms of whether they might have a  
18 weapon or access to a weapon?

19 A. I would discuss that when I thought there was a  
20 serious risk ...

21 Q. Yes.

22 A. ... but not for the sort of casual suicidal thoughts

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1 that are low risk.

2 Q. Okay. Any specific discussions for delving into  
3 hurting others other than himself, so homicidal ideation, or  
4 just saying I'm thinking about hurting somebody else or have you  
5 ever, that kind of a thought?

6 A. I don't normally ask that unless the story includes  
7 issues to do with abuse or violence or something along those  
8 lines.

9 Q. Yes, okay, I understand. Did you ask him whether he  
10 ever hit his wife?

11 A. Yes.

12 Q. Okay. And the answer was no?

13 A. He said no and that was when I saw them together.

14 Q. Oh, so that's in October 24th?

15 A. Yes, and he said or she said it was just hitting  
16 things and that she wasn't afraid of him.

17 Q. I noticed, and now I'm over at page 27 of your report,  
18 and I'm just going to read a few parts from what at the top of  
19 page 27 is the continuation of your history section, his  
20 history, and then also into the mental status examination. And  
21 so I note that you say: "He cannot retain multiple instructions.  
22 He cannot follow a conversation which is rapid or sustained. He

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1 says he picks up only a little of what is said and forgets the  
2 rest. He cannot follow a conversation when there is a  
3 distraction present such as a television on. He is easily  
4 rattled." And then at the bottom under the mental status  
5 examination: "Cognitive difficulties were evident in that he  
6 reported difficulties with information processing and said  
7 during the interview with me that he missed and could not retain  
8 many of the words I was saying." You put that in your report,  
9 you remember that?

10 **A.** Yes.

11 **Q.** I'm just wondering and I'm not in any way suggesting  
12 this is on you, but under the homework section, of course, and  
13 you didn't call it homework this morning in response to the  
14 questions, but you were asking him to get his records. A person  
15 with those qualities that you note in your assessment, Mr.  
16 Desmond, so he's having trouble retaining things, could you see  
17 that possibly, whether it was with Mr. Desmond or someone else  
18 with his kinds of qualities that you know, does that become a  
19 barrier to someone? It may seem simple to you or to me, but who  
20 just cannot get it together to get their medical records without  
21 some kind of outside assistance, a navigator or a support person  
22 to get through the process of helping them access things?



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1           **A.**    Yes, that could be a barrier.

2           **Q.**    Okay.  Would that be something that might be worthy of  
3 review by the Inquiry so that people in his situation and maybe  
4 a combat veteran with specifics with PTSD severe like he had,  
5 could use assistance to help them obtain records?

6           **A.**    Yes.  If I can add something?

7           **Q.**    Yes, of course.

8           **A.**    Generally with patients, if I make two or more  
9 suggestions and I'm prone to making that, more than one  
10 suggestion, I usually always write down what I want them to go  
11 home and do so they can remember.

12          **Q.**    Okay.

13          **A.**    When it's only one item I tend not to do that in hopes  
14 that they can remember one thing but I don't know, in his case,  
15 but I would hope I wrote something but I probably didn't.

16          **Q.**    Sure.

17          **A.**    But you're correct, it would be helpful in a situation  
18 like this to write it down.

19          **Q.**    The December 21, 2016 missed appointment that he  
20 missed, the purpose of it I wasn't quite clear this morning, was  
21 it to think about putting him on depression medication?

22          **A.**    So it was two parts.  I said the focus would be on

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1 treatment but I still had a little homework to do. I think I  
2 mentioned this morning that the jealousy issue and the ADD issue  
3 I didn't think I finished really going into those because I  
4 didn't have time after dealing with what I thought were the more  
5 important or at least more immediate issues.

6 Q. Yes.

7 A. So I would have, I think, gotten into that a little  
8 more as well as checking how he was doing on the depression side  
9 and the sleep side and then I would have wanted to get into the  
10 treatment but I would had to have had his record present to do  
11 that properly.

12 Q. Yeah. I heard this morning when you spoke to Mr.  
13 Murray about borderline delusions and were you here, I think you  
14 were here for some of Dr. Rahman's evidence last week?

15 A. No, none of it, I wasn't here.

16 Q. Okay. So Dr. Rahman was of the view there is no such  
17 thing as a delusion and I heard your evidence this morning and  
18 am I right in saying you may be both on the same page now?

19 A. It's my own term.

20 Q. Yes, okay, okay. And do you ... is it possible that  
21 someone could be borderline delusional, that other  
22 psychiatrists, some would see it your way, some would see it Dr.

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1 Rahman's way?

2       **A.** It's semantics. It's the term I was using and that's  
3 why I was thinking when I said earlier today that I didn't write  
4 this for lawyers.

5       **Q.** Right.

6       **A.** The way I wrote it in the assessment risk, it sounds  
7 like it's a type of delusion but what I was really getting at is  
8 what I spelled out a little longer in the text saying that his  
9 thoughts border at times on delusions, they aren't delusions but  
10 they're kind of near it.

11       **Q.** Yes, okay. One of the things Judge Zimmer last week  
12 with Dr. Rahman, played a video of Mr. Desmond in the firearms  
13 store choosing the weapon that he ultimately used and at the end  
14 of it, Judge Zimmer asked Dr. Rahman to the words to the effect,  
15 tell us what you see and I know you haven't seen the video and  
16 I'm not going to ask ...

17       **A.** I have seen the video.

18       **Q.** Oh, you have seen the video, okay. My question is  
19 this. So my understanding of what Dr. Rahman saw and his  
20 comments, and with a room full of lawyers and a judge I'm sure  
21 I'll hear about it if I get any of it wrong, so he's in a gun  
22 store, there are other customers. He is walking, he's looking

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1 at guns, he's looking at used guns that are behind the counter,  
2 he's looking at new guns that are behind the counter, he's  
3 interacting with maybe it's the owner of the store but a store  
4 clerk. He sites the guns, he physically handles them, one of  
5 each, he finally chooses a gun that happens to be a used gun, he  
6 chooses ammunition and looks at the box of ammunition. He  
7 thinks about, my word, getting a gun case, handles it, ends up  
8 not buying that. Helps the owner of the store put the gun he  
9 purchases into a plastic sleeve and, of course, completes, is  
10 interacting with the owner, but also completes, as Dr. Rahman  
11 put it, a financial transaction, he pays for the weapon.

12 You're not a forensic psychiatrist, I know that. Is there  
13 anything you could offer by way of as a long-term practicing  
14 psychiatrist, to offer any little glint of examination in terms  
15 of how a person could present like that less than three hours  
16 before he then takes his own life and his family's life? What  
17 happens to his state of mind or triggers or just speculation, I  
18 know, but informed speculation from a psychiatrist.

19 **A.** I ...

20 **MR. HAYNE:** Your Honour, I appreciate that Mr. Macdonald  
21 addressed it, it is speculation and I just wanted to raise the  
22 concern, I guess, that Dr. Slayter wasn't there at the time so

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1 it's in that context if he's going to provide any evidence on  
2 that point subject to Your Honour's thoughts on that question.

3 **MR. MACDONALD**: And that's fine with me, Your Honour. Of  
4 course, Dr. Rahman was not there at the time either.

5 **THE COURT**: Dr. Slayter would understand the question.  
6 Do you understand the question and the point? Go ahead.

7 **A.** If we can agree it's not area of expertise exactly,  
8 it's experience you said in knowing people and working with  
9 people.

10 **MR. MACDONALD**: Agreed, Dr. Slayter, absolutely.

11 **A.** Okay. So I did look at it late last week and when I  
12 go shopping, I'm a bit of a people watcher and I watch a lot of  
13 the other shoppers especially when I'm waiting for something and  
14 he looked to me like a lot of people I see when they're  
15 shopping. He's just kind of bored, the first part, a long  
16 section for the first part he was waiting for the salesman or  
17 manager, whatever, to come and attend to him and he was walking  
18 back and forth, kind of kicking his feet about a little bit. He  
19 looked very bored and he also looked a little bit like he had  
20 something on his mind. I didn't (audio blip) particularly but  
21 then I couldn't see his face very often so I was going more by  
22 body language but I thought he looked a little bored and like

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1 most other shoppers I see when they're bored waiting for  
2 something to happen.

3 I was struck that he was focused on guns with scopes since  
4 suicide doesn't require a scope and that he was worried about  
5 which gun to buy when, again, it doesn't really matter much  
6 which gun you get if you're going to shoot yourself, that kind  
7 of thing.

8 Towards the end when I could see the side of his face a  
9 little bit when he was talking at the back at the other side of  
10 the room, he seemed a little more animated, his arms were moving  
11 around and his face was moving a little bit it looked like  
12 having a conversation.

13 So I would think most people, if they're considering  
14 shooting themselves an hour or two later, would look a little  
15 different but I don't have experience in spending time with  
16 people who shoot themselves two hours later so I don't really  
17 know but I would think it would be different.

18 **Q.** Understood, thank you. I know you mentioned earlier  
19 in your evidence with Mr. Murray that you have had some  
20 experience with veterans when you were in the US?

21 **A.** A little bit.

22 **Q.** Yes. And you were in Pittsburgh and then you were in

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1 Maine. Can you offer any balancing of people you may have seen,  
2 veterans with PTSD, at those stops in your career in relation to  
3 Mr. Desmond's PTSD that you observed and made notes about on  
4 December 2, 2016 and October?

5 **A.** Not particularly. I remember one case who I saw for  
6 several visits unlike Mr. Desmond as I say, who I met, in  
7 particular had a lot of waking up in the middle of a firefight  
8 or something in his mind and being very agitated for a couple  
9 minutes or so until he realized that everything was okay. But  
10 basically, no, I don't. Everyone I've seen, the PTSD is a  
11 little different but I could say the same with anxiety disorder  
12 or depression, people can have the same basic condition but it's  
13 a little bit individualized.

14 **Q.** And again, you weren't there and it's very clear I'm  
15 not asking you for an opinion on something happened when you  
16 weren't there but in general psychiatric medicine mode, can you  
17 explain any of the kind of factors that could possibly trigger  
18 in a person who presents as normal a few hours before a tragic  
19 event happens, what kind of triggers might go off in a person to  
20 change them and get them to do an act like happened here?

21 **A.** I can simply say I would expect something upsetting  
22 would have to happen.

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1           **Q.**    Yes.  It could be a life event or it could be many  
2 things?

3           **A.**    It could be many things, yeah, but something upsetting  
4 ...

5           **Q.**    Upsetting.

6           **A.**    ... because if he was low risk immediately beforehand  
7 which I thought, or at least Dr. Rahman did and he and I do  
8 things much the same way, I would think something had to have  
9 come up that afternoon or he had something else on his mind.

10          **Q.**    When you say he had something else on his mind, could  
11 you elaborate on that a little bit?

12          **A.**    Well, I'm ...

13          **Q.**    I don't mean with Mr. Desmond specifically but an  
14 individual who might have something else on their mind.

15          **A.**    Well, this would be speculation ...

16          **Q.**    Yes, of course.

17          **A.**    ... but if his intent was to shoot his wife and not  
18 himself, that might have had a different look on his face during  
19 the gun shop time.

20          **Q.**    In response to a question, it may have been Mr. Murray  
21 or Ms. Grant, it was about resources, about more resources, I  
22 think it was Mr. Murray, you made a statement something to the



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1 effect, Well, we're not going to get them, I'm not going to put  
2 words in your mouth, but do you ...

3 **A.** Yes, I said that.

4 **Q.** What do you see is the limit? It seemed like such a  
5 firm statement from you, I'm just wondering if you could expand  
6 in terms of what you see, why so direct a statement in terms of  
7 resources aren't coming?

8 **A.** Well, for many of us working in health care, it's the  
9 impression that the Province, the Health Authority, doesn't have  
10 a lot of money to spend on new things. We see, to be fair, we  
11 have seen small increases at times, for example, our crisis  
12 service started, I'm not quite sure when, but maybe four years  
13 ago or five years ago and that was an add-on and it grew from  
14 one person to two persons to three persons so that was an  
15 increase. It's the only one I can immediately think of.  
16 There's a new intake service in the province which has taken  
17 some money but generally there's a not a lot of money, that's my  
18 impression anyway.

19 **Q.** Can you offer any suggestions or recommendations to  
20 the Inquiry knowing what we now know, what happened three years  
21 ago, in terms of something that would assist in your field or  
22 generally to help these situations from repeating?

**DR. IAN SLAYTER, Cross-Examination by Mr. Macdonald**

1           **A.**    I think that some education on domestic violence but  
2 particularly on serious violence and homicide would be helpful.  
3 These are forensic psychiatry issues which most of us don't get  
4 any training in or don't have any experience of. I've never had  
5 anyone who shot someone before in my care. So I think getting  
6 some help in learning how to identify the red flags for that  
7 kind of thing would be helpful.

8           **Q.**    And do you think would it be helpful if that training  
9 flowed through the broad body of health care professionals so  
10 whether it's the family doctor or the nurses at the ER or the  
11 emergency room physicians and the psychiatrists that that  
12 training would benefit that entire group and I don't mean to  
13 exclude others in the group?

14           **A.**    Yes, sometimes physicians prefer it to be a little  
15 shorter and quicker when education comes and others tolerate  
16 two-day sessions, we would benefit from a half-day session.

17           **MR. MACDONALD:** Okay. Those are my questions, thank you  
18 very much Dr. Slayter.

19           **THE COURT:**        Ms. Bennett-Clayton?  
20  
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22

DR. IAN SLAYTER, Cross-Examination by Ms. Bennett-Clayton

CROSS-EXAMINATION BY MS. BENNETT-CLAYTON

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**MS. BENNETT-CLAYTON:** Thank you.

Dr. Slayter, I'm Karen Bennett-Clayton and along with my colleagues, Rory Rogers and Amanda Whitehead, we represent the Health Authority. I have just a few questions for you. You've been asked questions about the mental health crisis team, I think that's the term you used, at St. Martha's?

**A.** Yes.

**Q.** Is that the term you would use?

**A.** Yes.

**Q.** Is it a crisis response team?

**A.** I think its formal name is crisis response service.

**Q.** Okay. And that service you described as currently having three people, is that right?

**A.** There's three positions, one's off on extended leave but yes.

**Q.** And what would those positions be, are they all nurses or are they different?

**A.** Two of the incumbents are nurses and one is a social worker.

**Q.** And I think I just heard you say that that team has

**DR. IAN SLAYTER, Cross-Examination by Ms. Bennett-Clayton**

1 grown ...

2       **A.** Yes.

3       **Q.** ... from its inception from one person now to a  
4 complement of three?

5       **A.** Yes.

6       **Q.** In 2016 was that team limited to one person to your  
7 recollection?

8       **A.** I think so.

9       **Q.** And that would have been Heather Wheaton?

10       **A.** Yes.

11       **Q.** So in 2016 the hours of that mental health crisis  
12 response service at St. Martha's, that would have been limited  
13 to the hours that Heather Wheaton would be working, is that  
14 correct?

15       **A.** Yes, and I think they were a little different then,  
16 they might have been 8 to 4 whereas now it might be ... it goes  
17 a little later.

18       **Q.** So that's Monday to Friday?

19       **A.** Yes.

20       **Q.** So it wouldn't be any evenings?

21       **A.** No.

22       **Q.** And it wouldn't be on weekends?

**DR. IAN SLAYTER, Cross-Examination by Ms. Bennett-Clayton**

1           **A.**    No.

2           **Q.**    And it wouldn't be on holidays?

3           **A.**    No.

4           **Q.**    So during those times, the evenings, the weekends, the  
5 holidays, if the mental health crisis response person at that  
6 time was not working, who provided mental health crisis response  
7 service at St. Martha's?

8           **A.**    So we have 24/7 coverage by psychiatrists including at  
9 nighttime and weekends and holidays. The three GPs I referred  
10 to earlier who have been doing it for a long time and they  
11 cover.

12          **Q.**    Okay. So it would be the three psychiatrists and the  
13 three GPs?

14          **A.**    Yes.

15          **Q.**    That would be on the on-call rotation?

16          **A.**    Yes.

17          **Q.**    But during the weekdays when the mental health crisis  
18 response team member, at that point, was working, would that  
19 person be the person that was called to the ER if there was a  
20 need for a consult on mental health?

21          **A.**    So during the daytime Monday to Friday from, we'll  
22 say, 8 to 5, it would be the person on the Psychiatry on-call...

**DR. IAN SLAYTER, Cross-Examination by Ms. Bennett-Clayton**

1 Sorry. The psychiatrists, the currently three - maybe two at  
2 that time - would cover the ER and we would go down when the  
3 Crisis nurse or social worker needed some assistance.

4 Q. Right. But, initially, would it be the nurse ...

5 A. Yes.

6 Q. Heather Wheaton at the time, would Heather be the  
7 person that would be called initially by the ER physician?

8 A. Yes.

9 Q. And she would come down and do an assessment?

10 A. Yes.

11 Q. If she was called by the ER physician?

12 A. Yes.

13 Q. Do you know whether she would be called on every  
14 occasion when there'd be a patient come into the ER, during her  
15 working hours, that required mental health care?

16 A. If I can rephrase the question?

17 Q. Sure.

18 A. Not everyone who comes in with a mental health  
19 concern or issue would be seen by the Crisis worker. The ER  
20 can deal with a lot of that.

21 Q. Okay.

22 A. But when they feel that, for whatever reason, it

**DR. IAN SLAYTER, Cross-Examination by Ms. Bennett-Clayton**

1 needs more than what they have to offer in the time that they  
2 have, then they would call in Crisis.

3 Q. Okay. And that would be at the time, in 2016,  
4 Heather Wheaton?

5 A. Yes.

6 Q. And once she does her assessment, to your knowledge,  
7 once she did her assessment or would do her assessment in the  
8 ER, would she be the person that would call a psychiatrist to  
9 come and be part of the consultation?

10 A. Yes.

11 Q. And is that how you became involved with Mr.  
12 Desmond's care on October 24th?

13 A. Yes.

14 Q. The mental health crisis response team, is that a  
15 service that provides care to all patients anywhere within the  
16 hospital or is it limited to the ER?

17 A. Limited to the ER.

18 Q. Okay. And are they called in to consult in the ER?

19 A. How do you mean?

20 Q. Is it, when you get a call from an ER physician to  
21 come on a consult, that's the same for the Crisis response team,  
22 they're called to consult?

**DR. IAN SLAYTER, Cross-Examination by Ms. Bennett-Clayton**

1           **A.**     Yes.  There was the time I mentioned earlier when we  
2 would sometimes have the Crisis worker just go in and identify  
3 who it might be, because we know we would get called eventually.

4           **Q.**     Mm-hmm.

5           **A.**     And it would speed up service to them.  That's  
6 changed and now requires the ER physician to see the person  
7 first and then they would consult with Crisis.

8           **Q.**     Right.  Generally speaking, what would be the  
9 occasions when the mental health crisis response worker would  
10 call in the psychiatrist to also be part of that consult in the  
11 ER?

12          **A.**     The most common reason is because they think that an  
13 admission is needed and the psychiatrist needs to be involved in  
14 making the decision to admit.  Sometimes it's because that  
15 that's not, it doesn't look needed, but the situation is complex  
16 in some sense and needs another opinion.

17          **Q.**     Okay.  So the mental health crisis response worker,  
18 as a nurse, they cannot admit patients?

19          **A.**     No.

20          **Q.**     Only a psychiatrist or a physician can do that?

21          **A.**     Correct.

22          **Q.**     If medication was required or thought to be required,



**DR. IAN SLAYTER, Cross-Examination by Ms. Bennett-Clayton**

1 can the mental health crisis response worker, as a nurse,  
2 prescribe medication?

3 **A.** No.

4 **Q.** And who can do that?

5 **A.** So a physician.

6 **Q.** Okay.

7 **A.** That's probably why I was called in that case.

8 **Q.** Okay. On the 24th of October?

9 **A.** Yes.

10 **Q.** And what about discharging a patient from the ER?

11 **A.** So they can discharge a patient from the ER with a  
12 physician's okay. So most people ... I should say most people  
13 they see the psychiatrist does not get called.

14 **Q.** Mm-hmm.

15 **A.** And they would report back to the ER physician, who  
16 would formally be the one behind the discharge.

17 **Q.** Okay. When you saw Mr. Desmond on December 2nd and  
18 you prepared your report, at that time you were aware that  
19 Catherine Chambers was involved in his care or would be involved  
20 in his care, is that right?

21 **A.** Yes.

22 **Q.** And that's information that came to you how?

**DR. IAN SLAYTER, Cross-Examination by Ms. Bennett-Clayton**

1           **A.**     From him.

2           **Q.**     Catherine Chambers does not work in the Outpatient  
3 Department at St. Martha's?

4           **A.**     No.

5           **Q.**     She's a private therapist in the community?

6           **A.**     Yes.

7           **Q.**     And did you have any knowledge as to how Mr. Desmond  
8 came to be connected with Catherine Chambers?

9           **A.**     He told me that - I don't know the exact words - but  
10 he told me what I took to be that the VA had arranged for her to  
11 see him.

12          **Q.**     Thank you. Those are my questions.

13          **THE COURT:**     Ms. Miller?

14

15   **CROSS-EXAMINATION BY MS. MILLER**

16

17          **MS. MILLER:**     Dr. Slayter, we met earlier. My name is  
18 Tara Miller and I represent Brenda Desmond and also share with  
19 my friend, Mr. Macdonald, representation of Aaliyah Desmond. I  
20 am going to go through a few different topics, based on what you  
21 have shared with us in your evidence this morning.

22           As I understood your evidence, you talked about research

**DR. IAN SLAYTER, Cross-Examination by Ms. Miller**

1 that you did to help develop the initial suicide assessment  
2 criteria tool, is that correct?

3 **A.** Yes.

4 **Q.** And that has been a project, I think, that has  
5 evolved over time, and we heard evidence through Dr. Rahman last  
6 week that most recently there's been a policy that came out in  
7 June of 2017 addressing that process and formalizing the  
8 checklist, making it updated?

9 **A.** Yes.

10 **Q.** Okay. When you were describing your role in that  
11 research work, I think you talked about you reviewed, with some  
12 other folks, a wide variety of publications and research papers  
13 and identified about 120 factors, but then you'd collapsed sort  
14 of them into 20 to 30 because there would have been repetition  
15 and different people saying the same thing in different ways.  
16 Did I understand that correctly?

17 **A.** Yes.

18 **Q.** Yeah. And I think I heard you say that despite all  
19 of the work that you'd looked at, the body of research that you  
20 looked at, no one had ever done a study where they could take  
21 those actual identified risk factors and identify that they were  
22 present a certain percentage of time. Did I understand that

**DR. IAN SLAYTER, Cross-Examination by Ms. Miller**

1 correctly?

2       **A.**     I am not aware of such and it would be difficult to  
3 do, so I doubt that it exists.

4       **Q.**     Okay. From your perspective, notwithstanding the  
5 fact that it might be difficult to do, would that be helpful in  
6 terms of getting the best evidence-based practice to assess  
7 risk?

8       **A.**     Not really. Let's say something ... Let's take blue  
9 eyes and brown eyes, if you will indulge me for a moment, and  
10 say that brown eyes are 80 percent of the time and blue eyes are  
11 20 percent of the time - I have no idea - and someone comes to  
12 me with a blindfold on and I have to say what colour their eyes  
13 are from their symptoms. The fact that 80 percent have brown  
14 eyes, I could say, well, it's likely that, so I'm going to say  
15 brown. That would obviously fail some of the time. And I could  
16 say it's blue eyes, on a guess, but that would fail. So knowing  
17 something is very common you err on the side of assuming this is  
18 common. Someone has chest pain, so I assume it's just  
19 indigestion and miss the heart attack. Or it's the other way,  
20 I'll say it might be something rare but that's unlikely. So  
21 knowing statistics doesn't help you with the particular  
22 individual. It tells you out of 100 people or 1000 people what

**DR. IAN SLAYTER, Cross-Examination by Ms. Miller**

1 you would see, but when you have an individual in front of you  
2 they're all possibilities and they all have to be given sort of  
3 equal value.

4 Q. But if you had an assessment that looked at, you  
5 know, the 25 or 30 risk factors and rank them in terms of the  
6 most percentage - you know, this occurs in 80 percent of  
7 suicides, this occurs in 60 percent - that strikes me as  
8 something that would be helpful in ...

9 A. You would keep an eye open for it but you can't rate  
10 it. That doesn't help you give it weight.

11 Q. Okay.

12 A. I'm probably a high risk of suicide because I'm an  
13 older white male - those are three risk factors and ... But that  
14 only tells you that of a group of 1000 old white men, that they  
15 might have a higher rate, not about me.

16 Q. Okay. The risk factor research work that you did you  
17 said was with respect to suicide. We heard evidence from Dr.  
18 Rahman there's no homicide risk factor policy tool that's been  
19 developed or is in the works through the Nova Scotia Health  
20 Authority.

21 A. No.

22 Q. Is that fair? Okay. You had indicated that one of

**DR. IAN SLAYTER, Cross-Examination by Ms. Miller**

1 the recommendations that you have is for further training with  
2 domestic violence, particularly training around serious violence  
3 and homicide. That's something ...

4 **A.** Yes.

5 **Q.** ... that you have identified, so, reflecting back,  
6 that would be valuable to you and your colleagues in this field  
7 of practice?

8 **A.** I think so.

9 **Q.** I want to go back to my question about identifying  
10 percentages. Are you familiar with, Dr. Slayter, the Domestic  
11 Violence Death Review Committee 2017 Annual Report from the  
12 Office of the Chief Coroner out of the Province of Ontario?

13 **A.** No.

14 **Q.** Okay. I will, just for the record, to help you  
15 understand, the definition of domestic violence death is defined  
16 as "all homicides that involve the death of a person and/or his  
17 or her children committed by the person's partner or ex-partner  
18 from an intimate relationship". That study involved 311 cases  
19 following 445 deaths that met that criteria, and that study, as  
20 I understand it, identified risk factors by way of percentage  
21 that were present in a certain amount of those cases. So that's  
22 where I was thinking ...

**DR. IAN SLAYTER, Cross-Examination by Ms. Miller**

1           **A.**     Okay.

2           **Q.**     ... that that type of information, particularly when  
3 you're looking for additional training about violence, domestic  
4 violence, particularly, serious violence and homicide, having  
5 access to an understanding of those risk factors with their  
6 percentages strikes me would be helpful in terms of your  
7 colleagues' education on that piece.

8           **A.**     Yes.

9           **Q.**     Okay. Thank you.

10          I am going to get you to look at Exhibit 67 - this is the  
11 St. Martha's record - and, in particular, at page 22. I'll just  
12 bring that up for you. This is a document that we have not  
13 addressed, I don't think, with anyone yet, but it is, as I  
14 understand it, and I'll get you to confirm, Dr. Slayter, what  
15 your understanding of this is, this is a December 1st, 2016 ER  
16 Report, so the day before Lionel would have come to see you for  
17 your outpatient consult.

18          **A.**     Yes.

19          **Q.**     He appeared again in the Emergency Room, that's my  
20 understanding of this, and under the triage assessment it says:  
21 "He looking to speak with someone in Mental Health. Problems  
22 with home life, anger issues. He and his wife are having

**DR. IAN SLAYTER, Cross-Examination by Ms. Miller**

1 personal relationship problems. Frequent outbursts at home, and  
2 in a temporary separation. Sees Dr. Slayter, last saw six weeks  
3 ago. Wants to see someone in Mental Health." So I understand  
4 he came in at 11:28 and at 3:10 there's a handwritten note: "Not  
5 in the waiting room." I take from that that when it was time  
6 for Lionel to be assessed in the Emergency Room someone would  
7 have gone to get him but he was no longer there. Is that a fair  
8 ...

9 **A.** I would assume that, yeah.

10 **Q.** ... understanding? Okay. When he saw you on  
11 December 2nd, did he share with you that he had gone to the  
12 Emergency Room the previous day?

13 **A.** No, and I wasn't aware of it at that time, so I  
14 didn't ask him about it.

15 **Q.** Okay. Would that have had any relevance to you in  
16 terms of you seeing him on the 2nd to understand and know that  
17 just the day before he had reached a point where he had gone to  
18 seek mental health treatment through the Emergency Room?

19 **A.** It would have been relevant. I would have wanted to  
20 know what was going on, et cetera.

21 **Q.** Yeah. And the note that he was experiencing, it said  
22 temporary separation, that strikes me as something different



**DR. IAN SLAYTER, Cross-Examination by Ms. Miller**

1 than what he would have conveyed to you on December 2nd. You  
2 understood there was interpersonal conflict with his wife?

3 **A.** I understood, I think, from the October visit that  
4 they did ... he did sometimes leave the house for a day and then  
5 go back the next day.

6 **Q.** Okay.

7 **A.** So I think this would have been one of those, but the  
8 fact that there was something going on, I would have, it would  
9 have been a chance to get more details because I had more time  
10 that day.

11 **Q.** Yeah. And would you have had access to that record,  
12 Dr. Slayter, in MEDITECH? This is an Emergency Room intake  
13 record from the day before.

14 **A.** The MEDITECH records are scanned.

15 **Q.** Yes.

16 **Q.** And, well, I know a year ago they were four months  
17 behind in being scanned. I haven't checked just lately but they  
18 take a while to get in there.

19 **Q.** Okay.

20 **A.** And I probably wouldn't have looked because I  
21 wouldn't have thought I had a reason to find anything there.

22 **Q.** Okay.

**DR. IAN SLAYTER, Cross-Examination by Ms. Miller**

1           **A.**     It wouldn't have been there, I don't think, anyway.

2           **Q.**     And do you recall asking Lionel if he had recently  
3 gone to the Emergency Room ...

4           **A.**     No.

5           **Q.**     ... as part of your consult?

6           **A.**     No.

7           **Q.**     Your report of December 2nd identifies, as you've  
8 already gone over, under "Assessment", the different diagnoses  
9 that you were able to confirm, and also that you wanted to rule  
10 out attention deficit disorder. I wanted to ask you this  
11 question about anxiety. Was Lionel, from your perspective, ever  
12 diagnosed with anxiety or is that a symptom of the PTSD? What  
13 is the role of anxiety vis-a-vis ...

14          **A.**     He was anxious, as a symptom.

15          **Q.**     He was anxious.

16          **A.**     And I saw that as part of his PTSD and part of the  
17 general difficulty he was having coping with getting his life  
18 direction and with his marriage and so on, so I ... He didn't  
19 come across to me that he had an anxiety disorder in the sense  
20 of what we call a generalized anxiety disorder or a social  
21 anxiety disorder. That sort of thing is more situational. So  
22 he sort of came under the other things that I identified.

**DR. IAN SLAYTER, Cross-Examination by Ms. Miller**

1           **Q.**     Okay.     So there was no DSM diagnosis of generalized  
2 anxiety?

3           **A.**     None was made.   One could make that but I didn't  
4 think that was the issue.

5           **Q.**     Okay.     As I understand your evidence, the anxiety  
6 that you saw with Lionel presented as a symptom of the PTSD?

7           **A.**     From the other problems.

8           **Q.**     Yes.     Okay.   A couple of other documents I just  
9 wanted to ask you for your information and perspective on in the  
10 St. Martha's records.   This is a document that appears at page  
11 11 of that exhibit.   Can you help me understand, Dr. Slayter,  
12 what this document is.   It says "Psychiatric Referral  
13 Disposition".

14          **A.**     So what's the date on it?

15          **Q.**     I'm not sure.   It says, "Patient last..."   There's a  
16 question, "Patient ..."

17          **A.**     Okay.   What it is or looks like is ... I mentioned  
18 earlier that the referral would have been received by our intake  
19 nurse.

20          **Q.**     Yes.

21          **A.**     So it would come through our intake process and those  
22 were the categories under which referrals to Psychiatry ...

**DR. IAN SLAYTER, Cross-Examination by Ms. Miller**

1 outpatient referrals to Psychiatry were being categorized.

2 Q. Okay.

3 A. So he was put in not as "urgent" but as a priority  
4 above regular.

5 Q. Okay. So you described earlier the process for a  
6 patient to see you in Outpatients was the referral typically  
7 comes in through a family doctor.

8 A. Yes.

9 Q. And if we look at page 13 of that same exhibit, it's  
10 my understanding that this is the referral that would have come  
11 in from Corporal Desmond's family doctor, and it's dated  
12 November 16th, if I can read the writing under his handwriting.  
13 Does that ...

14 A. Yes, yeah.

15 Q. ... accord with how you understand that document?

16 A. Yes.

17 Q. Okay. So he would have been referred by his family  
18 doctor on November 16th. Then if you turn to page 12 we see a  
19 document, it says St. Martha's Regional Mental Health Wait Times  
20 Form. Can you help us understand this document?

21 A. Can you pull that further down, I can only see part  
22 of it. Can you go down the page? Okay. Okay, back up a bit.

**DR. IAN SLAYTER, Cross-Examination by Ms. Miller**

1 There. So at that time there were three official levels or wait  
2 times to wait for an appointment: urgent, within seven days;  
3 semi-urgent, within a month; and regular, basically after that.  
4 This was in flux over the past several years, that system, and I  
5 have created for Outpatient Psychiatry one called priority,  
6 which was quicker than regular and later than urgent, so what  
7 that meant for me was that, if he was urgent, meaning he had to  
8 be seen within seven days, it would be done then. If I thought  
9 it ... And priority meant it would be next on the list after the  
10 urgent referrals were taken care of.

11 Q. Okay. So this is sort of an internal St. Martha's  
12 Hospital form?

13 A. Yeah. So it was in between the urgent and the  
14 regular, and I think we had stopped using semi-urgent, but it  
15 meant they were to be seen next, priority referrals were to be  
16 seen next after the urgent ones were taken care of.

17 Q. Okay. So who would have completed this document,  
18 because it says referral date November 3rd versus the  
19 handwritten referral from Lionel's family doctor at page 13,  
20 which says November 16th.

21 A. That's curious. I can't explain the dates.

22 Q. Okay.

**DR. IAN SLAYTER, Cross-Examination by Ms. Miller**

1           **A.**     Can you go back to page 12. The one that says  
2 priority on it, whichever one that was, the first one you showed  
3 me.

4           **Q.**     Oh, at page 11?

5           **A.**     Page 11.

6           **Q.**     Yeah, page 11.

7           **A.**     I'm going to guess the check mark on priority is my  
8 handwriting, the rest isn't.

9           **Q.**     So this is page 11 of ...

10          **A.**     Yeah.

11          **Q.**     ... Exhibit 67.

12          **A.**     I'm guessing that might be my handwriting that's  
13 checked on the priority one but not on the rest of it.

14          **Q.**     Okay.

15          **A.**     But why it would be dated before the referral is  
16 received I have no idea.

17          **THE COURT:**     I might just make this observation, that  
18 when you look at page 13, that it looks like there's a fax  
19 header across the top and it has a date 11-03-2016. That would  
20 suggest November 3rd, as well, and not November 16th.

21          **MS. MILLER:**     Okay.

22          **THE COURT:**     And if it was November 3rd, then it would

**DR. IAN SLAYTER, Cross-Examination by Ms. Miller**

1 kind of coincide with page 12.

2 **MS. MILLER**: Just I was curious about the discrepancy,  
3 Your Honour, yeah.

4 So we know one way or the other that a referral was sent in  
5 either on November 3rd or November 16th from Corporal Desmond's  
6 family physician. Do you ... Sorry, going back to page 11, do  
7 you review that initial referral and make a determination of how  
8 it's going to be categorized in terms of urgency?

9 **A.** I think I was doing ... I cannot remember what we  
10 were doing at that particular time, 2016, but there have been  
11 times when ... there was a time when our intake nurse retired  
12 and that's when I started vetting the Psychiatry referrals to  
13 make sure they seemed appropriate.

14 **Q.** Yes.

15 **A.** So it seemed to me that was earlier than that but I  
16 can't remember.

17 **Q.** Okay. You classified it as Priority 1, I'm sorry, 1  
18 - Priority, and what would that have triggered in terms of the  
19 turnaround time for someone ...

20 **A.** As I say, we would address anyone urgent first.

21 **Q.** Yes.

22 **A.** They had to be seen within a week, and if there were

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1 none of those, he would be the first on the list.

2 Q. Right. So he would be seen within ...

3 A. It would be quickly.

4 Q. Quickly. And he was seen on December 2nd.

5 A. And he was seen quickly.

6 Q. Thank you. My friend, Mr. Macdonald, reviewed this  
7 with you. You had given ... you had reviewed in your report and  
8 reviewed here today the concerns you had with the cognitive  
9 issues that were demonstrated by Corporal Desmond. You talked  
10 about that it was quite concerning to you that he had that  
11 information processing, and then you had indicated that,  
12 typically, when you give homework, using that term homework,  
13 that you would, if there was anything more than one item you  
14 would write out a list. I wanted to ask you to look at a  
15 document to see if this is, in fact ... A list was found in  
16 Corporal Desmond's vehicle.

17 A. Okay.

18 Q. And the author of which we do not know and I'm  
19 wondering if it is you. So I'm going to get you to ... We're  
20 going to go to Exhibit 42, and this is a document, it's in a  
21 series of photos.

22 A. And I don't record those documents, so I wouldn't



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1 know when I'd done it.

2 Q. Right.

3 A. But I usually do it.

4 Q. And I believe it is at page 24 ... it's photo 24 or  
5 page 24.

6 A. That's my handwriting.

7 Q. That is your handwriting. All right. So this is, as  
8 you had earlier indicated, you weren't able to recall whether or  
9 not you had done a handwritten list, but you did write out a  
10 list for Corporal Desmond.

11 A. Yes.

12 Q. Dated December 2nd. One, to contact OSI Halifax.  
13 Two, we see "Start antidepressant". I'm going to get you first  
14 to read it and then, I know that it's been scratched out, but if  
15 you can read what you wrote and then explain to us why you  
16 scratched it out.

17 A. The scratched out.

18 Q. Yeah.

19 A. It says "Start antidepressant fluoxetine 20 mg. once  
20 a day, in the morning." I don't know why it was written.

21 Q. Okay. You don't know why it was written?

22 A. Why I wrote it and then unwrote it. I didn't ... I

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1 decided not to give him an antidepressant, so I don't know how  
2 that got on there.

3 Q. Okay.

4 A. Obviously I changed my mind or my mind was somewhere  
5 else.

6 Q. Fair enough. Third, therapy, which you've talked  
7 about. Fourth, gym and yoga, and we reviewed the official  
8 letter that you had recommended for payment for that. And then  
9 the fifth thing, neuropsychological assessment re cognition.

10 A. Um-hmm.

11 Q. And that you indicated and identified in your  
12 December 2nd consult note. Then we see "Problem: PTSD, post-  
13 concussion syndrome, jealousy, question ADD." Those were your  
14 diagnoses, correct?

15 A. I left out depression, but yes.

16 Q. Okay. Any reason why you would have left out  
17 depression?

18 A. I might have thought about putting it in there ... My  
19 focus was on these other ones.

20 Q. Right. And then the final note is: "Get medical  
21 records."

22 A. Yes.

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1           **Q.**     And that is what you had left Lionel to secure those  
2 records. My friend had asked you about the value of, you know,  
3 having a system in place that would help clients, patients with  
4 cognitive issues, difficulty processing information, to help  
5 them follow up on those types of things, which you indicated  
6 would definitely be helpful in the future. Is that something  
7 that the current Crisis team could assist with, or are they  
8 really only used in the front-line Emergency Room intake system?

9           **A.**     Essentially, along with Urgent Care that I talked  
10 about, but that's sort of distinct from that service, but they  
11 do both, yeah. I think a lot of the things we learn is that  
12 people, a lot of people don't take their medications, they don't  
13 do what we suggest they do, and so on. We often ask people in  
14 surveys were you given anything to do and they'll say no. So  
15 I've been for quite some time, if it's more than one item,  
16 writing them down.

17           **Q.**     Yes, so that ...

18           **A.**     In hopes - it probably doesn't very often - but in  
19 hopes that makes a difference.

20           **Q.**     No, it seems like a great resource for someone to take  
21 away.

22           **A.**     Mind you, the way I've written it would be, someone

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1 with cognitive processing difficulties might have trouble with  
2 one crossed out and one not numbered, but, anyway, yes.

3 Q. So my question, again just to make sure I understand,  
4 the current crisis intake team, is the scope of their mandate  
5 strictly within the Emergency Room?

6 A. Yes.

7 Q. Okay. So they wouldn't be working with you and  
8 patients in Outpatients to ...

9 A. No, only in the ER.

10 Q. ... to help follow through?

11 A. Yeah.

12 Q. Okay. You talked earlier about Lionel's post-  
13 concussion syndrome, the brain injury piece, and that although  
14 you'd identified a neuropsych assessment, that was nothing that  
15 could be done locally in certainly this region?

16 A. No.

17 Q. Were you aware of and are you familiar with the ABI  
18 Clinic, the Acquired Brain Injury Clinic in Halifax?

19 A. I know there is a clinic, yes.

20 Q. Okay. Do you ever refer ...

21 A. No.

22 Q. No. And is there a reason that you wouldn't refer

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1 patients to the Acquired Brain Injury Clinic in Halifax?

2 **A.** Probably largely lack of awareness of it, and,  
3 generally, head injury issues are not really in my area. They  
4 go ... we have a concussion clinic in Antigonish and they would  
5 go there and they would process them, things like that, and so  
6 on.

7 **Q.** Okay. So I guess I'm hearing you say you would, as a  
8 first step, be referring to the local concussion clinic in  
9 Antigonish before you would be ...

10 **A.** I'd do that and, in the old days, Mental Health in  
11 Halifax had access to a neuropsychologist and we used to do that  
12 but that became unavailable.

13 **Q.** Did you have any thoughts of referring Corporal  
14 Desmond to the concussion clinic in Antigonish?

15 **A.** No. I was waiting also to see the records to see  
16 what I thought they would have identified before, but I couldn't  
17 tell from him.

18 **Q.** Okay. I'm going to talk now ... You talked about  
19 treatment options for individuals with PTSD both in the hospital  
20 and then in the private sector. I believe you said that there  
21 really is a sub-specialty of therapists developing specific to  
22 trauma.

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1           **A.**     Mm-hmm.

2           **Q.**     And I think you said there were two in the Antigonish  
3 area, two or three.

4           **A.**     I'm not sure of the number. I think we have two, it  
5 might be three.

6           **Q.**     Okay.

7           **A.**     We have one or two in Port Hawkesbury, Mulgrave.

8           **Q.**     And when you say you have, you think you have two in  
9 Antigonish ...

10          **A.**     So the ones that have gone on and gotten some extra  
11 training in EMDR is how I identify that.

12          **Q.**     Okay. Would Catherine Chambers have been one of  
13 those individuals?

14          **A.**     No, she didn't work for us.

15          **Q.**     Okay. Sorry. I ...

16          **A.**     So she was doing some trauma work at the Women's  
17 Resource Center.

18          **Q.**     Yes.

19          **A.**     And went private. And so she had PTSD experience  
20 there. I don't know what form of therapy she was using. There's  
21 more than one.

22          **Q.**     Okay. She wasn't the sub-specialty ...

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1           **A.**     No.

2           **Q.**     ... treatment provider that you were referring to?

3           **A.**     So on our own clinic in the hospital, yeah.

4           **Q.**     Gotcha. Okay. Thank you.

5           And then my last sort of area I wanted to just touch on -  
6 it strikes me that ... First of all, I'll say this. Do you know  
7 that, did Lionel share with you that on December 2nd - we know  
8 he didn't tell you he'd gone to the Emergency Room the day  
9 before - did he share with you that he was seeing, had seen, or  
10 was going to see Catherine Chambers on the same day?

11          **A.**     He told me he was seeing her after he saw me.

12          **Q.**     Okay. So you understood that he was going to go from  
13 ...

14          **A.**     Yes.

15          **Q.**     ... your office to see Catherine Chambers?

16          **A.**     Yeah. I think that's in my report.

17          **Q.**     Okay. And was there any direction to Lionel to take  
18 this homework sheet to Catherine? That's the one you looked at,  
19 it's Exhibit 42.

20          **A.**     Not that I know of. Probably a good idea but I doubt  
21 I said that.

22          **Q.**     So you would agree that it might have been helpful

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1 for her to have that list of homework?

2 **A.** Yes.

3 **Q.** And also probably to have your consult report? Would  
4 that be fair to say?

5 **A.** Yes. We haven't been doing that, but, yes, that  
6 would be helpful to her.

7 **Q.** It strikes me that when you're dealing with mental  
8 health, there are many different people who play valuable roles  
9 in that complex picture, and what I am hearing over and over  
10 from folks is that the more information the better, in terms of  
11 ultimately providing the best care. Is that fair to say?

12 **A.** Um-hmm.

13 **Q.** You're nodding your head "yes"?

14 **A.** Yes.

15 **Q.** Yes. Okay. So Catherine Chambers would not have  
16 been able to access your records, that detailed helpful consult  
17 report, correct?

18 **A.** Right.

19 **Q.** You were not able to access her records.

20 **A.** Right.

21 **Q.** And whatever she would've assessed that day. So  
22 you're both essentially working in the same direction, trying to



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1 do the best you can do but you're in silos. Is that fair to  
2 say?

3 **A.** That's worth looking at.

4 **Q.** Yes, yeah. And she, as we understand it, was retained  
5 through the Veterans Affairs system which had its own case  
6 manager. And I guess we're going to hear evidence that there  
7 was also a clinical manager. So we have all of these folks who  
8 are trying to help Corporal Desmond, and certainly other  
9 military and veterans out there, I would assume, but nobody is  
10 able to share the information which would allow them to have the  
11 best evidence to make the best decisions and clinical treatment  
12 for those individuals. Is that fair to say?

13 **A.** Yes.

14 **Q.** Okay. And the last point on that. Your  
15 understanding, Dr. Slayter, was that Lionel had fallen through  
16 the cracks. That there was a gap in service to him.

17 As I read the records, and I think you have said this as  
18 well, the last time we understand he was in any active treatment  
19 would've been when he was admitted to Ste. Anne's in Quebec?

20 **A.** Yes.

21 **Q.** And it looks like he was released there in August?

22 **A.** I think so.

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1           **Q.**    So from August to December, a four-month span, other  
2 than going to the Emergency Room on October 24th and on December  
3 1st, to the best of your knowledge, there's no other treatment  
4 that he would've been receiving in that period of time.

5           **A.**    Yes, that would appear.    Yes.

6           **Q.**    Yeah.  And for someone who is struggling with PTSD and  
7 the multitude of presentations that Corporal Desmond had, is  
8 that problematic to go for four months without any active  
9 treatment?

10          **A.**    He would've done better, I think, to have had service,  
11 yes.

12          **Q.**    Yeah.  And, again, going back to the silos, it may  
13 have been that Veterans Affairs was working to try to get him  
14 that, but you didn't know that.

15          **A.**    And they didn't know about us.

16          **Q.**    They didn't know what was going on and, in the  
17 interim, he's left with nothing.

18          **A.**    Right.

19          **Q.**    Thank you.  Those are my questions.

20          **THE COURT:**    Thank you.  Mr. Rodgers?

21

22

DR. IAN SLAYTER, Cross-Examination by Mr. Rodgers

CROSS-EXAMINATION BY MR. RODGERS

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**MR. RODGERS:** Thank you, Your Honour. Dr. Slayter, I'm Adam Rodgers and I'm representing the personal representative of Corporal Desmond.

**A.** Okay.

**Q.** A few questions for you here. First, just picking up on something from your list. One of the recommendations or suggestions was a gym membership, and I guess I'll ask. We have some internet search records from Corporal Desmond that he was seeking out or searching for a gym membership, I think around January 1st. So I guess I'll ask. Does that surprise you to hear that or please you to hear that or not surprise you? Your reaction?

**A.** If the incident hadn't occurred, it wouldn't surprise me.

**Q.** Yeah.

**A.** No.

**Q.** Right. What I want to ask you, Doctor, is just to maybe discuss a little bit for us why it's a complex situation when you have somebody who is diagnosed with PTSD and post-concussion syndrome? Why is that more difficult in one or the

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1 other?

2       **A.** I think that you have two significant problems added  
3 on that interfere with how he processes what's going on around  
4 him, and they, I wouldn't think, interact with each other. So  
5 if he can't make out what people ... sorry. If he has trouble  
6 following conversations or making out what people say, then,  
7 well, I think he has trouble processing things in two different  
8 ways. One from the PTSD which affects his emotions and his  
9 reactivity, and another from the cognitive processing issues of  
10 the brain injury. And so the two are added together and would  
11 make things more complicated. I'm not very precise about that.

12       **Q.** No, no. That's fine. It was a broad question.

13       One of the treatment options, it seems, in this EMDR, the  
14 eye movement desensitization and reprocessing, seems along this  
15 line is some form of exposure therapy for PTSD treatment. Is  
16 that your ...

17       **A.** Essentially.

18       **Q.** ... understanding of one good way or a broad ...

19       **A.** Yes. That's a ...

20       **Q.** ... framework of treatment?

21       **A.** That's a one-word explanation.

22       **Q.** Now would somebody with concussion syndrome or, you

**DR. IAN SLAYTER, Cross-Examination by Mr. Rodgers**

1 know, concussion symptoms have more difficulty exposing  
2 themselves to their own memories because of those cognitive  
3 issues?

4 **A.** I don't know the answer to that. I would think, and  
5 this is speculation, that if they're dealing with very  
6 uncomfortable, distressing memories and they're trying to  
7 process them at the same time and put them into words, it would  
8 be more complicated, but I don't know what the research would  
9 say about that.

10 **Q.** Okay. Now, I want to ask you generally, I mean, so  
11 people come in to see you and then, generally, you see them once  
12 and refer them out to others, and I take it there are two ways  
13 that you refer people out. into the public system and then into  
14 the private practitioners. Is that correct?

15 **A.** Usually, it's in the public system.

16 **Q.** Okay. So who gets to see a private practitioner?

17 **A.** It would be someone who has an insurance plan and can  
18 access them. That's where it depends ...

19 **Q.** An insurance plan or the private means to do so?

20 **A.** That's what it's all about, yeah.

21 **Q.** Yeah.

22 **A.** The advantage of having that is you can get into a

**DR. IAN SLAYTER, Cross-Examination by Mr. Rodgers**

1 service quicker.

2 Q. What's your sense of the availability? When I do a  
3 quick internet search on the EMDR and people who do that kind of  
4 treatment in Nova Scotia, I get 30-some psychiatrists that pop  
5 up right away that appear to be ...

6 A. You don't mean psychiatrists.

7 Q. What?

8 A. You don't mean psychiatrists. Somebody else. I don't  
9 think there are 37 psychiatrists who do that.

10 Q. Okay, sorry. Maybe some of them were counsellors.

11 A. Okay.

12 Q. But listing people that are using that methodology.  
13 If you're referring somebody to a private psychiatrist, what's  
14 your expectation in terms of how quickly they'll be able to see  
15 that person?

16 A. I assume, but I don't know, that it's a matter of  
17 weeks as opposed to months.

18 Q. Yeah. In your experience in referring people onward  
19 to either the public system and the private system in Nova  
20 Scotia, how would you comment, or what would your comment be, on  
21 the balance there and whether that's a good balance or something  
22 that should be examined?

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1           **A.**    You mean how many see private and how many go public?

2           **Q.**    Yes.  And, you know, whether there's room to think  
3 about whether the public system should be expanded at the cost  
4 of the private system.

5           **A.**    I think the quality on both sides is probably equal.  
6 There's no reason why it wouldn't be anyway.  It's all about  
7 access.  I'm not sure I've answered your question.  I'm not even  
8 sure what the question is.

9           **Q.**    Well, I'm not a hundred-percent clear what the  
10 question is either, but I guess I'm trying to get a sense of, an  
11 insight into the system, if somebody needs to see a  
12 psychiatrist.  We'll think of it from the perspective of a  
13 veteran.

14          **A.**    You mean a therapist.

15          **Q.**    A therapist, yes.  If there's, you know, thousands of  
16 people trying to see a few psychiatrists in the public system  
17 versus hundreds of people trying to see hundreds of therapy  
18 providers in the private system, there seems to be an imbalance  
19 there.

20          **A.**    So the point is there should be more therapists of  
21 either kind and people should be able to afford them.

22          **Q.**    Yeah.

**DR. IAN SLAYTER, Cross-Examination by Mr. Rodgers**

1           **A.**   Whether it's through free public or assistance to pay  
2 for the private.

3           **Q.**   Okay.

4           **A.**   It's, you could say, an unfair barrier, but it's  
5 there.

6           **Q.**   Yeah. Well what do you see ... I guess the question  
7 is do you see significant negative implications of the way the  
8 system is structured now in that regard?

9           **A.**   I don't know if it's a problem. It's just a lack of  
10 therapists. I don't know if more people could afford private  
11 ones if there were more private ones. I certainly ... if we  
12 were larger publicly, we would take more people because there's  
13 no barrier to seeing them.

14          **Q.**   Yeah, okay.

15          **A.**   If I had a choice, I would add ten new therapists to  
16 the public system because that's where the need is because of  
17 financial reasons.

18          **Q.**   Yes.

19          **A.**   Does that answer your question?

20          **Q.**   It does. I guess what I'm trying to do for myself  
21 and, I guess, for the Inquiry, generally, is to get some insight  
22 into how that dynamic works and if there's a recommendation to



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1 be made in terms of Veterans Affairs being able to handle this  
2 kind of thing internally or not.

3 **A.** So it's interesting in this case. Veterans Affairs  
4 hired Catherine Chambers, so they contracted out to her.

5 **Q.** Yeah.

6 **A.** And I suppose there's no reason the middle ground,  
7 that the public system, if it had the funds, couldn't contract  
8 out to private people to provide so many hours a week or  
9 something like that.

10 **Q.** Yeah, okay. I'll switch topics with you, Doctor. A  
11 question on the suicide risk study and factors that you've  
12 identified, and I'll just ask you to comment on one thing. I  
13 notice in the reports that individuals are asked whether they  
14 have suicidal or homicidal ideations. And the question is  
15 whether that, in any way, implants an idea that wasn't there  
16 previously or whether that's just something you should ask and  
17 that's the only way to find out?

18 **A.** I've never had the impression that it's been implanted  
19 like it's a new idea. I mean it's something most people  
20 experience a little bit and moreso the people who would come to  
21 see me.

22 **Q.** Yeah.

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1           **A.**    It's a weakness of our suicide assessment that it does  
2 depend a lot on people saying they have suicidal thoughts, and  
3 we tend to assume, when they say no, that they don't, as I  
4 indicated earlier, there's some situations which might be  
5 ignored, you know, a statement if, for example, they were very  
6 anxious and not sleeping, I would think that they would be high  
7 risk anyway. So there are times when we would not pay attention  
8 to that, but it does tend to be our primary marker for  
9 identifying who might be worth assessing further.

10           **Q.**    Yes.

11           **A.**    One of the studies I read some time ago, I think in  
12 Australia, looked at ... some group followed 800-and-something  
13 people with mental health diagnoses for a number of years, and  
14 30-some of them, 32, I think, committed suicide. And they  
15 looked back and they found the majority of the ones who  
16 committed suicide had not voiced suicide thoughts. The smaller  
17 number had.

18           The point being that some people don't ... either ... maybe  
19 they don't get asked, but they don't volunteer that they have  
20 suicidal thoughts, and there's not much we can do about that.  
21 And if, otherwise, they seem fairly unremarkable in terms of not  
22 seeing acute risk, then we're going to miss those.

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1           **Q.**    It seems like a very difficult thing to predict.

2           **A.**    It works most of the time but it doesn't work all the  
3 time.

4           **Q.**    Yeah. I want to ask you about firearms regulation,  
5 Dr. Slayter, but not in the particulars, necessarily, of this  
6 situation with Corporal Desmond. But, generally speaking, is it  
7 something where, you know, you see somebody that you think  
8 shouldn't have a firearm, that does? What's your procedure  
9 there? How do you go about making that determination and then  
10 what do you do with that information once you have it?

11          **A.**    Yeah. Usually if we think is at risk of suicide, they  
12 have access to guns, generally, in the house, it's something  
13 like that and so we would talk to them and their family about  
14 having the guns removed, and if they come up with a way of  
15 getting them removed that seems to work, then that's what we do.

16          **Q.**    Yeah.

17          **A.**    We don't usually end up, that I know of, going to sort  
18 of getting the police to remove guns, although sometimes we do  
19 that but it's usually ...

20          **Q.**    Most of the time, families will agree with you and ...

21          **A.**    The families will remove them and take them off to  
22 Cousin Joe's to take care of or something, and lock them up.

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1           **Q.**   Voluntarily, okay. All right. Now what about looking  
2 at that situation, I guess, in the other way around. Would you  
3 see some benefit when you see an individual, you see them for  
4 the first time, being able to access their firearms history,  
5 history of anything, if they've had their firearms taken from  
6 them for mental health reasons? Would that benefit you?

7           **A.**   I think it would be rare is the problem because, okay,  
8 I've been doing Psychiatry for about four years. This is the  
9 first time I've had someone shoot himself.

10          **Q.**   Yeah.

11          **A.**   So I would've had to gone through thousands of people  
12 to get at this one case, and that wouldn't seem to be effective.

13                Another thing is that in this area, in my experience,  
14 hanging is the most common form of suicide. That's readily  
15 available too.

16          **Q.**   Yeah, okay. So the next thing I want to ask you  
17 about, Doctor, and you've talked about this already, is some of  
18 what your awareness is of the Veterans Affairs and OSI programs.  
19 And I guess what I want to ask is what is presented to you, if  
20 anything, about these programs as a practicing psychiatrist in  
21 Nova Scotia?

22          **A.**   I never had anything presented until this happened.

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1           **Q.** All right, so prior to this, if you ... I presume  
2 you've treated other veterans before. Nobody's made a  
3 presentation or had a seminar with you to say, All right, well,  
4 here are the services that are available and how to do it.

5           **A.** Not that I can recall, no.

6           **Q.** Okay.

7           **A.** Which seems odd, but I think that's the case.

8           **Q.** Have you had occasion to make referrals to Ste. Anne's  
9 in Montreal?

10          **A.** One. Our psychologist did it with my backing, but  
11 yeah.

12          **Q.** Okay, or OSI in Fredericton or Halifax?

13          **A.** I talked with OSI Halifax about another case, that's  
14 all I can think of.

15          **Q.** Okay. Do you have a sense, even though you haven't  
16 done referrals, of how that process might work or how easily it  
17 might work?

18          **A.** Sorry?

19          **Q.** To refer somebody to OSI, that a veteran in your ...

20          **A.** It's not clear to me. Now that I better understand,  
21 it's under the Health Authority, and perhaps they operate like  
22 other facilities in the Health Authority in which case it would

**DR. IAN SLAYTER, Cross-Examination by Mr. Rodgers**

1 be quite simple. But I'm not sure.

2 Q. Okay, and you've talked about records and the  
3 difficulties in receiving records. How would you foresee that  
4 system working well, from your perspective, to get the  
5 information you would need to make an assessment of a veteran  
6 that you hadn't met before?

7 A. It had to be the same with what I call a regular  
8 hospital or clinic or outpatient service, to be able to make a  
9 referral simply by writing a letter to them directly and have on  
10 the internet where to send it and all that kind of thing. And  
11 for records to be able to have a phone number or a fax number to  
12 contact their records department. And we would send in a  
13 consent with a request and they would send it right back.

14 Q. Is ...

15 A. That's what we do at the regular healthcare  
16 facilities.

17 Q. Okay. Now two questions from that. One is a timing  
18 question and, you know, if everything happened efficiently and  
19 you got the records in a couple of weeks or a week or so ...

20 A. So with any hospital in Canada I would expect to get  
21 something back by tomorrow.

22 Q. Okay, and is that fairly timely in your opinion?

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1           **A.**    Yeah.

2           **Q.**    Okay.  And I suppose if you thought the records were  
3 urgently needed and there was a serious situation you'd hold the  
4 patient till then.

5           **A.**    Yeah, and in his case, it didn't seem urgent, but I  
6 would like to have had them by the second visit before I saw him  
7 again.

8           **Q.**    And the second barrier to that might be, as we've  
9 discussed or you've discussed today already, is having the  
10 patient sign the consent form.  Now there's obviously reasons  
11 for that, but in a mental health context do you see that as a  
12 barrier and would you see it working any other way?

13          **A.**    That's an old question because it comes up in other  
14 contexts.  For most of the time that's not an issue but it can  
15 be an issue.  You have to explain to the person the benefit of  
16 us having the information to treat them and most of the time we  
17 very seldom can't get that.  But I guess that could happen.  But  
18 that's their information and they have a right to it.

19          **Q.**    Yeah.  You are teaching some still?

20          **A.**    Mm-hmm.

21          **Q.**    Are you aware of anything within the university  
22 education program that deals specifically with military veterans

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1 and the specialty that that would entail?

2       **A.** To be fair, I'm doing clinical teaching. That means I  
3 see patients with a resident and see how they do it and give  
4 them advice and help them learn. I'm not in the classroom in  
5 Halifax to see what they're doing ...

6       **Q.** Okay, and you're not ...

7       **A.** ... per classroom teaching.

8       **Q.** And you're not as familiar with the remainder of the  
9 education program.

10       **A.** Not at that part, no.

11       **Q.** Okay. Fair enough. The last thing I want to talk  
12 about is there was a part of your report, you talk about  
13 Corporal Desmond seemed to want to discuss his military  
14 experience or was at least open to it. Well, do you recall  
15 whether it was one or the other that he wanted to talk about it,  
16 or that he was open to it?

17       **A.** Heather Wheaton wrote that. So it probably came up  
18 when she was interviewing him.

19       **Q.** Yeah.

20       **A.** Just before I came in. So I don't know what was said  
21 exactly about that.

22       **Q.** Is it something you recommend to people dealing with



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1 PTSD or other diagnoses that would benefit them to speak to  
2 peers about their situation?

3 **A.** Generally, yeah.

4 **Q.** I wonder if in Corporal Desmond's ... you know, in his  
5 situation. Did you see it as an issue of him perhaps not having  
6 peers with whom he could speak about ...

7 **A.** Well, peer support ...

8 **Q.** ... his experiences?

9 **A.** ... is always helpful. So that would have been  
10 another service. Again, we don't have an organized peer support  
11 program here in the rural area but that would be helpful. He  
12 needed more than that, but yes.

13 **Q.** All right. And you mentioned yoga and going to the  
14 gym. Is nature itself something that you recommend?

15 **A.** Well, to be fair, not only did he say, I asked him  
16 what he had found helpful already and he said those things were  
17 helpful so, therefore, I thought they were a good idea. But  
18 let's take exercise. There's lots and lots of research to show  
19 that exercise is good for anxiety and depression and self-esteem  
20 and so on. So I recommend to most people doing that and  
21 everyone comes back saying that it's helpful. It doesn't cure  
22 by itself but it does help. And every little step you can take

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1 that helps is worth it.

2 Q. Very good. Okay. Thank you, Dr. Slayter. Those are  
3 my questions.

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

5 **MR. HAYNE:** Just a few questions, Dr. Slayter.

6

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

8

9 **MR. HAYNE:** If we could first just go quickly to Exhibit  
10 P69.

11 **EXHIBIT P-00069 - HISTORY OF VISITS DATED OCTOBER 24, 2016 TO**  
12 **JANUARY 4, 2017**

13 So, Dr. Slayer, this is part of your record for Lionel  
14 Desmond. Correct?

15 A. Yes.

16 Q. And are you familiar with the term "cumulative patient  
17 profile"?

18 A. No.

19 Q. Okay. Then is it fair to say, though, that this  
20 particular document, this two-page document, is a summary of  
21 your interactions or your understanding of the interactions with  
22 Mr. Desmond? Is that fair?

**DR. IAN SLAYTER, Cross-Examination by Mr. Hayne**

1           **A.**    Yes.

2           **Q.**    Okay.  And if we look at page 2, for example, the  
3 entry at the very bottom, "ER crisis note 24 October 2016,  
4 Heather Wheaton, RN", is that your summary from Heather  
5 Wheaton's crisis note?

6           **A.**    Yes.

7           **Q.**    And then similarly, the box above that dated 24  
8 October 2016, is that a summary of your notes in your  
9 interaction with Mr. Desmond?

10          **A.**    Yes.

11          **Q.**    Okay, and then on the first page, similarly, we have  
12 one for 2 December 2016.  We've already looked at your actual  
13 consultation note but this is a summary of that consultation  
14 note.

15          **A.**    Yes.

16          **Q.**    Okay.  Just a couple of quick other questions to  
17 clarify a few things.  You were asked about asking the question  
18 about suicidal ideation, and you noted that some people will say  
19 no.  And then I think you said that in circumstances, however,  
20 even with a no, you may follow up or probe further.  Is that  
21 right?

22          **A.**    Yes.

**DR. IAN SLAYTER, Cross-Examination by Mr. Hayne**

1           **Q.**    Okay.  And you use your clinical judgment as to when  
2 that's necessary.  Is that fair?

3           **A.**    Yes.

4           **Q.**    Okay.  You were asked a question just by Mr. Rodgers a  
5 few moments ago.  He put to you that Mr. Desmond had conducted  
6 internet searches seeking a gym membership and he asked you  
7 whether that was surprising to you.  And I think your evidence  
8 was, and correct me if I'm wrong, that you had said if the  
9 incident hadn't occurred it wouldn't surprise you.

10          **A.**    Well ...

11          **Q.**    And so my question is is seeking out a gym membership,  
12 would you consider that to be in the class of future-looking or  
13 forward-looking activities?

14          **A.**    Yes.

15          **Q.**    Okay, and that class of activity is something that  
16 would weigh against risk of suicide.  Is that fair?

17          **A.**    Yes.

18          **Q.**    Okay.  Ms. Miller asked you - I think it was Ms.  
19 Miller - regarding the records, that she put to you that Mr.  
20 Desmond was seeing Catherine Chambers and that she didn't have  
21 access to your consultation note.  Is it fair to say that if a  
22 request was made by Ms. Chambers with the appropriate consent

**DR. IAN SLAYTER, Cross-Examination by Mr. Hayne**

1 for Mr. Desmond, that you would have provided those records to  
2 her? Correct?

3 **A.** I have done that before in situations where a  
4 therapist has requested from me with consent, yes.

5 **Q.** Okay. You've been asked a lot about suicidal  
6 ideation. I have one question for you in that respect and it's  
7 regarding a statement that's in the records. Ms. Chambers'  
8 records, in fact. The statement - and I think I have it quoted  
9 correctly - is: "I wish I had just been blown up in  
10 Afghanistan."

11 So from your perspective as a psychiatrist, would that  
12 statement by itself constitute suicidal ideation?

13 **A.** No.

14 **Q.** Okay. Would it perhaps prompt follow up? We  
15 discussed earlier about when you may use your clinical judgment  
16 to follow up, but that's something that may prompt you to follow  
17 up further. Is that right?

18 **A.** I would look into it further, yes.

19 **Q.** Okay. Those are my questions. Thank you.

20 **THE COURT:** Thank you.

21

22

**DR. IAN SLAYTER, Examination by the Court****EXAMINATION BY THE COURT**

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**THE COURT:** I have a couple questions. So I'm going to work my way backwards here. And the suggestion was that if Ms. Chambers had called and requested a copy of, for instance, your December the 2nd report that you prepared that would have been forwarded to her?

**A.** I have some ambivalence about the concept and some support for it but when therapists in the community have asked me I have forwarded, yes.

**Q.** Okay. That would require just, what, consent from Mr. ...

**A.** Yes.

**Q.** In this case, Mr. Lionel Desmond?

**A.** Yes.

**Q.** And what concerns would you have about ...

**A.** I'd feel more comfortable if I know the person that I'm sending to and I know what they're going to do with the information. I don't want to see it on the internet or something. That's the main concern of what happens to the information if you don't know someone.

**Q.** Once it gets out of your hands.

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1           **A.**    Yeah.

2           **Q.**    Or the hospital's hands. Okay. The Exhibit 69 that  
3 was up, who would have prepared that?

4           **A.**    I did.

5           **Q.**    You prepared all of that?

6           **A.**    I do my own typing by dictating into Dragon, yes. We  
7 have lots of discussions. The hospital system takes time to get  
8 things transcribed and this way I get it done right away and I  
9 have records if somebody calls back or something comes up.

10          **Q.**    It's there, yeah.

11          **A.**    Yes.

12          **Q.**    But would you have formatted it that way? Or do you  
13 dictate your notes and so the ...

14          **A.**    I have a template and I dictate into it.

15          **Q.**    Yeah. Okay. Thank you, and ...

16          **A.**    That was an easy one.

17          **Q.**    They're all easy. Just give me a chance to see if I  
18 can collect my thoughts here.

19                When you were talking about whether it was Mr. Desmond in  
20 particular, or maybe just general comment, that when you see  
21 some patients ... the words you used were "regimented". So they  
22 might be more regimented in their presentation. Or maybe that

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1 was those with military background?

2       **A.** I was trying to get at two things. Some people sort  
3 of behave better with me than they do with other people because  
4 I have authority and sometimes you don't get as much of a story.  
5 Or at least you don't see their emotions. So that's one issue.  
6 It makes it harder for me to read into what's going on.

7       **Q.** All right.

8       **A.** And the other is some people may feel like they're  
9 supposed to give you certain answers and which is almost the  
10 same thing.

11       **Q.** So would you see any variation between information you  
12 might get from an individual and what information nursing staff  
13 might have gotten from the individual?

14       **A.** Yes.

15       **Q.** Do you see those variations?

16       **A.** Yes. So Heather Wheaton, for example, and her  
17 colleagues, will sometimes say after I've gone in with them to  
18 do my part at the end of their piece ... say, Well, she was  
19 quite different with you than she was with me. And so we'll  
20 compare notes and try and make sense of what that tells us.

21       **Q.** All right. So when a third-party observer comes along  
22 and reads your report and reads the nurse's reports and there



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1 seems to be some different flavour and tone and attitude, that  
2 might be just simply because of the way the patient or the  
3 client perceived his audience. Or his or her audience.

4 **A.** Correct, yes. So two people will have different  
5 lenses. Or the patient will have different lenses with us. And  
6 we get somewhat different results. It's not usually a big  
7 problem, but it's there.

8 **Q.** Yeah. So if we could go to Exhibit 67, please, and  
9 it's page 8. It's the last paragraph. So if you could just  
10 maybe kind of make the last paragraph a little larger, and I was  
11 just having trouble reading it. So I was going to have the  
12 doctor read his own handwriting for me beginning with ...

13 **A.** It's Heather's.

14 **Q.** Oh, sorry.

15 **A.** Which normally is better than mine. But not this  
16 time.

17 **Q.** So it starts, "Travel" ... sorry. "Trouble navigating  
18 Veterans Affairs system."

19 **A.** Yeah. Okay: "Trouble navigating Veterans Affairs  
20 system and worried about what they will offer and what they will  
21 cover. Waiting for Veteran Affairs ..."

22 **COUNSEL:** Case.

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1           **A.**    "Case manager in (something) transfer not complete."  
2    New Brunswick, probably. Case manager in New Brunswick.

3           **THE COURT:**        So it's waiting for Veterans Affairs case  
4    manager in New Brunswick and so ...

5           **COUNSEL:**    I think that might be, "Waiting in NS."

6           **THE COURT:**        Newfoundland?

7           **COUNSEL:**    NS.

8           **THE COURT:**        Okay. Waiting for Veterans Affairs case  
9    manager in N ... so that would be Nova Scotia. But we can  
10   always ask Ms. Wheaton anyway. But thank you.

11           Now one of the topics that was discussed earlier was that  
12   ... it came up maybe a couple times about stability and  
13   stabilization programs. So I'm going to ask you to tell me if I  
14   have this, if I understand correctly. You have an individual  
15   who presents. In this case, you know, Mr. Desmond, or Corporal  
16   Desmond. Have PTSD. And there were a lot of things that were  
17   going on in his life and to the extent that you would look at  
18   trying to create some stability. Would you look at creating  
19   stability before you looked at therapeutic interventions or  
20   options so that he would then kind of be receptive to that  
21   opportunity?

22           **A.**    Yes, the trauma part of the therapy in particular. So

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1 the general therapy would be helping with that stabilization,  
2 but before he can start dealing with his memories that are  
3 terrifying he would have to ... the rest of his life should be  
4 stable.

5 Q. So we have Exhibit 115. It's document CAN001909.

6 **EXHIBIT P-000115 - LETTER DATED DECEMBER 15, 2015 TO OSI CLINIC**  
7 **FROM DR. MATHIEU MURGATROYD**

8 Q. And Dr. Slayter, this is a letter that was written on  
9 letterhead that would indicate it was written the Operational  
10 Stress Injury clinic in Fredericton and was written by Dr.  
11 Murgatroyd. It was a recommendation for Ste. Anne's  
12 stabilization and residential program. Are you familiar with  
13 Ste. Anne's stabilization program at all?

14 A. A little bit. I had another patient who went there.

15 Q. Mm-hmm.

16 A. And they were doing, basically, activities. They were  
17 helping them develop routine and develop activities and just  
18 sort of that kind of thing.

19 Q. Right. So it's actually page 3 of 3. If we go over  
20 to the next page. Partway down, the full second paragraph  
21 begins:

22 The goals of admission are for medication

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1           reassessment, approving his coping skills,  
2           increasing his structure and daily  
3           activities, and psychosocial rehabilitation.  
4           Once stabilized, the client will have  
5           outpatient follow-up with his psychologist,  
6           his psychiatrist here, and OSI clinic. He  
7           does not have a family physician. He is  
8           medically fit. Client's not actively  
9           suicidal or homicidal. He's not a risk for  
10          aggression or violence. There are no  
11          present legal issues.

12          And then there's a recommendation for a teleconference at  
13          the time of discharge for collaboration in relation to ensuring  
14          appropriate follow-up care.

15          So it would appear that at the time that this was written  
16          the idea was to get Corporal Desmond into the program at Ste.  
17          Anne's for stabilization.

18          **A.**    Yes.

19          **Q.**    Okay. Exhibit 116.

20          **EXHIBIT P-000116 - RTCOSI DOCUMENT FROM STE. ANNE'S HOSPITAL**

21          You have page 1. If you can go to page 2. Or the second  
22          page. It's entitled "Disciplinary Discharge Summary". This is

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1 from Ste. Anne's Hospital. It's the RTCOSI, which is the  
2 Residential Treatment Clinic for Operational Stress Injuries.  
3 Appears that the corporal was admitted on Monday, May 30th to  
4 the stabilization program. He was transferred to the  
5 residential program July 4th, 2016 and discharged from the  
6 residential program August 15th of that same year.

7 At the very last paragraph on that page it indicates that:  
8 "Teleconference took place on August 9, 2016 with the RTCOSI  
9 team and Mr. Desmond's outside care team to share observations  
10 and recommendations in preparation for his discharge from the  
11 RTCOSI to ensure his continuity of care in the community."

12 So there had been a recommendation for the teleconference  
13 and they had that and it would appear that they were trying to  
14 facilitate Mr. Desmond's continued care back in the community.  
15 Okay? Because we know he didn't go to the OSI clinic in  
16 Fredericton because he wound up coming back to Nova Scotia.

17 **A.** Yes.

18 **Q.** One of the recommendations in relation to Mr. Desmond  
19 was - and you had, I think, kind of recognized it as well - that  
20 they recommended a detail neuropsychological evaluation. And  
21 they say in part: "The results of the evaluation did indeed  
22 indicate the presence of mild cognitive dysfunction. The nature

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1 of the test done does not allow the identification of the  
2 proportion to which different elements may have influenced the  
3 performance." And there are some other things.

4 So they recommended that he have a neuropsychological  
5 evaluation to determine his cognitive capacities. That was  
6 recognised in August. And sorry, Doctor, if you want to just go  
7 over to the next page, which is page 3 of the report, under  
8 Recommendations. If you can stop there.

9 **A.** Okay.

10 **Q.** there. No. You've got the wrong page. And that's  
11 the page, yes right there. And stop right there. In the second  
12 paragraph they talk about:

13 Having a clear portrait of the actual impact  
14 of cognitive deficits on the client's  
15 functioning, if any, will serve to orientate  
16 treatment in that it will support the  
17 process of setting realistic therapy goals  
18 which are to help Mr. Desmond attain a  
19 satisfying level of participation in his  
20 activities and develop a sense of having an  
21 improved quality of life.

22 So my question is really this. He's discharged in August

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1 and you see him in December and he still hasn't had that kind of  
2 an assessment.

3 **A.** And did not have it arranged.

4 **Q.** And did not have it arranged.

5 **A.** No one had referred him for that, I presume.

6 **Q.** And you continued to recognize that it was a need in  
7 his life. All right. I take it that it would have been  
8 certainly a lot better for Mr. Desmond to have had that done  
9 presumably shortly after he was discharged in Quebec.

10 **A.** May I ask a couple questions? One is rhetorically.

11 **Q.** Sure.

12 **A.** One is I'm wondering if he finished his full program  
13 in Ste. Anne's. I thought they were usually longer than five  
14 weeks.

15 **Q.** I believe he left a little early.

16 **A.** Okay. And secondly, it sounds like he didn't go back  
17 to Fredericton and that's why things probably got dropped at  
18 that point.

19 **Q.** Well, it appears that the plan was to go back to  
20 Fredericton but I think he sold his house and returned here.

21 **A.** Yeah, so that's probably where the breakdown came.

22 **Q.** All right. But appreciate that during this

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1 teleconference call on August the 9th, he was talking that  
2 people were going to be involved in his outside care were on  
3 that call. I understand that, that would have included the case  
4 manager, his case manager at that time, Ms. Doucet. She was on  
5 the call.

6 And so to the extent that Veterans Affairs was assisting  
7 Mr. Desmond in moving through the system, I guess there might  
8 have been some expectation that that would not be a crack he  
9 would fall into if somebody was managing what he required.

10 **A.** Yes.

11 **Q.** All right. As I said, from August to December, that  
12 had not happened.

13 Now there is something else that I want to refer you to  
14 just briefly, and I was trying to pull that document up.

15 Can you pull that up for me? I need to go to a date,  
16 August. Let me see. It would have been August the 9th. I'm  
17 not sure if that was the date it was. You can just back up?  
18 Let me see.

19 It's in August. You have to go to the August date,  
20 probably around the 9th. No, back up a bit. Can you center  
21 that progress note right there?

22 **THE CLERK:** The top one or ...



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1           **THE COURT:**       No, the progress note. The second one. The  
2 one that's at ... that one right there. Thank you very much.

3           **EXHIBIT P-000117 - CASE PLAN**

4           **THE COURT:**       So just for the record, we're on page 10 of  
5 that particular document.

6           Now that would appear to be the note of PM Doucet, who I  
7 understand here is the case manager. It would indicate she  
8 participated in the case conference with Ste. Anne's Hospital,  
9 that at the same time Dr. Murgatroyd was involved in the phone  
10 call, and he had sent the original referral for the RTCOSI  
11 admission. It would appear that they're making arrangements and  
12 are prepared to deal with Corporal Desmond when he returns to  
13 New Brunswick in expectation that he'll be dealt with at the  
14 clinic there.

15           **A.**    There's nothing specific there.

16           **Q.**    No.

17           **A.**    Other than how to transport him.

18           **Q.**    How to transport him. Mmm. I know that there are  
19 additional notes, but I'm not going to ...

20           **A.**    Okay.

21           **Q.**    We won't bother with those. But my point being this,  
22 I guess, is that there was an expectation that if Mr. Desmond

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1 was involved in the call, then I'm going to suggest that Mr.  
2 Desmond would have had some expectation that things were going  
3 to be managed for him once he returned to New Brunswick and then  
4 to Nova Scotia. And at least as it relates to that particular  
5 neuropsychological assessment, that never happened. And to the  
6 extent that that would have impacted his ability to try to get  
7 on with his life or overlap and compounded his PTSD symptoms.  
8 Then it could not have been addressed.

9 **A.** Sadly.

10 **Q.** There was a report that came out. It's called  
11 **Preventing and Reducing the Risk of Suicide: A Framework For**  
12 **Nova Scotia.** It was just published recently. Have you had a  
13 chance to see that?

14 **A.** I don't ...

15 **Q.** It's not there.

16 **A.** ... think so. I'd have to see it.

17 **Q.** Well, we don't have that in. Do we have that as an  
18 exhibit? I don't think we do do we?

19 **A.** I don't think so.

20 **THE CLERK:** And Exhibit 105 is the Suicide Risk  
21 Assessment and Intervention Policy. Is that ...

22 **A.** That's not it.

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1           **THE COURT:**       No, that's not it. I was going to ask a  
2 couple questions but I don't think I will if you haven't read  
3 it.           I'll ask you just a brief question about methods of  
4 suicide. You made a comment that hanging is the ...

5           **A.**    I think so.

6           **Q.**    Statistically?

7           **A.**    You know, my experience from what I hear and what the  
8 police bring in for serious suicide attempts, hanging is the  
9 more common. More common than shooting for suicide.

10          **Q.**    Well, the document that I have in front of me, it's  
11 called **Preventing and Reducing the Risk of Suicide: A Framework**  
12 **For Nova Scotia** dated January 2020. At page 5 under the heading  
13 "Understanding Suicide in Nova Scotia" it makes the following  
14 comment: "The most commonly used method of suicide is hanging,  
15 strangulation/suffocation, followed by poisoning and firearms in  
16 men." So it would appear to be ...

17          **A.**    (Unclear.)

18          **Q.**    ... fourth on the list.

19          **A.**    Yeah.

20          **Q.**    And poisoning and drowning/submersion for women.

21 (Unclear) with what the observations were you made.

22          **A.**    So we need to restrict firearms when someone has them

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1 who is suicidal but it's not the only thing, unfortunately.

2 **Q.** Statistically, it would appear to be clearly more  
3 lethal.

4 **A.** Mm-hmm.

5 **Q.** But not at the top of the list.

6 All right. Any questions, Counsel? No? All right. Thank  
7 you, Dr. Slayter. Appreciate your time.

8 **WITNESS WITHDREW (15:18 HRS.)**

9 **THE COURT:** Thank you. Mr. Murray? Or Mr. Russell?  
10 What do you have planned next?

11 **MR. MURRAY:** Our thought was to call some of the nursing  
12 staff. I don't know whether we wish to start with that today or  
13 not. I don't know if we need a short break to discuss that.

14 **THE COURT:** Well, we'll take a break for maybe 15  
15 minutes and you can have a discussion whether it's fruitful to  
16 start your next witness today or not. All right? So you can  
17 discuss that amongst yourselves.

18 **COURT RECESSED (15:19 HRS.)**

19 **COURT RESUMED (15:36 HRS.)**

20 **MR. RUSSELL:** Yes, Your Honour. Inquiry counsel would  
21 call nurse Heather Wheaton.

22 **THE COURT:** Good afternoon.

1 **HEATHER WHEATON**, affirmed, testified:

2

3

**DIRECT EXAMINATION**

4

5 **MR. RUSSELL**: Good afternoon, Nurse Wheaton. I understand  
6 you have a bit of a cold today, so try the best you can to speak  
7 as loudly and clearly as possible.

8 **A.** Okay.

9 **Q.** If at any point you need a break, just sort of let us  
10 know and we'll see if Judge Zimmer will accommodate it. I can't  
11 promise.

12 So I just wanted to start with a little bit of background.  
13 So what is your full name for the Court?

14 **A.** Heather Wheaton.

15 **Q.** And what is your occupation?

16 **A.** I'm employed as a mental health crisis clinician at  
17 St. Martha's Hospital.

18 **Q.** How many years have you been a nurse?

19 **A.** 1992.

20 **Q.** And you said you were a mental health crisis  
21 clinician?

22 **A.** Yeah.

**HEATHER WHEATON, Direct Examination**

1 Q. At St. Martha's?

2 A. Mm-hmm.

3 Q. That's your official title now?

4 A. Yes.

5 Q. How many years have you been in that role as a mental  
6 health crisis clinician?

7 A. Wow. I guess it's almost four now. Four?

8 Q. So you would've started roughly in 2016?

9 A. It was the summer, I think, of 2016.

10 **EXHIBIT P-000111 - CURRICULUM VITAE - HEATHER WHEATON**

11 Q. I'm going to show you - and it's been marked as an  
12 exhibit so it's a document you'll be familiar with - it's 111.  
13 So it'll be on the screen in front of you and it'll also be in a  
14 binder that should be up front, perhaps?

15 **THE CLERK:** It's here on a table and it would be Volume  
16 2.

17 A. Oh. I've got it here maybe.

18 Q. Okay. So I just wanted to start walking through your  
19 employment history. So if we look at page 2 of that document,  
20 1992 to 1998, it indicates "Registered Nurse, CDHA." What's  
21 "CDHA"?

22 A. Capital District Health Authority.

**HEATHER WHEATON, Direct Examination**

1           **Q.**    So that was sort of an old ...

2           **A.**    What's the Central Zone of NSHA now.  Yeah.

3           **Q.**    And the Central Zone today is what?

4           **A.**    Halifax-Dartmouth, the HRM.  Halifax Regional  
5 Municipality, I think.

6           **Q.**    Okay.  So from '92 to '98, what was your nursing  
7 speciality, I guess, at that time?

8           **A.**    So I was working at the Nova Scotia Hospital as a  
9 mental health nurse in a variety of different areas.

10          **Q.**    So acute care.

11          **A.**    Mm-hmm.

12          **Q.**    And forensic psychiatry, inpatient units.

13          **A.**    Yes.

14          **Q.**    What is that?

15          **A.**    So I worked on acute care units, adult.  So adult  
16 acute care units at the Nova Scotia Hospital, mental health  
17 inpatient units, and I worked for a time on the psychiatric ...  
18 on the forensic inpatient unit which, at that time, at the Nova  
19 Scotia Hospital on the fourth floor was the forensic unit.

20          **Q.**    So what is the forensic psychiatric inpatient unit?  
21 How is it different than the regular inpatient unit?

22          **A.**    So that would've been what existed before we had the

**HEATHER WHEATON, Direct Examination**

1 actual East Coast Forensic Hospital in Dartmouth.

2 Q. So that would've dealt with a number of people that  
3 would perhaps have been charged with criminal offences?

4 A. Yes.

5 Q. And you indicated that you completed a psychiatric  
6 nursing speciality program.

7 A. Yes.

8 Q. What is that?

9 A. So at that time ... I don't even remember who offered  
10 ... but at that time they had a post- ... so when we graduated  
11 from Nursing, they had a post-grad program that was specialized  
12 in mental health or psychiatric nursing. You are working at the  
13 time so it involved having a preceptor and some supervision in  
14 your workplace as well as some sort of classroom-style learning  
15 about mental health and psychiatry.

16 Q. So is it fair to say that not every nurse would have  
17 that specialized training?

18 A. No, that's right.

19 Q. And it says "completed CBT training program". What is  
20 "CBT" and what's the training program?

21 A. Cognitive behavioural therapy.

22 Q. And, generally, if you could indicate, what is



**HEATHER WHEATON, Direct Examination**

1 cognitive behavioural therapy? I know it's a broad term.

2 **A.** It is, yeah. So cognitive behavioural therapy  
3 generally focusses on two areas, cognitive and behavioural, for  
4 supporting people who have problems with things like anxiety and  
5 depression. So the guiding principle is that there are  
6 different areas or domains that affect. So our thoughts affect  
7 our mental health, our emotions or feelings and our behaviours.  
8 So it looks at targetting cognition and behaviour in order to  
9 support people to be more well.

10 **Q.** Okay.

11 **A.** Yeah.

12 **Q.** So I'm going to skip ahead a little bit in your  
13 employment history. At the top of page 2 of your CV, in 2003  
14 and 2006 where were you working then?

15 **A.** Sorry. 2003 ...

16 **Q.** It looks like May of 2003 to May of 2006. At the very  
17 top.

18 **A.** Oh yeah. So I was working at the Nova Scotia Hospital  
19 on acute care and the short-stay psychiatric inpatient units.

20 **Q.** So what is "acute care" and "short stay"?

21 **A.** So at that time, there were a couple of acute care  
22 units. So adults requiring psychiatric stabilization for acute

**HEATHER WHEATON, Direct Examination**

1 psychiatric illness. So that tended to be ... it could be  
2 anything but, for example, people with psychotic illnesses.

3 The short-stay units at that time were focussed more on ...  
4 there was a presumption that the person would require a brief  
5 hospitalization. So that generally was people who were  
6 experiencing a crisis of some sort. Could include suicidality,  
7 psychosocial issues, difficulty managing their emotions and  
8 their behaviours. That type of thing.

9 **Q.** So I guess keeping with the mental health theme, if we  
10 look at page 1 of your CV, from May of 2006 and August of 2011  
11 what were the various positions you held in part of your  
12 employment as a nurse?

13 **A.** Do from 2006 to 2011, I worked as a member of the  
14 Mental Health Mobile Crisis team which is located in Halifax  
15 and, at that time, it was a service that had mental health  
16 clinicians partnered with Halifax Regional Police officers, and  
17 the mental health clinicians could be employed by either Capital  
18 District Health or the IWK, and the service provided telephone  
19 support as well as a mobile response to individuals experiencing  
20 mental health crisis in the community. Generally, the HRM.  
21 There was a boundary on the mobile response. Yeah.

22 **Q.** And I plan to get into later of what the mobile crisis

**HEATHER WHEATON, Direct Examination**

1 unit is.

2       **A.**    Okay.

3       **Q.**    What it does.

4       **A.**    Yeah.

5       **Q.**    I understand, during this period of time as well, you  
6 had some involvement in triaging?

7       **A.**    Yes.  So part of that position required triaging,  
8 predominantly on the telephone.  So triaging for a response.  So  
9 was it something we would respond to in person?  Go mobile?  Or  
10 was it something that required us to call 9-1-1?  Was it  
11 something that we could provide some sort of brief solution  
12 focus crisis support on the telephone?

13       **Q.**    So would this be a situation which would be, rather  
14 than somebody showing up in the ER with some form of mental  
15 health illness or in a state of mental health crisis, they would  
16 call, I guess?

17       **A.**    Yes.

18       **Q.**    Is that what it was?

19       **A.**    Yes.  It was a 24-hour service that people could call  
20 if they were experiencing a mental health crisis.

21       **Q.**    And you indicate psychiatric assessment was part of  
22 your duties that you were trained in.

**HEATHER WHEATON, Direct Examination**

1           **A.**    Yes.  Yeah.  So there was, at that time, if we saw  
2  somebody in person, we would complete a brief psychiatric  
3  assessment.  So biopsychosocial assessment.  And part of what we  
4  may be assessing, if we were mobile in the community, it would  
5  be accompanied by a Halifax Regional Police officer who worked  
6  on the team and so it would always be two of us.  So a clinician  
7  and a police officer.  That allowed for a situation where we may  
8  assess that somebody would meet criteria for the police, say, to  
9  arrest them under the **Mental Health Act**.  We could support the  
10 police in that process and then perhaps transport the person to  
11 the emergency room.

12           **Q.**    And you indicated there, finally, you said:  "It  
13 provided education and support to families and to community  
14 members and agencies."

15           **A.**    Yeah.

16           **Q.**    So what did that involve?

17           **A.**    So sometimes it would be families that would be  
18 contacting our service and so sometimes their visits would be to  
19 family homes.  For example, somebody might call and be  
20 requesting some support for a family member in the home and we  
21 could arrive.  That family member may not even be there, the  
22 individual who was in crisis.  So sometimes we'd be meeting with

**HEATHER WHEATON, Direct Examination**

1 the family and trying to provide them with some education and  
2 support either about supporting their loved one who has mental  
3 illness or about how to get support and help when they needed  
4 it.

5 And, likewise, we would respond to community partners or  
6 community agencies like group homes or nursing homes. That kind  
7 of thing. And so there was a component about providing some  
8 support to the staff of some of those homes. Yeah.

9 **Q.** So August of 2011 to May of 2012, what is your role  
10 in, I guess, mental health nursing at this point?

11 **A.** So from 2011 to 2012, I was employed in, it was a  
12 recovery and integration model, so they called it "intensive  
13 case management" and, basically, I think there was a couple of  
14 us and we worked out of an outpatient mental health clinic, but  
15 the support we provided was in the community, so with people in  
16 their homes.

17 By and large, these would've been people with, say,  
18 persistent mental illnesses like schizophrenia, for example.  
19 And so sometimes it was about helping them get to appointments,  
20 helping them to integrate into their communities, connecting  
21 them with services, monitoring and supporting them and learning  
22 how to sort of monitor their own wellness, I guess, and illness

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1 and symptoms of their illness.

2 Medication. We did medication in people's homes. So  
3 people who are on injectable medications. So long-acting  
4 medications for psychosis, that kind of thing, we did that in  
5 their homes.

6 Supported people going to court. Yeah.

7 **Q.** Okay. So from May of 2012 to November of 2014, I  
8 guess again, you're still involved in mental health nursing but  
9 your role again changes slightly.

10 **A.** Right.

11 **Q.** What are you doing at this point?

12 **A.** I was working in a mental health outpatient clinic in  
13 Dartmouth and basically as a community mental health nurse. And  
14 so there was a lot of different things I would do. So there's  
15 some group facilitation work. There was assessment, so people  
16 coming for the first time, doing an actual psychiatric  
17 assessment. There was medication clinics, so again providing  
18 long-acting injections, medication monitoring for clozapine, so  
19 we ran a clinic for people to monitor that. Then I got some, I  
20 guess, education. I did some training in a couple of different  
21 kinds of therapy, predominantly solution-focused therapy.

22 **Q.** What's "solution-focused therapy"?

**HEATHER WHEATON, Direct Examination**

1           **A.**    So I struggle to remember the textbook definitions of  
2 things.

3           **Q.**    That's okay. But, in general, what is it?

4           **A.**    So, basically, it's a brief therapy that's actually  
5 ... it's fairly ... it's a therapy modality. So there's,  
6 generally, a certain type of interview or interaction you would  
7 have with somebody and it's brief and it's focused on setting  
8 goals with the person and ...

9           **Q.**    And I guess ...

10          **A.**    ... supporting them, I guess, and ...

11          **Q.**    And I guess that particular mode of therapy would be  
12 patient dependent, I take it? Not all patients ...

13          **A.**    So at that time, no, not all, although there was a  
14 system in place at that time where all people coming into the  
15 clinic for the first time would meet with a clinician who would  
16 basically do a solution-focused therapy session as your first  
17 visit with somebody. It's a good way ... it's a good approach  
18 to hear a person's story and help to kind of narrow down where  
19 the problems areas are ...

20          **Q.**    So I get it ...

21          **A.**    ... fairly quickly and ...

22          **Q.**    It's a technique, I guess, at initial ... early phase

**HEATHER WHEATON, Direct Examination**

1 to draw information out to sort of get a complete perspective as  
2 best you can?

3 **A.** Sort of. It's ... yeah.

4 **Q.** What was "group facilitation" that you were involved  
5 in? What was that?

6 **A.** So there was ... we would run groups for clients of  
7 the clinic. So there was ... so self-esteem, anger management,  
8 healthy communication. Those were the three that I facilitated  
9 that I recall facilitating. And then we ran ... there was an  
10 anxiety group, I think I co-facilitated once.

11 **Q.** So I'm going to ask you about 2014 to 2016. It has a  
12 reference to Alberta Health Services. So what were you doing in  
13 Alberta as your role as a nurse?

14 **A.** I was working on acute care and geriatric mental  
15 health inpatient units.

16 **Q.** So, again, your entire role as a nurse again is mental  
17 health related?

18 **A.** Yes.

19 **Q.** And then finally bringing us up to 2016 until today,  
20 and I plan later to go through what a mental health crisis  
21 clinician is, but you indicated you, as well, are crisis  
22 coordinator? What is that?



**HEATHER WHEATON, Direct Examination**

1           **A.**    So originally when I came to the position, the title  
2 of the position was crisis coordinator. So there was, I would  
3 say, a slightly expanded role to the crisis coordinator position  
4 in that there's ... there would be more time, opportunity, and  
5 expectation for things like case conferences and support to the  
6 role, maybe like some places have like a clinical nurse educator  
7 almost. So if crisis clinician needed ... if the crisis service  
8 at that early time in 2016, for example ... the crisis service  
9 was fairly new and developing. So the crisis coordinator would  
10 help to kind of establish those connections within the service  
11 and figure out what the service needed in order to be most  
12 effective.

13           **Q.**    So this role of mental health crisis clinician ...

14           **A.**    Yes.

15           **Q.**    ... that ... you've held that title since 2016 at St.  
16 Martha's. Do you know if that was in place prior to 2016 or if  
17 it was something that was developed?

18           **A.**    It was. So when I came into the position, the person  
19 who was leaving that position was the person who was the first  
20 person in it, sort of. And she had actually gone a long ways  
21 towards developing it and sort of advocating for that position  
22 at St. Martha's. So I don't recall how long the position had

**HEATHER WHEATON, Direct Examination**

1 been in place at that point and she was leaving that role. And  
2 so when I was hired there, I took that role and there was just  
3 the one person in a crisis role there.

4 Q. And that was ...

5 A. And so that would have been me when I took that role.

6 Q. Okay.

7 A. Yeah.

8 Q. So this concept of mental health crisis unit, we're  
9 going to get into what that is. In 2016, is it fair to say that  
10 was kind of early days for that sort of project?

11 A. So there was ... yeah. There was one mental health  
12 crisis clinician position. There was one.

13 Q. Was there such a thing as a mental health crisis unit  
14 back in 2016?

15 A. No.

16 Q. So I take it that it was one person and that was you.

17 A. Yes.

18 Q. And at some point that expanded, I believe.

19 A. Uh-huh.

20 Q. Do you recall when that expanded?

21 A. I think it wasn't that long, but I ... honestly, I  
22 don't remember. I'm pretty sure by ... I'm pretty sure it was

**HEATHER WHEATON, Direct Examination**

1 just months and a second position. So the position that I took,  
2 I took as a ... it was a temporary. So it had to be posted or  
3 it was posted and nobody applied. I don't remember the ... I  
4 was new to Antigonish, I was new to St. Martha's, so I had it as  
5 a temporary position. And then at some point, within months, I  
6 think, somebody with more seniority was hired into that  
7 position. But by then, they had created a second position and  
8 there became two crisis clinicians. And so I was successful in  
9 my application for that position. Yeah.

10 Q. We'll go back to that later. So your work experience  
11 in your entire ... I believe 28 years nursing career, it's been  
12 entirely in mental health?

13 A. Yeah. There was about a four-and-a-half years where I  
14 left working publicly and ... or left working and worked in the  
15 private sector. And then when I did a reentry to nursing and  
16 tried ... I think I did six months with the VON and then back to  
17 mental health.

18 Q. So I'm looking at it ... your CV references forensic  
19 psychiatric nursing ...

20 A. Uh-huh.

21 Q. ... inpatient/outpatient nursing, community nursing,  
22 crisis nursing. You'd agree that that's a pretty broad sort of

**HEATHER WHEATON, Direct Examination**

1 career to have in mental health nursing?

2 **A.** Yeah. Yeah.

3 **Q.** And are there any sort of departments or  
4 subspecialties in mental health nursing that you haven't been  
5 involved with?

6 **A.** I've worked with child and youth only in my role as a  
7 crisis clinician, so I haven't done any inpatient or outpatient  
8 clinic work with children and youth.

9 **Q.** But other than that?

10 **A.** Yeah. I can't think of anything.

11 **Q.** Can't think of any? So typically in this province,  
12 based on your experience and your knowledge of nursing  
13 throughout Nova Scotia, is it typical for a nurse involved with  
14 mental health to spend their entire career as a mental health  
15 nurse with that specialty?

16 **A.** I don't know, to tell you the truth. I'm sure there's  
17 a few of us.

18 **Q.** But if you were to follow say ...

19 **A.** But, yeah ...

20 **Q.** ... say 100 nurses, how many would you expect would  
21 have spent their entire career focused strictly in mental  
22 health?

**HEATHER WHEATON, Direct Examination**

1           **A.**    Maybe not a lot because there are so many different  
2 areas and there's so many different opportunities with nursing  
3 that people can move around. And, honestly, my experience is  
4 working with ... so I work with different specialties, not just  
5 nursing. So I've been ... you know, only in my maybe inpatient  
6 experiences would I be sort of working with just nurses. So I  
7 work with other mental health clinicians with all different  
8 backgrounds, so ...

9           **Q.**    Okay.

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

11          **Q.**    And during your period of time in various settings as  
12 a mental health nurse, have you had any sort of experience in  
13 dealing with either retired veterans ... military veterans or  
14 veterans that are temporarily not in active military service?  
15 Have you had any experience with those types of patients?

16          **A.**    I'm sure I have. Yes. Do I remember specific ...  
17 actually, I don't recall any specifics other than a ... I've  
18 actually had a couple of more recent contacts with people that  
19 would fall in that category.

20          **Q.**    Would you say ... if I was to suggest frequent,  
21 infrequent, hardly ever, all of the time, in terms of your  
22 actual ...

**HEATHER WHEATON, Direct Examination**

1           **A.**    Infrequent.

2           **Q.**    Okay.  So on your CV there's one particular aspect of  
3 your skills, experience, and training.  It's at the top of page  
4 one.  It's the third one down from skills and experience.  It  
5 says, "Suicide Risk Assessment Course and Trainer for SRAI  
6 Tool".

7           **A.**    Uh-huh.

8           **Q.**    I guess what is the "SRAI tool"?

9           **A.**    So that's the Suicide Risk Assessment Intervention  
10 Tool that is in place now that you would see.

11          **Q.**    And what is the Suicide Risk Assessment Course?

12          **A.**    That's a course that's offered by the RNPDC.  So  
13 that's a course that's offered in suicide risk assessment.  It's  
14 offered through the RNPDC.  I'm sure you're going to ask me what  
15 that stands for.  I'm going to struggle.  So it's NSHA.

16          **Q.**    So how long of a course is that?

17          **A.**    And so I was just trying to think that.  I think it's  
18 ... ooh, it was a couple of months anyways.  I can't remember  
19 specifically how many ...

20          **Q.**    The course ...

21          **A.**    ... months ... the course.  So a lot of it is study on  
22 your own and on your own time and then there are ... there's

**HEATHER WHEATON, Direct Examination**

1 papers that you write and there's tests that you have to do.  
2 And then there's a component ... they call it in the "lab". But  
3 there's a component of clinical ... of interviewing. They use  
4 actors and such in order to ...

5 **Q.** And the actors are in a state of sort of mental health  
6 crisis, I guess, or ...

7 **A.** Or they would be people experiencing ... it would be  
8 to do a suicide risk assessment. So not necessarily just in a  
9 crisis situation but just in doing suicide risk assessment.

10 **Q.** Do you know when this course came into effect or when  
11 did it start?

12 **A.** Oh! I'm not sure. I'm going to say years now.

13 **Q.** Would it be earlier than 2016, after 2016 ...

14 **A.** Oh, earlier than 2016. Yeah.

15 **Q.** So who ... is this course ... who would normally take  
16 this course, suicide risk assessment?

17 **A.** When I did the course, I think there was ... there  
18 were nurses, social workers, occupational therapist. I think we  
19 may have had either a resident psychiatrist or an intern or  
20 something and ... or maybe it was a resident. So, basically,  
21 anybody could apply to take it, but it would be people working  
22 in mental health and addictions program or people working in

**HEATHER WHEATON, Direct Examination**

1 mental health and addictions.

2       **Q.** So do you know if it's mandatory for someone working  
3 in mental health, whether it's a nurse or a social worker, is  
4 that suicide ...

5       **A.** So my understanding is that it's mandatory, but I  
6 can't ... I don't know ... I'm not going to say that that's  
7 across every single area of the mental health and addictions  
8 program in Nova Scotia because I don't know that for sure. But  
9 I believe that it is mandatory for people working in inpatient,  
10 in crisis ... you know, in certain areas. And ...

11       **Q.** Is this ...

12       **A.** ... I don't ...

13       **Q.** ... particular to St. Martha's or ...

14       **A.** My understanding would be it would be beyond St.  
15 Martha's. The time I took it, it was mandatory I think in the  
16 position I was in and that was for Capital Health.

17       **Q.** And how long have you been involved in teaching that  
18 course in the SRI- ... or, sorry ...

19       **A.** So I don't teach ...

20       **Q.** ... SRAI tool.

21       **A.** ... the course.

22       **Q.** Okay.



**HEATHER WHEATON, Direct Examination**

1           **A.**    I ... yeah.  So I've completed the course, like  
2 participated or ... but I'm a trainer for the tool.  So ... or I  
3 was a trainer for the tool.  That was one ... I think I did one  
4 training session at St. Martha's but ...

5           **Q.**    And ...

6           **A.**    Yeah.

7           **Q.**    ... the same groups of people have to take training in  
8 learning the tool ... the risk assessment tool?

9           **A.**    Anybody who would have occasion to or be expected to  
10 complete the tool should get the training with the tool.  My  
11 understanding is they've done ... when I did the training was, I  
12 think, early when they first brought the tool out and were  
13 implementing it.  And then after that, I believe they developed  
14 a learning module online that I think people might be able to  
15 take if they missed the sort of initial go-around of training on  
16 how to use the tool.

17          **Q.**    Are you able to say whether or not there's sort of  
18 mandatory training or whether or not ER physicians or  
19 psychiatrists have to take training in the SRAI tool?

20          **A.**    I am not sure.  I wouldn't ...

21          **Q.**    Are you able to comment about nurses?

22          **A.**    Outside of mental health or ...

**HEATHER WHEATON, Direct Examination**

1           **Q.**    Within mental health.

2           **A.**    Oh, within mental health? The tool ... so registered  
3 nurses working in the mental health program at St. Martha's, and  
4 I'm pretty sure it's provincially, have to use the tool;  
5 therefore, they should have training in using the tool.

6           **Q.**    What about sort of a nurse working in the ER?

7           **A.**    They wouldn't be completing the tool, so they wouldn't  
8 need training in the tool.

9           **Q.**    Okay. So always ... I guess my question is if someone  
10 presents to an ER sort of after hours, whether it's 10 o'clock,  
11 say, on a Friday night is what I mean by "after hours," and  
12 they're presenting in some form of mental health crisis, various  
13 stressors, various symptoms, I guess, the nurse that they  
14 interact with, would they have training in this suicide risk  
15 assessment tool?

16           **A.**    No, because it's ... no. It's a tool ... it's only  
17 mental health and addictions. Clinicians are people who would  
18 actually use this tool because it's a tool that aids in prompts  
19 and documentation of the suicide risk assessment. So if you are  
20 not trained, comfortable, experienced, and it's not part of your  
21 job to do a mental health or suicide risk assessment, then you  
22 wouldn't use the tool.

**HEATHER WHEATON, Direct Examination**

1           **Q.**    So I guess my question is if somebody appeared this  
2 Friday ...

3           **A.**    Yes.

4           **Q.**    ... at 10 o'clock ...

5           **A.**    Right.

6           **Q.**    ... to an ER at St. Martha's ...

7           **A.**    Yes.

8           **Q.**    ... and they have all the signs and symptoms of ...  
9 their chief complaint is mental health.

10          **A.**    Okay.

11          **Q.**    It's a situational crisis, let's say, does someone  
12 complete that suicide risk assessment while they're there?

13          **A.**    I don't know.

14          **Q.**    Would the ER nurse or the nurse that's on staff  
15 complete that?

16          **A.**    No.

17          **Q.**    No?

18          **A.**    No.

19          **Q.**    If there was a consult, say the ER doctor had called  
20 for a consult with Psychiatry, would there be any sort of nurse  
21 involved in doing an assessment ... suicide risk assessment?

22          **A.**    After hours? No. At St. Martha's, no.

**HEATHER WHEATON, Direct Examination**

1           **Q.**    So if it happened at 1 o'clock in the afternoon on  
2 Friday ...

3           **A.**    Right.

4           **Q.**    ... same scenario, somebody presents, situational  
5 crisis, number of signs and symptoms relating to mental health,  
6 would the tool be completed at that time?

7           **A.**    If the ... if mental health ...

8           **Q.**    Mental health is ...

9           **A.**    ... crisis response service was consulted, then yes.  
10 Yeah.

11          **Q.**    Who makes the decision that there's a mental health  
12 crisis consult?

13          **A.**    The Emergency Room physician.

14          **Q.**    Okay. So if the ER doctor calls for a consult,  
15 presumably somebody would attend and administer that suicide  
16 risk assessment?

17          **A.**    Yes. If the ER physician consulted crisis response,  
18 then presumably one of us would attend and we would do ... every  
19 time we see somebody in the Emergency Room when we're consulted,  
20 if we attend, then we complete both the crisis assessment as  
21 well as the suicide risk assessment intervention tool.

22          **Q.**    Okay.

**HEATHER WHEATON, Direct Examination**

1           **A.**    Yeah.

2           **Q.**    So as of now, I guess your understanding is if there's  
3 an ER consult requested after hours ...

4           **A.**    Right.

5           **Q.**    ... outside of what perhaps a psychiatrist might do,  
6 if they're present, there's no formal completion of a suicide  
7 risk assessment tool. Is that correct?

8           **A.**    My understanding is the tool is not completed.  
9 Correct. Yeah.

10          **Q.**    So we'll talk a little bit about your title as mental  
11 health crisis clinician. So what exactly is a mental health  
12 crisis clinician?

13          **A.**    Would be a professional in a variety of different  
14 disciplines, so it could be a nurse or a social worker, an  
15 occupational therapist, that has training and experience and is  
16 employed in a mental health role where they have contact with  
17 clients.

18          **Q.**    How many currently ... I guess we'll start at St.  
19 Martha's. Are you aware how many mental health crisis  
20 clinicians there are at St. Martha's Hospital?

21          **A.**    Yes. There are two of us. There are three positions  
22 but there are two of us working in the crisis service.

**HEATHER WHEATON, Direct Examination**

1           **Q.**   And of the three positions, what are the relative  
2 backgrounds? Yours, obviously, is nursing.

3           **A.**   Yeah.

4           **Q.**   And what are the other two?

5           **A.**   So my colleague who's on leave is a nurse. And then  
6 my colleague that I work with right now is a social worker.

7           **Q.**   Is there a mental health crisis clinician in every  
8 hospital that you're aware of throughout the province?

9           **A.**   No, there's not.

10          **Q.**   For example, Guysborough Hospital here ...

11          **A.**   No.

12          **Q.**   There's no mental health crisis clinician?

13          **A.**   No.

14          **Q.**   The hospital ... Cape Breton Regional Hospital in  
15 Sydney, are you aware if there is ...

16          **A.**   Yes.

17          **Q.**   So if someone attends in the middle of the afternoon  
18 at say Guysborough Hospital in a form of ... symptoms again, I  
19 guess, with mental health related concerns, in a form of mental  
20 health crisis, how do they get access to a mental health crisis  
21 clinician? Is there any way the mental health crisis clinician  
22 can get involved there?

**HEATHER WHEATON, Direct Examination**

1           **A.**    So if an Emergency Room physician decides that they  
2   ... there's a need or that they want to consult mental health  
3   crisis and they're at one of the hospitals outside of St.  
4   Martha's that don't have that service, then they call us,  
5   basically. They speak to one of us on the phone and they give  
6   us a report and they let us know that they'd like to send the  
7   person to St. Martha's ER to see the mental health crisis  
8   clinician for a consult.

9           **Q.**    So if the person isn't sort of admitted into the  
10  hospital, they're there, they attend, they're transported to the  
11  local hospital where the mental health crisis clinician is?

12          **A.**    So I can ... yes. I can only speak to what happens  
13  really at our hospital. But, yes. So if somebody presents to  
14  Guysborough or Strait Richmond Hospital or Eastern Memorial  
15  Hospital and the ER physician would like a mental health  
16  consult, then the ER physician from that hospital calls our  
17  service. They give us a verbal report and they let us know why  
18  that, you know, they're seeking a consult and that they're going  
19  to send the person. And then we support that process.

20           And so they ... generally speaking, the person remains  
21  under the care of that physician and are transported, most often  
22  by ambulance because the referring physician is still

**HEATHER WHEATON, Direct Examination**

1 responsible for their care and most often that is the way that  
2 they feel most comfortable, and they're transferred to our  
3 Emergency Room and then we would see them when they arrive. And  
4 then we would discuss our assessment with the referring ER  
5 physician at whatever hospital.

6 **Q.** Are you familiar with any scenarios where someone may  
7 attend for mental health crisis in a more rural area where there  
8 isn't the clinician present and they're looking to access  
9 services, but when they find out that they have to be  
10 transferred to another hospital in a more central location  
11 there's a resistance to that? And, if so ... if you're familiar  
12 with that, what takes place at that point? How is the situation  
13 managed?

14 **A.** I'm not aware that anybody ... so most often they're  
15 being transported by ambulance. There has been some concerns  
16 about how they will get back to their home area and that has, at  
17 times, been quite inconvenient for people. So if we can  
18 transport them back to that hospital by ambulance, they might  
19 have to wait for a very long time for that type of transport.

20 **Q.** And sometimes how long would they have to wait to get  
21 back home?

22 **A.** To get back to their home ... so if a person is not



**HEATHER WHEATON, Direct Examination**

1 going to be admitted to St. Martha's Hospital and they're ...  
2 then they would ... we would help them ... or we would be  
3 responsible to transport them back to the emergency room from  
4 whence they had come, so to speak.

5 Q. Okay.

6 A. So we would ... our Emergency Room would call an  
7 ambulance and request that ... I don't even know the  
8 terminology. They do it. I don't call them for transport ...  
9 but just for transport. So it would depend on how busy  
10 ambulance services were but they could wait many hours.

11 Q. Okay.

12 A. Yeah.

13 Q. And you indicated, I believe, in 2016 and perhaps  
14 early 2017, you were the only mental health crisis clinician at  
15 St. Martha's?

16 A. Yes.

17 Q. And my understanding is a mental health crisis  
18 clinician, you are primarily based out of the hospital, I take  
19 it.

20 A. So the role at St. Martha's of mental health crisis  
21 clinician, at that time in ... was carrying a cell phone, some  
22 borrowed space, and then at that time in an office, sort of a

**HEATHER WHEATON, Direct Examination**

1 small sort of swing office, I think, for a while it was. And  
2 then we got a permanent sort of office space. And at the time  
3 of 2016, the crisis clinician would take calls from community,  
4 as well. So if somebody primarily from community partners, so  
5 ... but sometimes also from individuals, they would call through  
6 the mental health outpatient service and then they would get put  
7 through to the cell phone being carried by the crisis clinician.

8 **Q.** So I guess a crisis clinician's point of contact with  
9 people, I guess, in a mental health crisis, I guess, or symptoms  
10 with crisis or mental health, is not always just the ER.

11 **A.** At that time in 2016, there was also on the phone.

12 **Q.** Okay. And ...

13 **A.** And then in the ER. Yeah.

14 **Q.** And what about today?

15 **A.** Today, there's less phone because the ... it would be  
16 ... the mental health mobile crisis team has now expanded to be  
17 also a Nova Scotia provincial mental health crisis telephone  
18 line. So people have that telephone crisis support available to  
19 them provincially 24/7 or 24 hours a day, seven days a week. So  
20 ... and, also, we just couldn't keep up realistically with the  
21 demand of trying to provide a phone service and an in-person  
22 consult service to the ER because we couldn't take calls when we

**HEATHER WHEATON, Direct Examination**

1 were in the ER seeing somebody. So less phone now and more now  
2 in person. Yeah.

3 Q. So I guess that's going to be my next sort of logical  
4 question is, you have, in effect, two mental health crisis  
5 clinicians at St. Martha's right now.

6 A. Right now. Yeah.

7 Q. In terms of patients showing up in ER and patients out  
8 in the community where you say you attend from time to time ...

9 A. No. We don't. That ...

10 Q. You don't?

11 A. That's the service provided ... the mental health  
12 mobile crisis team ...

13 Q. Okay.

14 A. ... in the Halifax area.

15 Q. So mental health crisis ...

16 A. So mental health crisis at St. Martha's Hospital used  
17 to be on the phone and still could happen that a phone call  
18 could get put through to us, and we respond to consults in the  
19 Emergency Room.

20 Q. Okay. So ...

21 A. Yeah.

22 Q. ... your role now as a mental health crisis clinician

**HEATHER WHEATON, Direct Examination**

1 is based out of the Emergency Room at St. Martha's.

2 **A.** We're not physically in the Emergency Room ...

3 **Q.** No, I know.

4 **A.** ... but, yeah ... yes, we provide ...

5 **Q.** You are engaged at that point through the ER.

6 **A.** Now, yes. And ... yes. And the crisis response  
7 service now also has the urgent care component to it. So the  
8 crisis ...

9 **Q.** And what is ...

10 **A.** Crisis response services now covers both crisis  
11 response in the ER, like to consults in the ER as well as an  
12 urgent care service, which is providing ... it's providing brief  
13 intervention for people who come through, say, the Emergency  
14 Room in a crisis and it's believed that they do not require an  
15 inpatient admission but it's going to take longer than an hour  
16 or two to sort of support their crisis being resolved and that  
17 they could benefit from some brief, fairly intensive, support.

18 Those people can also get referred to urgent care from the  
19 central intake. So when somebody is intaking for service, if  
20 Intake believes that they require some urgent support and that  
21 it looks like it might be something that's brief and doesn't  
22 require long-term therapy, then they can also refer to our

**HEATHER WHEATON, Direct Examination**

1 service. So my colleague and I make up the crisis response  
2 service at St. Martha's Hospital and right now, we share ... we  
3 do half days. So half a day responding to consults in the  
4 Emergency Room and half a day with sort of booked urgent care  
5 appointments.

6 Q. So is there always ...

7 A. Yeah.

8 Q. ... a mental health crisis clinician at St. Martha's  
9 covering the ER except for after hours?

10 A. Between the hours of ... yes. Between the hours of  
11 8:30 and 6, there's always a crisis clinician.

12 Q. What about weekends?

13 A. No weekends.

14 Q. And what about holidays?

15 A. No holidays.

16 Q. So I want to get into sort of how that role is  
17 slightly different than another service which you mentioned  
18 earlier was a mobile crisis unit.

19 A. Yeah. That's very, very different.

20 Q. Is that offered through St. Martha's?

21 A. No.

22 Q. No. Where is that offered?

**HEATHER WHEATON, Direct Examination**

1           **A.**    No.  So that's a one specific ... the mental health  
2 mobile crisis team is a specific service that is located in the  
3 Halifax Regional Municipality.

4           **Q.**    And is that the only ...

5           **A.**    Yes.

6           **Q.**    ... municipality it's offered in, as far as you know?

7           **A.**    As far as I know.  Yeah.

8           **Q.**    And, generally, what is their role?  How does a mobile  
9 crisis unit ... how do they ever get involved in what it is that  
10 they do?

11          **A.**    So that's a very ... my understanding is that it's a  
12 fairly unique service.  And I'm not aware of any other ones in  
13 the province.  So they would take calls directly from  
14 individuals in crisis.  So as I said, that's ... they run the  
15 provincial ... or I don't know how ... but they operate the  
16 provincial mental health crisis line.

17          **Q.**    I'll give you ...

18          **A.**    So ...

19          **Q.**    ... an example.

20          **A.**    Yeah.

21          **Q.**    Would they become involved if, say, a wife had called  
22 the police ...

**HEATHER WHEATON, Direct Examination**

1           **A.**    Yeah.

2           **Q.**    ... and said, My husband has a history of PTSD ...

3           **A.**    Yes.

4           **Q.**    ... he has signs of being manic today, he's not coping  
5 well.

6           **A.**    Yes.

7           **Q.**    Police are sort of actively looking for him.

8           **A.**    Yes. They ...

9           **Q.**    Is ...

10          **A.**    ... might become involved in that situation.

11          **Q.**    Is that the sort of scenario that a mobile crisis team  
12 ...

13          **A.**    There would be multiple different scenarios covering  
14 any kind of ... yeah.

15          **Q.**    But would that be one example?

16          **A.**    But that could be one example of a scenario. Yeah.

17          **Q.**    So sort of out in the community ...

18          **A.**    Yeah.

19          **Q.**    ... I guess, we'll say roadside, the patient or ... at  
20 the time, the person undergoing the crisis has access to mental  
21 health professionals along with the police?

22          **A.**    Yes.

**HEATHER WHEATON, Direct Examination**

1           **Q.**   And that mobile crisis team, could that involve a  
2 nurse, say, trained in mental health?

3           **A.**   Yes.

4           **Q.**   Could it involve a social worker trained ...

5           **A.**   Yes.

6           **Q.**   ... in mental health?

7           **A.**   Yes.

8           **Q.**   And as far as you know, that particular service is  
9 unique to Halifax.

10          **A.**   Yes.

11          **Q.**   Are you aware of any sort of rural regions within the  
12 province that that is available?

13          **A.**   No.

14          **Q.**   And do you believe that it's sort of a valuable  
15 service in terms of an interface with the person in the crisis  
16 and a mental health professional as opposed to just simply a  
17 police officer?

18          **A.**   Yes.

19          **Q.**   And why is that?

20          **A.**   Because people who are experiencing a mental health  
21 crisis, I believe a ... somebody who is trained in mental health  
22 would be the best person to be providing intervention. And



**HEATHER WHEATON, Direct Examination**

1 sometimes ... in my experience, sometimes police officers can  
2 struggle a little bit with the mental health ... like with  
3 interpreting the **IPTA, Involuntary Psychiatric Treatment Act**,  
4 the part that pertains to their ability to arrest people under  
5 the **Mental Health Act**, for example. Sometimes they struggle  
6 with that. And I think sometimes it might be a benefit to have  
7 a mental health clinician available to support that process in  
8 the community.

9 **Q.** So I'm going to go back to your role as a mental  
10 health crisis clinician and the mental health crisis team as it  
11 operates out of the ER at St. Martha's, for example. What does  
12 this crisis team comprise of as it exists ... I guess in 2016,  
13 you said it comprised of you, basically.

14 **A.** Yes.

15 **Q.** And what does it comprise of today?

16 **A.** So my colleague and I ... so there are three  
17 positions, but there are two people currently. The third  
18 position is not filled. So right now it's comprised of my  
19 colleague and I. And we have office space in a building  
20 adjacent to the hospital ... attached to the hospital, so we  
21 have office space in the hospital. And we comprise the crisis  
22 response service and then we have support from other people.

**HEATHER WHEATON, Direct Examination**

1 But it's ...

2 Q. I guess so what ...

3 A. Yeah.

4 Q. ... do you do as part of the crisis response service?

5 So you at some point in today ... how do you first get involved  
6 with a potential patient that ...

7 A. So there's ...

8 Q. ... presents to the ER?

9 A. If there's a person ... so if an ER physician is  
10 making a consult to our service, then somebody calls to tell us  
11 that. Could be different people. Could be one of the nurses.  
12 Could be the ER physician directly. It might be the clerk or  
13 ... so somebody calls to say that there's somebody here who's  
14 consulted to your service.

15 Q. And so I take it you go down and eventually meet with  
16 the patient?

17 A. Yes. Oftentimes, if I'm ... yeah. If I'm not in the  
18 Emergency Room or if we're not in the Emergency Room, sometimes  
19 I'll ask for the person's name and then I'll take a quick look  
20 on MEDITECH to see if they've had recent contact with anybody in  
21 the mental health program or if they've had recent Emergency  
22 Room visits. We do see children and youth, as crisis

**HEATHER WHEATON, Direct Examination**

1 clinicians, at St. Martha's. So I would do that if it was a  
2 child or an adult. And then on my way to the Emergency Room may  
3 swing by either the child and youth or the adult outpatient  
4 service, if I've noted in MEDITECH that they're connected with  
5 those services, to take a look at the paper charts which are  
6 currently not scanned into the computer. So I may do that if it  
7 looks, from MEDITECH, like there's information there to see.

8 **Q.** So when you get a call for a consult, I guess before  
9 you get there, you're given sort of the role as well to sort of  
10 gather up and try to piece together what the patient's medical  
11 history has been up to that point?

12 **A.** Insofar as it might be helpful or applicable in the  
13 moment in the crisis. So I don't ... I can't dig into records  
14 from five years ago or go trying to track things down. It's  
15 only ... it has to be what's accessible if there's something  
16 accessible right then.

17 **Q.** So I guess if you said ...

18 **A.** Yeah.

19 **Q.** ... can't go digging and ...

20 **A.** Yeah.

21 **Q.** ... get records from five years ago, what's  
22 prohibiting you from doing that?

**HEATHER WHEATON, Direct Examination**

1           **A.**    The time. I'm seeing so many ... if somebody was in  
2 the Emergency Room in crisis ... so I'm not going to take hours  
3 to try to, you know, track down records or call other hospitals.  
4 And the records wouldn't arrive in time for me to view them  
5 anyway.

6           **Q.**    How long does it ...

7           **A.**    So ...

8           **Q.**    ... typically take say from another ...

9           **A.**    ... I don't ...

10          **Q.**    ... hospital in the province to arrive?

11          **A.**    I don't know but it wouldn't be within the hour or two  
12 that ... I'm guessing.

13          **Q.**    Yeah. And I ...

14          **A.**    Yeah.

15          **Q.**    ... certainly appreciate ...

16          **A.**    I don't know.

17          **Q.**    ... that an ER situation ...

18          **A.**    Yeah.

19          **Q.**    ... is sort of immediate here and now. So just before  
20 we, I guess, talk about the timing of things, when you're  
21 gathering up records sort of as you say you're on your way down,  
22 you're swinging by one place and another, can you get access to

**HEATHER WHEATON, Direct Examination**

1 outpatient or ER records from other hospitals within the  
2 province right away?

3 **A.** So on the MEDITECH system ...

4 **Q.** Yes.

5 **A.** ... I can only view ... right now, anyways, I can only  
6 view ER ... like hospital or ER visits for a couple of different  
7 locations.

8 **Q.** What ... So is your evidence that you can't view from  
9 all locations across the province right now?

10 **A.** Not on MEDITECH. I believe there's a way to do it on  
11 some other system, but I don't have access and I don't know.

12 **Q.** So you, as mental health crisis clinician, you have  
13 even today a limited access to records from particular  
14 hospitals?

15 **A.** Yes.

16 **THE COURT:** Is that by somebody's policy or design?

17 **A.** I'm sorry, I don't even really know. I just know that  
18 the computer ... the MEDITECH system doesn't show me if somebody  
19 has been to an emergency room in Halifax, for example. It will  
20 show me, I think, New Glasgow and Antigonish and Cape Breton and  
21 this area. But I can't see if they've attended an emergency  
22 room in ...

**HEATHER WHEATON, Direct Examination**

1       **THE COURT:**       Any other ...

2       **A.**       Yeah.

3       **THE COURT:**       ... information that you would normally  
4 expect to see on MEDITECH from another location, you don't  
5 access anything?

6       **A.**       I ... no. I can't see ... I can't even ... I can't  
7 see it to access it. So, you know ...

8       **THE COURT:**       Yeah.

9       **A.**       ... I don't know whether it's ...

10      **THE COURT:**       Yeah.

11      **A.**       Yeah.

12      **THE COURT:**       You don't know if it's there or not.

13      **A.**       Yeah.

14      **THE COURT:**       It's just ...

15      **A.**       It's not ... yeah.

16      **THE COURT:**       You just don't have access.

17      **A.**       No. No.

18      **THE COURT:**       So you ... would it just be of the hospitals  
19 that would feed St. Martha's that you would have access to?

20      **A.**       I guess so, yes. I know I can see the Aberdeen. Like  
21 I know I can see Pictou County. And I can see the ... like  
22 Strait Richmond Hospital in Port Hawkesbury. And I can see Cape

**HEATHER WHEATON, Direct Examination**

1 Breton. Yeah.

2 **THE COURT:** Okay.

3 **A.** Yeah.

4 **THE COURT:** Sorry.

5 **MR. RUSSELL:** I'm wondering, Your Honour ...

6 **A.** I don't know why.

7 **MR. RUSSELL:** ... I notice it's 4:30. I know there are  
8 other people here other than me. At that point, I guess it's  
9 sort of ... I would plan to canvass access to sort of records.  
10 Given the nature of the topic and the time of day, I'm wondering  
11 if it's best to maybe try to read the room and get a sense of  
12 perhaps we could break until tomorrow?

13 **THE COURT:** I'll read the room for you right now. It's  
14 4:30. We're going to break for the day. All right?

15 **MR. RUSSELL:** I guess I'll stop there.

16 **THE COURT:** Thank you. Ms. Wheaton, you're available  
17 tomorrow, please?

18 **MS. WHEATON:** Yes.

19 **THE COURT:** Thank you very much. So what time are we  
20 going to start tomorrow, appreciating that the weather that you  
21 had driving in this morning might not be the same weather you'll  
22 have driving in tomorrow? 9:30 or 10 o'clock? Where do you

**HEATHER WHEATON, Direct Examination**

1 come from, Ms. Wheaton?

2 **MS. WHEATON:** Antigonish.

3 **THE COURT:** Antigonish? Okay. So ten o'clock, please.

4 **MS. WHEATON:** Thank you.

5 **THE COURT:** All right. Thank you.

6 **COURT CLOSED (16:33 HRS)**

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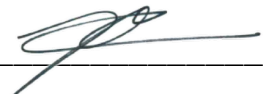
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**CERTIFICATE OF COURT TRANSCRIBER**

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



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Margaret Livingstone

(Registration No. 2006-16)

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**DARTMOUTH, NOVA SCOTIA**

**February 12, 2020**