CANADA

PROVINCE OF NOVA SCOTIA

IN THE MATTER OF THE

FATALITY INVESTIGATIONS ACT

S.N.S. 2001, c. 31

THE DESMOND FATALITY INQUIRY

TRANSCRIPT

HEARD BEFORE: The Honourable Judge Warren K. Zimmer

PLACE HEARD: Guysborough, Nova Scotia

DATE HEARD: February 11, 2020

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P-000113	Crisis Response Service Mental Health/`142 Risk Assessment	

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COURT OPENED (10:01 HRS.)

THE COURT: Good morning.

COUNSEL: Good morning, Your Honour.

THE COURT: Ms. Wheaton, could we have you return to the witness stand, please. Thank you. Ms. Wheaton was testifying yesterday when we adjourned. She has been sworn in and she remains under oath.

HEATHER WHEATON resumed stand, still affirmed, testified:

DIRECT EXAMINATION

MR. RUSSELL: Good morning, Ms. Wheaton.

A. Good morning.

Q. So I just want to recap very briefly the last area which we were talking about yesterday before we broke until this morning. We were reviewing, I guess we were at a spot where, in 2020, you're going to do an assessment in the ER as a mental health clinician and you were going to gather up some records and then reviewing records. There were a series of questions of

what you had access to. I believe you indicated that you had searched MEDITECH and there were limits on what you could see on MEDITECH, and, in particular, you indicated you didn't believe you had access to records based out of Halifax-Dartmouth, is that correct?

A. Um-hmm, yes.

Q. And do you know if there's another system in place that may allow you to access those records from Halifax or Dartmouth if necessary?

A. I believe that there's a system called SHARE that physicians can access, and I'm not exactly sure what it encompasses at this point, no.

Q. Okay. So in terms of your role as the Mental Health Crisis clinician and gathering up that information, you're not sure, I guess, how to access certain records even if they do exist?

A. I know I can access records if I know somebody has visited somewhere. I'm not sure that I can view a visit history outside of a certain geographical area.

Q. Okay.

A. Yeah.

Q. And is it fair to say that, as it stands now, if

someone with your experience, being the Mental Health Crisis clinician, if you have sort of or feel that there's restrictions to accessing all sort of visits throughout the province, that concern is probably shared by other nurses?

A. Possibly. Again ...

MR. ROGERS: Your Honour, I'm not sure that's entirely fair to ask Ms. Wheaton how she thinks other nurses ...

THE COURT: Thank you. She may be able to answer, she may not, she may have had conversations with other nurses or other individuals she worked with, she may have discussions with individuals at conferences or other opportunities. So if you're able to answer the question, if you think you can answer it meaningfully, please do.

A. Again, if we know somebody has had a visit somewhere, we can access those records.

MR. RUSSELL: Okay. So just so, I want to be clear, so when you're attending to do a mental health assessment, one of the things you do is gather up prior medical history for a potential patient?

A. One of the things I would do is look to see if there's been contact somewhere, and this is prior to speaking with the person.

Q. Yes.

A. And look at records that are readily available in the moment.

Q. Okay. And there are, as we indicated, some limits as to what records are readily available to you?

A. Yes.

THE COURT: Mr. Russell, I'm going to stop you for a minute.

MR. RUSSELL: Yes.

THE COURT: So if you have a given individual, that they have an appointment, they come in, they're going to come in and see you or they're already there to see you?

A. So, generally speaking, in my role I don't have booked appointments as a Crisis clinician.

THE COURT: Appointments, okay.

A. It's in the moment when they present.

THE COURT: All right. So they presented, the ER physician has asked you to come and do an assessment.

A. Mm-hmm.

THE COURT: You have some information about that individual.

A. Mm-hmm.

THE COURT: If you go and do a general ... I'm going to call it a general search in MEDITECH ...

A. Mm-hmm.

THE COURT: ... you can only get the local geographic information on that individual?

A. Yes.

THE COURT: Correct. If you knew they had visited a hospital in Halifax ...

A. Yes.

THE COURT: They've been to the QEII on a particular date, could you get that record ... can you get that specific date record?

A. I could. Yes, I could. It would be possible.

THE COURT: How would you go about getting that record?

A. I would probably make a phone call because that would be the quickest way to do it in that situation. To ...

THE COURT: But you could ... Sorry.

A. Mm-hmm, no ...

THE COURT: I cut you off.

A. That's okay. To actually get a copy of the record itself would probably not be something that could happen in a timely fashion given the person is in the Emergency Room in

crisis. But I could make a phone call and try to speak to the person who saw or speak to somebody who could share pertinent information from their health file.

THE COURT: But you wouldn't necessarily get access to the information so you could review it yourself and incorporate that into your assessment?

A. I probably would not get actual paper copies or faxed copies.

THE COURT: All right.

A. Um-hmm.

THE COURT: And apart from knowing about that one specific thing, you would not be able to find out if they had had other visits to that, say, QEII or wherever they might have been in Halifax?

A. Not without having reason to make phone calls and try to find out that way. I wouldn't be able to view it on our MEDITECH system.

THE COURT: Even though it might, even if it was still electronically available, you would still not have access to it because you don't have authorization to access beyond certain geographical points, is that ...

A. I'm actually not ... So because I had ... The access

that I have is what I know. I'm actually not positive about what is acceptable by other health professionals. I'm not positively sure.

THE COURT: All right. Thank you. Sorry, Mr. Russell.

MR. RUSSELL: In terms of other documents, Ms. Wheaton, if a patient who presented in the ER and you get the call for the assessment, to do the assessment, and they had attended sort of a private clinic, say, they had been treated by a therapist in the community, would you have access to that, ready access to that, those records?

A. No.

Q. What about if they had visited their family physician for anything, mental health-related issues, would you have access to those records?

A. No.

Q. If they attended an ER in another province for, say, a mental health-related concern or other medical issues, would you have access to those records?

A. No.

Q. If they attended sort of the OSI Clinic in Halifax, would you have access to those records?

A. No.

Q. If there were any sort of military health-related records, would you have access to those?

A. No.

Q. And one of the roles, I guess, as a mental health crisis clinician, is it fair to say you're trying to get as much information from the patient in the moment of crisis?

A. Yes.

Q. And would you say that the lack of that prior information or medical history, if it's available, may at some point hinder your ability to be as comprehensive as you would like to be?

A. I would say most often not. The exceptions I could think of would be if I was seeing somebody who was in crisis and who might not be the best historian in the moment and then it might be helpful to know if they had been visiting emergency rooms across the province or visits with a GP or if they had a private therapist. It might be helpful. I don't know that it would be essential for the care in the moment.

Q. All right. So would you say, is it fair to say that the ER is fairly busy?

A. Yes.

Q. And so your time is sort of important, I guess?

A. Yes.

Q. So would the fact that you would have to look at various different places for a record, would that sort of take away from the time that you could spend getting the narrative from the patient in that moment?

A. I wouldn't say it takes away from that time, but it certainly does take some time.

Q. Would it be helpful if there was sort of a central database where you, as a Mental health crisis clinician, before you meet with a patient go to, you see the history of ER visits perhaps, visits to a family doctor, visits to a mental health clinic or, say, a social worker? Would that be helpful in any way?

A. Yes, sure, yeah.

Q. In what way would it be helpful?

A. How do I say ... Sometimes it would help provide some clarity, it would give me some things to be curious about when I meet with the person. Some people, while they can provide lots of information and they may be open and forthcoming, sometimes they may not even have an understanding. So, just for example, I might ask somebody if they see anybody for their mental health, any counselors or therapists, and they ... sometimes

people say no. It turns out that they are but they didn't realize that person was a counselor, they thought they were something ... you know, that kind of thing. So sometimes it might help for clarity.

Q. I know we sort of live in a world of consent, you know, and there's privacy in relation to records. Would it be helpful in that where you are there, the patient presents in the ER, you're the kind of a person of early contact, if you were sort of equipped with, whether it was a consent form, where a patient would then consent to getting, you could access the information at some later date? Would it be helpful if you presented that to them?

A. When we ... when I see somebody in the Emergency Room in crisis, that usually is an encapsulated visit, so I may never see that person again or have any contact with that person again. So for me to get records that would come tomorrow or next week to me would not necessarily be helpful, no.

Q. What about ... And we're going to review the form that you actually use when you're doing your assessment.

A. Mm-hmm.

Q. Would it be helpful if there was a document with that form that was very comprehensive in terms of who did you see,

name of that person, area of expertise, and go through that, sort of get that, all of that information from a patient that presents in crisis?

A. We do ask a patient or client those questions, and there is a section on the current form where we document that information.

Q. Do you know if that was in place in 2016?

A. I think so but I can't remember. We've been using our new form for a while.

Q. You'll get a chance to see it, sure.

A. Yeah.

Q. So where do you do your ... If somebody presents in the ER for mental health-related complaints and issues, where do you have your sort of clinical assessment encounter? Where does that usually take place?

A. Now or then?

Q. I guess we'll do both. 2016?

A. Okay. So in 2016, in the Emergency Department there is a room that they call the family room, so it has chairs, a loveseat, a little table, and I believe its intended purpose is if there's somebody critically ill and there's family present, they can wait in that room as opposed to out in the Emergency

waiting room. That family room was predominantly where we most often would see people that we were consulted to see for mental health. That wasn't always an ideal option because if we were seeing somebody that meant that if there was family, they had no place to sit or wait or be other than the waiting room. So at some point, and I know you're going to ask me when, but I can't remember ...

Q. Just roughly, that's fine.

A. At some point within the last year and a half maybe, two years. The Emergency Department, there was a room in the Department that was a manager's office, and so they cleared that out, kicked the manager out, and designated that room as we call it an interview room, it's an interview room, and it has a small desk and a desk chair and it has two sort of comfortable chairs. That is most often where we see people now.

Q. Okay. So when you're doing your assessment is there ... are you looking for sort of collateral information?

A. If at all possible, then we would seek collateral information.

Q. And why would you be looking for that?

A. Because it helps to provide some context and perspective and just valuing what other people ... We're only

seeing people in that one moment and we don't know anything about what's happening out in the world or their relationships with people, and it's just helpful to have that information.

Q. What are some of the collateral sources that you're looking for when you're doing an assessment?

A. If there's collateral available from their circle of care, whoever that might be, friends, family. Again, we see children, so it might be from schools, guidance counselors, principals, teachers.

Q. So you go about sort of gathering that information the best you can?

A. If we can, yeah.

Q. In your experience, your long experience working in mental health crisis and mental health, in general, do you sometimes ... do you always get sort of a very clear account and a direct account from patients attending in crisis?

A. Not always.

Q. And do they always appear totally truthful, I guess, with you or ...

A. The majority of people who attend the Emergency Room with a mental health crisis come of their own volition. They come voluntarily because they're seeking support or help. So I

certainly would enter into all those conversations with the idea of trusting and respecting that person to tell me what was important and what they thought was important. If a person lies to me there's very little I can do about that. Getting collateral information certainly would be helpful but, you know, somebody could lie about how much alcohol they're drinking versus lying about a symptom that they're experiencing versus lying about their marital status or ... Some of those things are not going to have any weight and some of them might.

Q. So separate and apart from sort of an outright lie or being untruthful, have you had experiences where there's sort of a reluctance or a sense of reluctance to share information with you when you're doing an assessment?

A. Yes, yeah.

Q. We've heard Dr. Slayter mention yesterday an interesting area where he had said when he would come in and also do the assessment and he had to leave, he said staff sometimes would say to him, They weren't that way with me.

A. Mm-hmm.

Q. Have you ever sort of experienced that sort of scenario?

A. Yes, less the content of what the person is speaking

about and more sometimes their manner or demeanor.

Q. What's an example? Could you give us some examples that you've seen.

A. Sometimes when the doctor comes in the room, people might make a little bit more of an effort to be more articulate or to maybe calm down some physical agitation that they might have had, they may speak more respectfully, they ... Yeah, it varies.

Q. What about sort of their general ... Did you ever experience a situation where their general, I don't know if I would describe it as mood, but their affect is sort of ... appeared to be slightly different when it came to meeting with you versus the psychiatrist?

A. Well, affect is a tricky thing. So we all have it, and if somebody's affect is effected by a symptom of illness it's hard for a person to change that or think that, so ... But, in general, people might, they might make more eye contact with a physician, because they kind of maybe rally up some of their energy and strength because they perceive the physician interview to be important.

Q. Have you had experiences where you've noticed that they ... somebody that appears in crisis has seemed to be more,

I guess, engaging with the psychiatrist as opposed to the nurse?

A. More engaging?

Q. More, I guess, lively, I guess.

A. I may have, but I wouldn't say ... Not remarkedly so.

Q. So, just generally, I understand that there's a few differences between how the mental health crisis assessment occurred in the ER in 2016 and how it occurs now. What's the difference?

A. In how ...

Q. In the process, I guess, how your services become engaged.

A. So in 2016, in 2016 I call it, we worked a little bit more of a parallel process. So an individual would come through triage in the Emergency Room and there would be a sense or an assessment or the person would state that they were there for their mental health. There would be no obvious ... there may be no obvious physical symptoms, nothing physical that drove them to come to the Emergency Room. They would be registered under the Emergency Room physician, but the triage nurse would give the crisis clinician a call and say that there was somebody there registered for a mental health concern, hadn't been seen by the ER physician yet, and we would attend or I would attend

and begin or do the mental health crisis assessment intervention. The Emergency Room physician was still involved and may or may not see the person of their own volition, and I would still report to the Emergency Room physician sort of the results of my assessment intervention. The change now is that Emergency Room physicians have to see the patient and write on a written consult paper before we're called to attend the Emergency Room.

Q. And from your perspective, in your role, do you see this as an improvement, much the same, any difference?

A. I would say the difference ... Emergency Room physicians and staff are very busy and I believe they make every effort possible if they know that there's somebody registered for mental health to consult that person as quickly as they can, but I believe that the individual has to wait longer now, because they have to see the Emergency Room physician. Maybe not every time, but I think there's a chance that they will wait longer now.

Q. Okay. Any other differences that you're able to speak to?

A. Not that are occurring to me right off.

Q. All right. I'm going to ask to pull up Exhibit 105.

Ms. Wheaton, that will be in the binder or on the screen, use either/or.

A. Okay.

Q. Do you recognize this particular document? It's called Mental Health and Addictions Policy and Procedure.

A. Yes.

Q. And my understanding, on that front page it says Approval Date: April 26, 2017, and Effective Date: June 30th, 2017.

A. Okay.

Q. So and I understand, and we'll get into it, that you had some interactions with Lionel Desmond on October 24th, 2016. So is it fair to say that this policy wasn't in effect at that time?

A. Correct.

Q. If we turn to the last page of that document, what are we looking at here?

A. That would be the Suicide Risk Assessment and Intervention tool.

Q. And you had testified yesterday that you are one of the trainers in this particular tool.

A. I was, yes.

Q. You were?

A. Yes.

Q. Okay. So how long did you do the training for?

A. I did one session of it at the time that the policy came into effect.

Q. One session as a trainer?

A. As a trainer, yes.

Q. But you're well familiar with this particular tool?

A. I am, yes.

Q. Are you able to sort of get a sense of other mental health care professionals that you work with, whether or not everybody has been trained that you work with in this particular tool, people that you interact with?

A. So my direct colleague would be the other crisis clinician and she has been. That's the only person I work with directly often.

Q. So you made comments earlier that your, you and your colleague as the mental health crisis team are available 9 to 5 Monday to Friday. Do you know if this particular tool gets completed when someone presents to the ER in a moment of mental health crisis on a weekend?

A. I don't know.

Q. Okay. Or after hours, after 5 o'clock, after the team leaves?

A. I don't know for sure.

Q. And I understand that there are three different levels of suicide risk.

A. Yes.

Q. According to this tool. And what are they?

A. Low, moderate, and high.

Q. And I'm just going to ask you a little bit about it. It has a number of boxes where you could check off a number of, I guess, categories or identifying factors. So when you're passing a judgment, you have to ultimately assess risk level, I take it?

A. Yes, yeah.

Q. Is it a matter of sort of counting the boxes?

A. No.

Q. What goes into you ultimately coming to a determination as to what risk level a patient may be at?

A. It's pretty hard to quantify that or to qualify it. It would ... So I would have to use my clinical judgment, paying attention to all of these risks. Yeah, it's a clinical judgment issue, it's not ...

Q. Well, I guess we'll take it step by step as to what goes into your clinical judgment.

A. Mm-hmm.

Q. So obviously the factors, risk factors that are identified, would that go into your clinical judgment?

A. Yes.

Q. Information that they provide you during the interview, would that go into your judgment?

A. Yes. So a person's mental status, their behaviour, their cognition, the number of what we might refer to as modifiable risk factors versus alleged number of risk factors that can't modify.

Q. So what are examples of modifiable risk factors?

A. If I can start opposite first?

Q. Sure.

A. I'll say. So the risk factors that are listed under "Individual Risk Profile" for example, are largely not things you can modify. So somebody's ethnicity, whether they have a family history of suicide. Those are things that aren't going to change.

Under the "Interview Risk Profile", those are modifiable risk factors. So, for example, if somebody has intense emotion,

they have severe anxiety, that's something that can be modified. So anxiety can be treated, that can be lessened.

Q. So I guess when you're trying to assess risk, you're looking at things that may be able to be removed from the pile that amounts to risk?

A. Sure, yes.

Q. And that will ultimately determine ... be helpful in determining the level?

A. It could be, yes.

Q. What about sort of information from previous health history, for example, if somebody had attended an ER with a similar complaint the week before ...

A. Mm-hmm.

Q. ... or a month before, does that factor in your evaluation or assessment of the patient's risk?

A. Yes, we know that there's an increased risk if people are having multiple presentations to hospital with crisis.

Q. What about the situation of information from family members? If you had an opportunity to speak to them and they voice various concerns, does that weigh into your assessment of risk?

A. Yeah, it can. It can.

Q. I'm going to ask you to, if we could turn to page two of that document.

Unfortunately, Ms. Wheaton, we've heard a lot about the policy but we haven't gone through it so you have the benefit of going through it a bit with me. So on page two, number one under Policy Statements it lists four, I guess, points of entry that it says: "Licenced health care provider, LHP, must assess patients/clients for risk of suicide during ..." and it lists a number of things. So I'd like to go through each one because that is ... when it says a licenced health care provider must assess patients, when it says assess is it referring to filling out this suicide risk assessment tool?

A. This part of the policy doesn't state that but I believe somewhere else in the policy it states when we do the assessment we must document it on the tool.

Q. Yes, okay. So in the first one it says entry into care so I guess in your world, what is entry into care?

A. That would be every time I see somebody in the Emergency Room, for example.

Q. So every time you see someone in the Emergency Room, I'm taking it if you're seeing them for a broken leg, you're not going to assess them for suicidal?

A. I don't see people for broken legs but, sorry, in my role as a mental health clinician ...

Q. Yes.

A. ... it would be when I see somebody in the Emergency Room.

Q. So we're at a scenario where the ER doctor is called for a consult, someone is there in some form of mental health crisis, you would then come down and it's at this entry point you would complete a suicide risk assessment?

A. Yes, along with ...

Q. And you would complete the tool?

A. Yes.

Q. And we know that you certainly would when you are there but are you able to comment about if someone from the mental health crisis team is not there, do we know who may be filling out this tool?

A. So it's my understanding that ... so only mental health, this policy only applies to mental health and addictions ...

Q. Yes.

A. ... clinicians, anybody who's doing a mental health assessment like as a mental health clinician. So if myself or

my colleague, as the mental health crisis clinicians, don't see the person after hours or for whatever reason, I'm not sure, so the only other people, like, would be the on-call for Psychiatry would be the only other mental health clinicians or personnel that would see the person. They do risk assessment as part of what they do. It's not my understanding that they fill out the tool but I'm not positive.

Q. Okay, that's fair. The second one, 1.2, it talks about transfer from service area, what is that sort of scenario?

A. For example, if I see somebody, if we see somebody in the Emergency Room and make a referral to say a community mental health nurse who's going to see them in an appointment next week or next month, when they see that person, that would be a transfer of care because we internally referred them so they've had contact with us and we're part of the mental health and addiction program.

If there's a referral to any other person in the mental health and addictions program in Nova Scotia, that's considered an internal referral so that would be a transfer of care from one service area to another. That person that they see in that appointment, for example, would repeat the suicide risk assessment because there's been a transfer of care.

Q. And there appears to be an exception to that that says "unless in the past 24 hours one had been completed"?

A. Yes, so if I completed the assessment in the Emergency Room and the person was going to be admitted to the mental health inpatient unit, for example, they don't have to repeat it when the person goes upstairs in an hour, they can use the assessment that's been completed in the Emergency Room.

Q. And 1.3 it says discharge from care. So a risk assessment ... suicide risk assessment is completed upon discharge?

A. So if a person is discharged from an inpatient unit or if they're attending their last appointment with a therapist and there's not going to be any more booked appointments, that would be discharge from care.

Q. And then a risk assessment is completed at that time?

A. Yes, unless ...

Q. But there is an exception so what's the exception?

A. The exception would be, for example, if somebody entered into ... say they're entering into therapy and their suicide risk has been low, there's not been any suicide risk changes, so their risk would have been low coming into therapy and in subsequent appointments in therapy there's been no change

in that then they don't have to complete one.

Q. And 1.4 appears to be a bit of a catch-all: when otherwise clinically indicated ...

A. Yeah.

Q. ... and it gives examples. I wonder if you could explain that in practice?

A. In practice? If a clinician is seeing somebody, again I'll just say a therapist because they see people in regular appointments, so if a therapist was seeing somebody and something changed in that person's presentation, so either internally or externally, more stressors, maybe some past trauma, things were being triggered and the person was having more anxiety or more emotion, then the therapist would note that there was sort of a change in that person's presentation or their experience and they would do a suicide risk assessment.

Q. So in this policy it seems pretty clear at various points which you would do a risk assessment, reevaluate, do another risk assessment, before leaving do a risk assessment. In 2016, one, was it clear when you were supposed to do that suicide risk assessment?

A. I can't speak for every individual mental health clinician ...

Q. Oh, that's fine.

A. ... working in the program but I would hope, and it's my experience with people that I've had contact with and worked with in the program, that it's something that we inherently do all the time, it's part of the mental health assessments we do, it's part of the care that we provide. We know suicides can be a risk for people, we know it's a symptom some people experience, and so I would hope that this was happening. I think the assessments by and large were happening, I think the documentation of that was not happening.

Q. Okay. And when you say documentation, the actual tool ...

A. There wasn't a tool, therefore, a lot of documentation for mental health clinicians is in more of a narrative sort of progress note format.

Q. As opposed to a specific place where you can now look?

A. As opposed to, yes, so I think in those sort of narrative notes then those people weren't, because it would be impossible to document everything that was happening, everything that you talked about, everything that you had assessed, the absence of things, the presence of things, and I think suicide risk and the assessment of suicide risk was not being documented

in those notes.

Q. Okay. So in today's terms, when this tool was completed at one of these various points, where do the results go, where does the actual form go after it's completed?

A. So it stays with the person's health record. So in the situation of emergency, for example, it stays with our crisis assessment and it becomes part of that person's health record.

Q. And so does it get shared with anyone?

A. If somebody is connected with a mental health provider, clinician, a psychiatrist in the program, then we would draw their attention to it either by providing them with a copy of it or notify them of the crisis or Emergency Room visit and then they can view it electronically now. So, again, things have changed.

Q. So in today's terms in 2020, someone presents to the ER (unclear) crisis, they're assessed by you, it's completed, the risk assessment tool, then they are discharged with sort of a follow-up plan which includes follow-up with your family physician. Do the results of this suicide risk assessment and the form in particular, does that get then sent and shared with the family practitioner?

A. I do not send it to the family practitioner unless the risk is moderate to severe or moderate to high, yes.

Q. So in situations where someone is assessed as low risk but there still is a risk ...

A. Right.

Q. ... they still presented with some form of mental health crisis and they're told as part of the plan, follow-up, that wouldn't just get sent automatically to the family physician?

A. So I don't send it, it's part of the Emergency Room health record. What parts of that record get shared with the family physicians, I'm not sure.

Q. Do you think that you could see a scenario where it may be helpful if the patient is told, Okay, we've treated you, we've adjusted your medications, but you really should follow-up with your family doctor, see if he can make any referrals? Do you think it would be helpful for that family doctor to know that they were in the ER and this was the risk assessment?

A. If we've changed something about treatment then I would let the family doctor know, yes, so if there's been a medication change or something, the family doctor would be made aware of that. And I would not tell somebody, except in very

rare circumstances, I wouldn't say to somebody, Go to your family doctor and get a referral for a therapist, I would refer them to the therapist in the current model.

Q. Okay. So I guess the sharing with the family doctor is not just as a, Oh, by the way, your patient was in the ER, he was saying that he wasn't getting along with his wife, he has PTSD, recurring nightmares, you just might want to know, there's no just sort of automatic sharing?

A. Again, you'd have to clarify with Emergency Room staff about what happens with the Emergency Room chart.

Q. Okay. But you personally wouldn't?

A. I personally don't do that, no.

Q. Wouldn't hand it off to get ...

A. No.

Q. Okay. With the suicide risk assessment tool, in your experience in using it, do you find ... are there any limitations to it?

A. To the tool?

Q. Yeah.

A. No.

Q. Do you see any ways in which it could be altered or improved to assist what it is that you do?

A. No.

Q. I note that, if we could look at the last page on Exhibit 67, yes, the last page of it. Or sorry, 105, Exhibit 105. I note there there's a tool for suicide risk assessment. Do you understand the concept of homicidal ideation?

A. Yes.

Q. And what is that to you, I guess?

A. That would be if a person's having thoughts or ideas about killing somebody.

Q. Is there any particular tool that you know of that's developed to sort of assess risk or harm to others in addition to risk of harm to self?

A. I'm not aware of any tools. It is part of this tool as far as aggression and violence.

Q. So are you able to explain how ... Do you, as a mental health crisis clinician, as part of what you do in your assessment, are you looking for homicidal risk cues?

A. Yes.

Q. And what are some of the things you look for?

A. Acts of violence or aggression against others, thoughts of violence or aggression against others, history of violence or aggression against others and thoughts of violence

or aggression against others.

Q. In your experience in the ER and meeting with individuals in crisis, are they forthcoming with that information, their thoughts of harming others?

A. I can say that a lot of people are forthcoming. If there are situations where they're not I probably don't know that.

Q. And how do you kind of get at or drill at whether or not someone in a form of crisis is a risk of harm to others? How do you get to that (unclear)?

A. So there's a difference between homicidal risk and risk to others because there can be a risk of hurting other people that's not necessarily the same as homicidal but how we get at it would be talking about it. So I would, for example, recognize that if a person ... people who have a lot of anger, whether it's expressed or not, but a lot of anger would increase their risk towards others so I would be looking to explore that a bit. People who have anger, how they currently express their anger, how that's manifesting itself as far as risk to others. There's also a risk to others from carelessness and impulsivity and sometimes people's risk to self also constitute a risk to others. For example, if somebody's having a thought of driving

their car into another vehicle, that could be a risk to other people.

Q. And so obviously you're familiar with domestic violence?

A. Yes.

Q. And the concepts surrounding domestic violence?

A. Yes.

Q. So is that something that you're on the alert for when you're doing one of these assessments is whether or not the person has a spouse or children that may potentially be the subject of some sort of violence?

A. Yes.

Q. You personally in your years of experience as a nurse in mental health and a mental health clinician, have you received any particular training as it relates to domestic violence?

A. Specifically on domestic violence, no.

Q. Are you aware if any sort of domestic violence programs have been offered to nurses in general?

A. I'm not aware.

Q. Do you think information about domestic violence may be helpful in doing what that it is you do when you evaluate

risk?

A. I'm not sure. I believe that we evaluate the risk. Information about domestic violence specifically, I wouldn't say no to any information that helps us to be more sensitive and more aware of things is welcome.

Q. If we could turn to page three of ...

THE COURT: I'm going to stop just for a second, Mr. Russell.

So when you look at the tool and talk about trying to identify risks for violence, talk about homicidal risks, risk to others and Mr. Russell was getting at it. So my question would be, you know, do you have specific questions you ask or indicators in the tool that help you make a judgement whether or not a risk is a risk of domestic violence, a risk of homicidal inclination, a risk to somebody driving a vehicle on the opposite side of the road, might be as a victim of a suicide head-on kind of thing. Do you try and kind of parse out the domestic violence aspects from ...

A. Absolutely, yes.

THE COURT: ... general?

A. Yes, absolutely.

THE COURT: How do you do that? What would be in the

... apart from asking the person, you know, are you going to target your wife, are you going to target your child, your uncle, are you going to target the person driving on the other side of the road?

A. So if there's a cue of any kind so if somebody has anger, for example, so somebody who has anger, they're talking about having anger, demonstrating or their collateral information is that there is anger, we would explore that fairly extensively with the person, ask for examples, again ask for examples of how that shows up and with an awareness of that if a person has anger and is going to act out violently towards another person, more often than not that's going to occur in their intimate relationships or in a family unit. So ...

THE COURT: So that goes on in your interview process, kind of your investigation?

A. Absolutely.

THE COURT: What they're thinking?

A. Absolutely, yes, we ask quite specifically and try to get an idea from the person exactly or from their collateral or both exactly how their relationships are, again how anger might be showing up, what their thoughts, again if it's thoughts of harm, we don't just ... I wouldn't, for example, ask a person,

Do you have thoughts of hurting anybody else other than yourself and they say yes and then I just leave that. So I would explore that, yeah, quite a bit, what are those thoughts, when do they show up, is it specific people or not, do you have feeling responses to those thoughts, yeah.

THE COURT: It really pretty much takes its cue from the responses that you're getting from ...

A. Yes, every time a person answers then that tells us sort of where to go and makes us ... yeah.

THE COURT: Thank you.

MR. RUSSELL: If we could move to page three of Exhibit 105, number three on that page indicates, I wonder if we could scroll down, a specific ... it reads: "A specific monitoring and management plan must be created for patients/clients assessed as moderate or high risk for suicide." I'm going to go back to low risk at some point, but in terms of where you have scored someone or they're assessed as a moderate to high risk, what is a monitoring and management plan?

A. So basically that point is saying that there has to be some kind of monitoring and management plan discussed and documented and what that monitoring and management plan is is going to vary depending on the individual and the situation.

Q. Who comes up with the monitoring and management plan, who sets that out, what it's going to be? So a patient appears in an ER, you're down for a consult, you do the interview, the psychiatrist does an assessment if they're available, meets with them, who ...

A. So the psychiatrist, just on that to clarify, would always be available if they were consulted but would not necessarily always be consulted.

Q. Right.

A. So the monitoring and management plan would be developed by whoever it is that's assessing the person as to their suicide risk. So if I assess the person, do my mental health assessment, do a suicide risk assessment, and my clinical decision is that they are at moderate or high risk for suicide, then it would be up to me to put a monitoring and management plan in place or to develop that.

Q. And I know obviously you say it varies depending on the patient ...

A. Absolutely.

Q. ... what are some examples that somebody attends in the ER, assessed moderate to high risk, you're putting a plan together. What are some of the things that are part of a plan

and I know it's specific to each person but just some general examples of what goes into a plan?

A. So the plan might be as simple or straightforward as admission to the hospital. Now, I can't decide to admit but, for example, if I let the psychiatrist know that I needed them in the Emergency Room and that somebody was high risk for suicide and admission to the inpatient mental health unit, that would be sort of the ... that would be the management plan in that moment that I and the psychiatrist were making and the monitoring plan might be the psychiatrist's admission orders are to monitor every 15 minutes and confine to the unit. So that would be a monitoring and management plan in that situation.

Q. So in a situation where someone presents, they're a moderate to high risk, you know that they're going to be eventually discharged back out to the community, and then you think, Okay, they really need to be speaking to a cognitive behavioral therapist, for example, they would benefit from that particular treatment. How does that plan get put in place? Who reaches out to that person, who lines that health care provider up for the patient, how does that happen?

A. Okay.

Q. In the transition, I guess?

A. Okay. So if the person is in the Emergency Room and the crisis assessment and suicide risk assessment is completed and that person is going to be discharged from the Emergency Room back into the community, then as part of that plan, there would be a plan for connection to other resources. So if that was a therapist ... so now in 2020, so if that was a therapist, I would make the referral to the outpatient services. In our hospital and/or if the person happened to be visiting from Sydney, send them to Sydney, whenever their home base is, I would make that referral and that would be that transfer of care that we were speaking of earlier. If the person is already connected, as they might be, to a therapist or a clinician, then I would share the information from the visit. We might call, I often call and say, This person is in the Emergency Room, can they have a quicker appointment with you. So that monitoring ... again, the monitoring and management plan or a follow-up plan, if it included connection or re-connection with a mental health clinician, then we would facilitate that.

Q. And is this for patients that are moderate to high risk, and I understand that the policy applies to Nova Scotia Health Authority employees whether in community employees or in the hospital setting, but is the plan shared with the family

doctor?

A. So if a person ... so a person who's at high risk usually would be admitted to the hospital and so when people are admitted to the hospital their family doctors are aware of that. If the person's at moderate risk and they're going to be discharged from the Emergency Room back into the community, then their family physician would be made aware by, if it was myself, by myself. Again, it varies so much.

So if a person has a family physician and there's anything related to ... some people have not seen their family physicians for three years or don't have family physicians, but if a person is actively involved with a family physician and, for example, there's medication being prescribed or something like that, or they find their family physician is quite supportive of their ... maybe this is not a mental health crisis that is new, you know, maybe they had a history of having some crisis or having some mental health or suicidality, then sometimes we call, when the person is with us in the Emergency Room, the family physician's office to help advocate for an appointment sooner than later.

Q. So if someone attends and a risk management plan is put in place, and during the course of the interview you find

out that they're a military veteran, they have a case manager who assists them in lining up various services for them. So they have a case manager, they have a social worker to help them with sort of their day-to-day affairs.

A. Yes.

Q. They have a trauma clinician for, say, PTSD symptoms. They also have a family physician in another sort of area.

A. Mmm.

Q. Does that plan get shared with all of those people?

A. That's a lot of people. I'm sorry. I'm just trying to wrap my brain around what you just said.

Q. You just gave me a scenario where ...

A. So ...

Q. ... sometimes people are connected to various agencies and departments and professionals.

A. Yeah.

Q. Does it get shared with everyone?

A. So if there are ... because I've had a situation where there was somebody who had a case manager, a veteran with PTSD who had a case manager. When the person is with me or if the person signs a consent, I can share verbally. So I'd make an attempt again in ... make an attempt with the person to call the

case manager and check in about the services being offered or let the case manager know about what was happening and if they could get earlier services or that kind of thing.

If it's a family physician, you said, in a different area, do you mean like a different province?

Q. No. Same province. Different community.

A. Oh, okay. Then yes. If somebody is at moderate risk and they have people they are involved with, even if it's in the community, we make every effort to notify those people that they've had contact.

Now that sometimes will be putting the responsibility on the person who's there. Again, if appropriate, and every situation is going to be a little different, and you sign ... I know I was hearing you saw that Dr. Slayter had written a note for people. We do something a little bit similar. So when we see people in the Emergency Room, if they're being discharged from the Emergency Room back into the community, then we sit with the person and, again, not every time, situation-specific, but a lot of times develop a written summary of what the plan is with the person. Yeah.

Q. So you talked about sometimes it'll be a phone call with an update.

A. Mm-hmm.

Q. Do those different providers, the sharing of information outside of Nova Scotia Health Authority with (unclear), do they get, with the consent of a patient ...

A. Oh, I see.

Q. Do they get the full chart, risk assessment tool, visit, the details?

A. Sorry. No, I cannot share that information with somebody outside of NSHA except for family physicians. So I can't share it with case managers or Veterans Affairs or I can't share it with a private psychologist. I can share with NSHA or with family physicians.

We make every effort to make sure that those other private providers are aware, and then those private providers, along with the person, can request their health records. Yeah.

Q. Okay. So I'm going to get to that. So you make every effort to see that they're aware.

A. Yeah.

Q. But sometimes people aren't aware of what they don't know.

A. Right. So ...

Q. So ...

A. Mm-hmm.

Q. My question is how do you make that trauma therapist aware that last week your patient was in the ER, symptoms of that trauma and was not doing well?

A. So there's two ways that I would attempt to go about that. If the person is with me in the Emergency Room, or with me, and this is a trauma therapist who's not an NSHA employee, then I would ask the person if we could make a phone call together to that person, to that therapist. Leave a voicemail or, if they're available, speak to them about the situation.

The other way is that, again, I would help the person to make a note that kind of summarized their Emergency Room visit, that they can then share with their private providers.

EXAMINATION BY THE COURT

THE COURT: Would you ever ask them the question, Would you like me to send this to your trauma therapist? Sign this consent and I'll send it out by fax?

A. I can't do that. So ...

Q. Now why can't you? Sorry. I'm going to stop you. So you can't do that because it's a policy that you can't do it?

A. The consent for sending information to another person, that's something that has to be done by the individual through the health records. I can get them to sign a consent that I can share verbally but I can't send my information. Health records can send the information.

Q. All right.

A. Yeah.

Q. So I may not have ...

A. Sorry.

Q. I may not have asked it the right way. So is there any reason why you couldn't say to them, Listen, I have this information. It may be of assistance to your trauma therapist. If you sign this consent now, I can forward it to Health Records and health records can send the SRAI, for instance, tool to the therapist. Would you like me to do that?

Could you do it that way? Appreciating you don't send it yourself but ...

A. Right.

Q. ... Health Records is going to get the consent?

A. So what I do in that situation is I believe that the person has to attend Health Records to complete that process and/or the therapist in the community requests it. But, yes.

Q. Okay.

A. Yes. So ...

Q. It seems to me that when you have a person who is in crisis, to download some formal administrative process and steps on him or her or them at a time when it might be most easily and most efficiently kind of moved to the person next in line to be dealing with the trauma, that rather than have them come back or make additional steps or trips to get something done when they may not have that inclination or ability ...

A. Yes. I hear your point and, absolutely, I will say that we don't discharge from the Emergency Room with the person in crisis as when they entered.

Q. No, I understand.

A. So there is a ...

Q. Of course.

A. And if there is any member of their (audio blip) care with them, then the management and monitoring plan, or the discharge plan, they are brought into that process. So, again, the hopes that they can help to facilitate them, making sure they let their private, you know, clinicians know, but, yeah. That's ...

Q. There's often talk about information being kept in

silos.

A. Yeah, yeah, there is. I know.

Q. It seems to be that this is a silo.

A. Yeah.

Q. That if there's a way to efficiently get that information into the next health care provider's hands so that they would even become aware of it without having to necessarily rely on that patient in crisis who you might settle down before their discharge, that they become ... maybe they're not reliable historians across the board for a lot of people.

A. Mm-hmm.

Q. And now it's going to be maybe overlooked or not looked at on a timely basis. That would be my concern.

A. Yes. I do think that most people make, and we have to res- ... most people have a lot of strength and resilience and the ability to make those decisions, even about what to share and with whom. And sometimes even if - I know this is slightly off this - but sometimes even if I think it would absolutely the best for them to share the information with their private clinician, I can't force them to. So there are situations where people don't want that information shared.

Q. My point was just that taking the opportunity while

they're there to give them a viable option ...

A. The support.

Q. ... that doesn't require more and additional steps on their part to get that information shared.

A. Yeah. So I will say that we do now in 2020 have the urgent care option which is we can bring people back into a scheduled appointment with ourselves or with crisis clinicians, urgent care clinicians. And so sometimes, if it seems that there might be a lot of ... so just in the example that Mr. Russell gave where there is a lot of different people involved, it might be that we would bring that person back into an appointment in the next couple of days to try to make sure that those people were getting information and that everything was connected and that the person was actually still connected with those people.

So sometimes we can do that. If we can't complete all of the sharing of health records and all of the notifying of people and connecting all those dots in the Emergency Room, we can bring the person back and attempt to do that.

THE COURT: Thank you. Mr. Russell?

DIRECT EXAMINATION

MR. RUSSELL: Just to follow up with a question arising out of the Judge's questions.

So in practical terms, when you're putting a plan together and a treatment plan, a model for a patient in a form of mental health crisis, whether it be depression, anxiety, post-traumatic stress disorder, or a combination of all of them, we talked about the importance of removing certain risk factors that can fluctuate. Can you remember the term you used?

A. Modifying. Modifying.

Q. Modified risk factors.

A. Yeah.

Q. And is it fair to say that, you know, hopelessness is listed as a risk factor ... so what I mean by "hopelessness", I guess, is someone that's frustrated. I'm looking for help. I'm going everywhere. I can't get help.

Is it important to sort of take steps to sort of make that barrier easier for the person to navigate?

A. So that would be sort of one definition of hopelessness.

Q. Oh yes.

A. More often than not, that situation is frustration or helplessness, I find. But absolutely. So even if people are low risk. But part of our whole assessment and intervention would be to modify as many factors affecting the crisis, the illness, the suicide risk, as we can and support the person to modify as much of that.

"Crisis" implies that something has changed or there's something different, so we would try to assess what that is or what those things are and then support the modification of those things.

So connecting people with services. First of all, hearing their story, validating their experiences, being really present and not rushing the time we have with them, involving people that are important to them, giving them space to share, asking lots of questions, doing our assessment, pulling at threads, being curious.

We do all that and then the modifying is something that happens as we go. So helplessness, hopelessness, frustration, feeling that they are not connected to people, if that is an issue, if that is something that's happening, then we absolutely try to support that being modified by connecting them with services, reconnecting them with services. Yeah.

Q. So in terms of "modifying", my question is is it logical to say, If we can make it easier for this patient to have one less thing on their plate, which is going and chasing after records, is that beneficial to the patient's wellness and mental health when they leave the hospital, that they know that someone there is going to take care of trying to get my record? Is it beneficial to their mental health and their treatment going forward?

A. It could be if that was an issue for them.

Q. Yes.

A. Yes.

Q. Is there any system in place ... you talked about how it gets sent to Records to see, and I know you don't work for Records.

A. Mm-mmm.

Q. Is there any sort of checks and balances in place where somebody looks at and says, These were all the signs and symptoms. These were all the complaints. From what I gather, these are the people involved.

Is there ever any check to see, to make sure that, Okay, we've sent all the information to all the parties that should have it?

A. I don't know.

A. I'm not ... I don't know.

Q. You don't know, okay. We spoke a little bit about it, could you turn to page six of the policy and, in particular, if we could zoom in 3.1. And this talks about patients that are assessed as low risk for suicide and I'll just read it, it says: "Where the suicide risk is assessed at low, the LHP which is a licensed health ..."

A. Provider.

Q. "Provider or treating team will monitor for changes in the patient/client's life situation, mental status and/or care pathways that may affect clinical status and suicide risk." So I guess first in an ER setting, they're assessed at low, how does this apply to you? It seems that you are to monitor for changes, what are you looking for?

A. If I'm assessing them as low and I'm not seeing them again, then I would not be monitoring them.

Q. Who does ... in terms of the policy it seems to suggest that somebody's assessed at the low risk for suicide and some sort of monitoring goes on to see if there's a change in the patient's life situation, medical status, and care pathways?

A. So this part would apply to somebody who was in the

mental health program who is seeing the person on a repeated basis.

Q. Okay. So what's an example of such a person?

A. A therapist, a community mental health nurse, psychiatrist.

Q. And so this is basically telling them to sort of be on the lookout for any changes?

A. Which we would be because that is what we do, yeah.

Q. So not necessarily applicable to an ER setting as opposed to ...

A. No, I mean, arguably when I see somebody at the beginning of an hour to the end of the one to two to three hours something might change but that's not what this is referring to.

Q. What's a care pathway?

A. A care pathway would be that sort of process of transferring of care so from an emergency room visit to a psychiatrist outpatient appointment and then maybe that the psychiatrist would then refer to a community mental nurse or a therapist so that would be the care pathway for that person would be entering the system through crisis and then their pathway through care.

Q. So we're nearing the end of the policy, I'm sure

you'll be happy to hear that.

THE COURT: Mr. Russell, you're not as close to the end as you might think. Just a brief question for you so that I understand.

MR. RUSSELL: So my ...

THE COURT: No, I have a question.

MR. RUSSELL: Oh sorry, Your Honour, I'm sorry.

EXAMINATION BY THE COURT

THE COURT: When the suicide risk is assessed as low, there would not be any kind of automatic sharing of any information with the family doctor or a trauma therapist or someone that the patient may be seeing, am I correct?

A. So if it was within our mental health and addictions program, yes. If it's outside of that then there's no automatic sharing, no.

Q. So you're talking about NSHA framework?

A. Yes, right.

Q. So when the risk is low, the treating team will monitor changes for a patient's life situation, et cetera, but that's only within the context of the NSHA structure, correct?

I mean, if you had a therapist ... that the person was seeing a therapist that had been a referral by the family doctor, this idea that there may be something that requires monitoring or should be alerted to monitoring, how does that get to them?

A. So remembering everybody is low.

Q. Say again?

A. So remembering that everybody is low risk.

Q. Yes.

A. So there is nothing below low so every individual would be considered low risk unless they're moderate or high. The default, so to speak, would be low. You're at low risk, I don't know, but I'm at low risk, everybody in this room would be at low risk for suicide if I had to provide that. So this isn't predisposing that somebody has been assessed at any specific risk, this is just saying that if somebody is involved with treatment for their mental health, even if they're at low risk of suicide, we must continue to be on the lookout and monitor for changes that could affect that and then reassess it.

This policy was developed for mental health and addictions clinicians treating people, so again it's written for or to myself as an urgent care clinician or one of the therapists in the mental health program.

Q. In the normal course of events if someone was dealing with an individual with mental health issues, you're looking for changes, you're looking for progress, you're looking for changes, you're looking for setbacks ...

A. Absolutely, absolutely.

Q. ... and so that really isn't telling you very much because you do that anyway?

A. That's right. Honestly, I think the purpose of this is just as the prompt that you should be continuing to ... you should reassess, I think it was mentioned earlier, that you should reassess when something changes with your patient's status and probably moreso you should document that.

THE COURT: Mr. Russell?

DIRECT EXAMINATION

MR. RUSSELL: My question, if we could turn to page seven of that same document, 4.14 talks about disclosure but I guess disclosure in a different sense. I'll just read it, it says: "Discloses patient/client personal health information related to risk without patient consent only if there are reasonable grounds to believe that sharing this information will avoid or

minimize an imminent and significant danger to any person or persons." What's this particular part of your policy and when does it come in play?

A. If a person is in the emergency room, again this is very simplistic for example, but says I don't want anybody to know I'm here but I'm going to run out of here whether you stop me or not and I'm going to go kill myself, then I don't need their permission and I don't have to respect their privacy because safety trumps that. So if they run out of the emergency room I can call the police. If they're heading for home, I can call their home and say, you know, If you see them or hear from them, they're at risk, the police need to be notified if you can find them.

Q. And your understanding of the policy, what is imminent and significant danger? It doesn't seem to be defined anywhere in there. What is it in your terms, I guess, from your perspective?

A. So imminent would mean that there's a risk now or in the near future.

Q. Would it be helpful ... I guess my next question actually would be because mental health clinicians, often nurses, health providers that follow this policy, would it be

helpful, I guess, to make it clear to them when they can start sharing this information, if there are certain flags that go up with things that they're told, would it be helpful for some direction on that?

A. I don't think so. I think that we pretty much have a good sense of it and if in the moment something seemed gray, we'd certainly have colleagues and managers and clinical leaders that we could consult if we felt something was grey in the moment and needed some clarification, but I think most of us know that we do have to do some online training and be quite familiar with PHIA.

Q. And who does this get disclosed to when you do disclose it?

A. It depends on ... it would depend on the situation. So if the imminent and significant danger was that they were going to harm another person, we could notify that person and the police to come in on this situation, I guess, if they didn't already know.

Q. So an example could be someone attends the ER, they say, Look, I'm a military veteran, I am diagnosed with PTSD. I'm not coping well. I'm extremely jealous over my wife. I haven't been sleeping well, I have recurring dreams, jealous

over my wife. I have firearms at home and in the past I've thought about using them to commit suicide. Would you alert the spouse?

A. I'd need to ask a whole lot of other questions about what you just said really.

Q. Yes, okay.

A. So in what you just said you didn't tell me if there was any ... one, if there was any thoughts of harming someone else or not right now.

Q. If they had answered no.

A. Okay. Then I would probably want to ... so they said they weren't having now but in the past. See, this is ...

Q. And I know it's very ...

A. ... but in the past they had, yeah. So, again, we'd look at the imminency and so I don't know if that person that you're referring to, if they were assessed as low, moderate or high risk for hurting themselves or other people.

Q. Okay.

A. I don't know if they ... I mean, it sounds like you're referring to Corporal Desmond without saying you're referring to Corporal Desmond so I don't know ...

Q. So I guess I take it there's a lot of information that

goes into answering that question? I want to be fair to you.

A. Absolutely. Absolutely there is, yeah, and ...

Q. Would you alert the police in terms of maybe that he shouldn't have firearms in that sort of scenario?

A. Would I alert the police in that scenario that maybe they shouldn't have firearms? Again, it's difficult for me to assess that exact scenario given that you just said a few things that I'm even having trouble now remembering what was included and what wasn't, but a lot of times if people have risk, if they are assessed as moderate to high risk. Well, if they're assessed as moderate risk or even low risk with impulsivity and they have weapons in their home, then we would work with family and significant others to remove those weapons from the home. Again, whether I'd notify the police about it would depend on a lot different factors that I don't have.

Q. And I guess if there were particular ... if there was somebody else that could provide the mental health crisis team members with insight and information about risk factors for domestic violence, would that be helpful when you're trying to make a determination as to whether to make such disclosures and whether it's to a spouse or a police officer?

A. I'm not sure if there's a deficit of knowledge about

risk factors for domestic violence or not so certainly my colleague and I know some of the risk factors for domestic violence and we know that domestic violence encompasses more than physical aggression and it is something that we are sensitive to and aware of when we see people. Yeah, I'm not sure whether statistics or risk factors would be ...

Q. That's fair. In terms of page four of the policy. Page four of the policy, just one moment. It continues over from page three. I guess on page three the heading is "Guiding Principles and Values Behind the Policy" and then on page four, 1.6 on page four indicates: "SRAI is conducted in a trauma-informed cultural and situational context. It is documented and relies on effective clinical judgement and communication as well as patient, client, family and inter-professional collaboration." That's a lot in three lines. What does that section of the policy mean to you? I guess I can break it down for you if you want if it's easier.

A. Into parts.

Q. What is "trauma informed"?

A. So trauma informed, again I'm not great with textbook definitions but what it means to me ...

Q. As a clinician.

A. ... as a clinician would be an awareness and a sensitivity that people may have experienced trauma, to inquire about that, to be aware that it could affect people's emotions, it could affect their comfort or their trust. Sometimes it just means asking people questions about what would make them more comfortable and what wouldn't in the assessment environment.

Q. So when it says the SRAI, the assessment, is conducted with that in mind ...

A. So if I can use an example?

Q. Yes, absolutely.

A. So part of our mental health and our suicide risk assessment would include asking people about their experiences of trauma so if they have experienced trauma in their past. Being trauma informed would mean that I would be aware that that might be an issue and to ask about it. To me it also means that I wouldn't say, Oh, tell me all about that or give me all the details. For example, a lot of people who have experienced trauma and, again, we're not just talking about combat trauma, there's all different kinds of trauma, might have a difficult time opening up and talking with somebody about that. Likewise if that was all they wanted to talk about was their trauma, in the emergency room in a crisis visit is probably not a great

place to allow that to continue for a very long time because they're not going to see me again so they're building a relationship which is important but to give me all the details of things that have happened to them, if that's something that they want to do, I would help them connect with somebody to do that.

Q. So being trauma informed, does it depend on trying to assess what type of trauma that someone has experienced?

A. Oh yes, yeah.

Q. For example, if you're trying to assess, in terms of a military veteran, does it ...

A. Yeah, so if somebody's had repeated trauma versus one.

Q. And some trauma is maybe different than others. Say if somebody as post-traumatic stress disorder as a result of military combat versus being a victim of sexual violence, do you know of any awareness of any differences that there may be between the two?

A. So not that would apply to what you're asking about this necessarily, no.

Q. Sure, okay. So is it important, I guess, to sort of know that there may be differences between PTSD in different contexts?

A. Yes, so not everybody who's experienced trauma has PTSD.

Q. Oh, yes, but I use that as an example.

A. So you're asking about trauma informed but I guess I'm not sure of your question now.

Q. Okay, I'll move on, that's fine.

A. Okay.

Q. Cultural and situational context, what is that?

A. So people from different cultures may have ... there may be things that are sort of more normal for their culture than would be in ours. I'm trying to think of examples so culturally, for example, some people are given to, I don't know if this is cultural, but some people are given to perhaps not feel as comfortable talking about emotions or feelings, that kind of thing. So being sensitive to that, being sensitive to that some people are not necessarily extremely anxious or agitated, it's just that they always speak with their hands at a high volume of voice due to that kind of thing.

Q. When it specifically references cultural and when you're evaluating suicide risk assessment, is there any sort of suggestion in there that somebody's ethnicity or cultural background is relevant when you're trying to evaluate risk, for

example, someone who is indigenous?

A. Sure. Yes, so we know that there's a higher risk for people, you know, who are indigenous people or who are in a race minority or who are refugees or who are newer to our culture. We know that there's a heightened risk.

Q. And is there any sometimes, I don't want to make too many generalities, but perhaps sometimes a difference in the way that they're expressing their symptoms and where they're coming from?

A. There may be or there may not be.

Q. In terms of is there any consideration given to the fact, for example Lionel Desmond, who was a black man in a rural community?

A. Mm-hmm.

Q. When you're doing a risk assessment, is there anything in particular that you're drawn to that you should be maybe culturally aware or seeing things from his perspective that may be helpful in evaluating risk and helpful in putting a treatment plan in place?

A. So all kinds of things are statistical risk factors and then there are things that you just mentioned that might come more into play when it comes to whether or not we can

support modifying risk factors or in the management and monitoring plan, so isolation and transportation issues, you said how he is in a rural area, you know, those types of things. So to my knowledge, living in a rural area isn't a risk factor for suicide but it may be a barrier to getting services, that kind of thing.

Q. There's a concept called cultural confidence ...

A. Yes.

Q. ... and basically it's trying to understand people from their perspectives and varying and different backgrounds. Is there any sort of cultural competence training for nursing staff or health professionals that you are aware of that deal with risk assessment?

A. I'm not sure.

Q. In terms of sort of, and I don't profess to know the answer, but if there is a sense that people from different cultures or ethnicity may present symptoms differently or may engage with services differently is there any training that you're aware of that deals with ...

A. So the training for culture competency, while there may be some specific here and there, generally speaking we deal with people from a lot of different cultures ...

Q. Yes.

A. ... so there would be a broadness to it to be aware of and mindful of and sometimes it's a matter of asking people about their specific culture and things that might come into play. But as far as risk, so we know that certain people are at a greater risk due to their ethnicity, for example.

Q. Yes.

A. So as far as the risk assessment is concerned, I'm not sure ...

Q. I guess my question is if we have health care professionals dealing with individuals from various backgrounds in moments of crisis and you're assessing risk and you're assessing a treatment plan, is there any training that you're aware of that you have ever taken or that anyone else in your position has ever taken that addresses perhaps this concept of cultural competence, things you may wish to look for and if it is an identifiable factor. Are you aware of any training in that regard?

A. No.

Q. Do you think there is benefit and merit in that training?

A. I don't think so because I'm not quite sure what that

training, about what you're ... yeah, I don't know.

MR. RUSSELL: Okay. Your Honour, at this point I was going to go into how things were connected with Lionel Desmond.

THE COURT: Let's take a morning break, if we could, and let's try for 15 minutes. Thank you.

COURT RECESSED (11:41 HRS)

COURT RESUMED (11:58 HRS)

THE COURT: Mr. Russell?

MR. RUSSELL: So Ms. Wheaton, we're going to look at document 67 and we can start at perhaps page 8.

THE COURT: Ms. Wheaton, that document will appear on the screen but also in the exhibit book. If you want a paper copy, it's in front of you right there, as well.

A. Okay. Thank you.

MR. RUSSELL: So Ms. Wheaton, do you recognize generally - and this is the first page of a multi-page document - do you recognize what that is?

A. Yes.

Q. And that is titled "Crisis Response Service Mental Health/Risk Assessment".

A. Yes.

Q. And that's the risk assessment that you had completed

as... or the documented risk assessment that you had completed as it relates to Lionel Desmond on October 24th, 2016?

A. Yes. Can I make a clarification about the title?

Q. Sure.

A. And I don't know if this is important or not, but "Crisis Response Service Mental Health Assessment/Risk Assessment", so the slash between the Mental Health and the Risk means it's...

Q. So it's two things?

A. It's two things. It's not just considered a risk assessment, in general.

Q. Sure. And you recall, the best you can, I guess, meeting with Lionel Desmond on October 24th?

A. Yes.

Q. And it indicates a time of 15:30 on that page 7.

A. Um-hmm.

Q. What's the significance of the time?

A. That would be around the time that I met with ... began meeting with him.

Q. Meeting with Lionel Desmond?

A. Yes.

Q. So just in terms of Lionel Desmond, had you ever met

him prior to this date?

A. No.

Q. And prior to doing this assessment and meeting with him, do you recall what sort of reports or medical records that you might have looked at or reviewed?

A. I don't recall.

Q. If we could look to page 6, this is an Emergency triage record as it relates to Lionel Desmond. Are you familiar with that document?

A. I'm familiar with the triage record, yes.

Q. And normally would you have reviewed or do you recall reviewing this document prior to meeting with Lionel Desmond?

A. It would be my usual practice to look at the chart and to look at whatever papers were on the chart when I arrived.

Q. As well, it indicates there, and I realize this is someone that entered it at triage, "Chief compliant - situational crisis".

A. Um-hmm.

Q. What's your understanding of what a situation crisis is?

A. It could be a bit of a catch-all, especially, you know, if used in, by non-mental health clinicians, but,

generally speaking, that there is a situation and that it's causing the individual to feel in crisis.

Q. So prior to meeting with Lionel Desmond and going through the full assessment, what was your sort of understanding of why he was there, why he was presenting to the hospital?

A. I don't recall that I suspected ... I usually don't ... I usually rely on my meeting with the person to gain an understanding of what's brought them to the hospital.

Q. All right. So just generally, overall your time you met with Lionel Desmond on that date, at page 10 of the report, down at the bottom it appears there's a signature, date of October 24th, and a time 16:30. Is that your signature?

A. Yes.

Q. And 16:30, what's the significance of that time?

A. That would be around about the time that we completed ... that I completed the mental health assessment.

Q. So 15:30, 16:30, so is it fair to say it was, roughly, an hour to complete this assessment?

A. I would say, roughly, an hour, yeah.

Q. And in your experience - I know it varies from patient to patient, situation to situation - this length of assessment, how does it compare to, say, generally, the

assessments you do, is it quicker or longer, average?

A. Generally, our assessments are anywhere from ... It's rare for it to be less than 45 minutes to an hour, very rare, if ever, and it can last as long as three, four hours, depending on how complex the situation is. They tend to be a little bit quicker if I'm consulting Psychiatry, because that would mean that I've identified that there are modifiable risk factors or modifiable factors to effect the crisis that I can't support or intervene on on my own, that I need Psychiatry for some reason. Those tend to be a little bit shorter in length.

Q. Okay. So in terms of overall, and we're going to get into the fine details ...

A. Mm-hmm.

Q. How did Lionel Desmond appear to you in terms of his willingness to discuss his symptoms, his concerns, what he was presenting there for?

A. I don't have a lot of specific memories. I don't recall and I didn't document that there was any reluctance or hesitation.

Q. Did he appear to sort of engage in the back and forth communication between you and him?

A. My memory is that, yes, he was engaging.

Q. And in terms of was he able to articulate in terms, to you, describing what it was that he was coping with or dealing with?

A. I don't have any memory that he didn't and I didn't document that he wasn't.

Q. Was there any ... do you recall if there was any reason for you to be alerted or sort of suspect that Lionel Desmond may have been untruthful in any way with you during the assessment?

A. I don't recall that.

Q. And I understand that Shanna Desmond was present with Lionel Desmond?

A. Yes.

Q. Do you recall if she was present during the course of this assessment?

A. Yes, she was.

Q. And, generally, what do you recall from her being there?

A. I recall that she was ... I recall my impression that she was managing care. She had something with her, like, papers or documents or papers that she, that I recall - again, this is an imperfect memory - that she was referring to at times, I

think, around things like dates or names or that kind of thing. I recall that she had an assertive manner. She spoke a lot. I recall that ... I think I did have to ask her to not answer for her husband, that I would look to her to answer if I needed, but she was doing a lot of the presenting of information.

Q. Were you able to say perhaps in the meeting with the two of them if one person was more dominant, I guess, in the sharing and discussion of information as opposed to the other?

A. Again, my recollection is is that my impression was that, again that idea of when a family member is sort of endeavoring to organize care and to keep track of care and to sort of advocate for their family member, that's kind of what my impression was that she was doing.

Q. You described her as assertive during the course of the interview.

A. Yeah.

Q. And assertive in that, was she willing to sort of dive into the bottom of what was happening here, why he was there?

A. My impression of assertiveness is more around, I guess, that she, there was a lot of spontaneous speech, no hesitation to ask questions or to interrupt, that kind of thing.

Good eye contact, you know, there didn't seem to be, like, you know, a shyness or an insecurity to speak. You know, she ... but, again, that was my impression.

Q. Do you recall if ever at any points during this assessment that it would seem that Desmond may be deferring to her at various points or ...

A. Again, it's an imperfect recollection. My recollection of my impression was that there wasn't necessarily any deference from one to the other.

Q. And when you say you got the impression that she was the one managing the care and you referenced that she had documents and she was referring to them ...

A. Mm-hmm, mm-hmm.

Q. Do you recall anything beyond that?

A. Recall anything at all about the whole assessment?

Q. The whole aspect of ...

A. Or just ...

Q. No, of her managing his care.

A. Oh. Not specifically, no.

Q. Did she seem organized?

A. She did not seem disorganized.

Q. But in terms of, I guess, questions of who Lionel

Desmond may have been in contact with, appointments ...

A. Mm-hmm.

Q. Who was sort of taking the lead in offering that information?

A. She was, to my recollection, yeah.

Q. And was she present during the entire assessment?

A. She was.

Q. Was there ever any discussion that she may leave for the assessment?

A. Yes.

Q. What was that?

A. So it was, and we can talk about the change, but always my practice to ask, when people are in the Emergency Room, to ask, with somebody else, to ask that we speak all together and then, I think I used to phrase, "and then if it's okay with you, I'll ask your friend/family member/whomever to step out for a little bit and we'll speak on our own." But she and he refused that. They wanted ... they both indicated that they wanted her present. But it was predominantly, I think, it was her that didn't want to leave the room.

Q. And how did you sort of manage that sort of scenario as it presented itself - she didn't want to leave, she wanted to

be there for the entirety?

A. Because he seemed in agreement, then I just ... I let it be, and they both stayed for the entire ... And I would just again ask, ask I always would, if the family member or the person there is tending to answer questions for the person, I would ask that they not do that and let them know that I'll check in with them for the answers after.

Q. And in this case did you happen to have to do that?

A. I don't recall.

Q. And today is your practice still the same in terms of ...

A. No.

Q. It's not?

A. No. So now I tell people that ... So now I make sure that there is space, with very exceptional circumstances, but that there is space where I speak to the individual alone and the person accompanying will step out.

Q. So why the change?

A. So when ... So, honestly, when I heard about what had happened, when I heard about the murder/suicide, that was a few months after I had ... after I had seen them both in the Emergency Room, but at that time I would have had obviously a

better recollection of things than I do now, and so one of the things that struck me was ... I began to hear things in the media and people began to talk about domestic abuse in this situation. I didn't know any details about that but I began to think if ... Honestly, my first thought was I wondered who was the abuser and who wasn't, because I don't know, and then my second thought was I wonder if I had have made sure to have time alone if anything ... if either of them would have disclosed anything differently or if there would have been anything different ...

Q. So it was a lot of sort of speculating on your part?

A. Yeah, yeah, it was. And so then I just, yeah, so then I just changed my practice to try to be sure to create that space.

Q. Is there any sort of training or directive or policy or anything that suggests, when you're doing these assessments, that you are to separate the parties at one point, or is there anything there that sort of gives a direction?

A. So I wouldn't say... There's no, like, policy or direction. If it's been raised as a suggested practice at some point, it's gone, I lost that, but I don't recall specifically that being ...

Q. We're going to get into the details, but Shanna Desmond, did she discuss any sort of aggression as it related to Lionel Desmond during the course of that?

A. So the only thing that I recall, and it is difficult to separate now what I remember from everything I've heard, the only thing that I would say, that when I heard about what had happened and I was sort of running things through in my head, that I kind of remember thinking about was, and again was under that umbrella sort of of the domestic abuse or domestic violence, was asking if there had been any aggression towards people and they disclosed that there was raised voices, and if there had been any aggression towards objects, so we ask that, as well, when we're exploring anger, and that there had been. And what I recall ... And then I would ask, because there was a child in the home, I would ask about that child's exposure to any of the raised voices or the aggression towards objects or anything like that, and I remember ... I remembered, I'm sorry, remember her saying ... her talking about how there was an incident where he had ... sort of had banged his hand of the, I think she said kitchen, on a table, and Aaliyah was in the room. And I remember that she said, I took her aside and I explained to her that Daddy wasn't mad at her, that he was just feeling

frustrated and angry and that it didn't have anything to do with her. And then I remember we had a brief exchange about how that was not healthy, could not continue, you know, steps to take to make sure that it didn't, you know, who to, you know, how to get help - do you have supports, are there people close by. You know, and then there would be a discussion about ways that, with Corporal Desmond, about ways that he could manage his anger differently, and we talked about him going, when he began to feel frustration building, his idea was to go outside, because that's what apparently he was doing or something, and that there was something outside that he would work on or do, but I don't recall what it was, but it was to go outdoors and do something. So I do remember having that conversation.

Q. Okay. So we're going to go through the form and its various points. So you look at page 7, the very top, there's a family doctor listed. So you would have taken the details of his family doctor, Dr. Ranjini?

A. Yes.

Q. And I guess we'll cut to the sort of very end. Did you ever - and I recognize this is pre-policy - but in 2016 did you ever, at the conclusion of all of this and Lionel Desmond leaves the hospital, did you ever have these reports sent to his

family doctor, Ranjini?

A. I did not.

Q. Do you know if you sent these reports and the risk assessment tool as it was then to any sort of other health care providers or professionals that Lionel Desmond was involved in?

A. No, I did not.

Q. It says "Agencies Involved".

A. Mm-hmm.

Q. And it's checked off Veterans Affairs.

A. Mm-hmm.

Q. Did he give you that information?

A. Yes.

Q. And what did he tell you about Veterans Affairs and their involvement, do you recall?

A. I don't specifically recall.

Q. But you noted that there was an agency involved and it was Veterans Affairs?

A. Yes.

Q. I notice that this part of the form, it talks about agencies involved, but there didn't appear to be any spot to say trauma clinician, stress injury clinic?

A. That would be Mental Health and Addictions.

Q. Okay.

A. Yeah.

Q. So under the next heading "Emergency Room Physician", it says "Patient seen by ERP." That's Emergency Room physician?

A. Yes.

Q. And it's checked off as "no".

A. Correct.

Q. So I understand that the policy changed now.

A. Yes.

Q. That it has to be the ER physician. So how did you become involved this night if you weren't alerted from the ER physician?

A. I don't recall specifically but I suspect it was probably the triage nurse or one of the nurses in the Emergency Room that called me.

Q. And this is 3:30 in the afternoon?

A. Yes.

Q. And that particular day, normally when does your shift end?

A. At that time it was 8:30 to 4:30 but I think ... I think we took referrals up until 4, I think.

Q. And to your knowledge, had the time ... had this been

at 7 o'clock in the night ...

A. Mm-hmm.

Q. Would there have been anyone available at St. Martha's to complete this one-hour detailed mental health and risk assessment?

A. No. No.

Q. So it's only, at that time, completed when a mental health crisis clinician was available?

A. This form is specific to the mental health crisis response, yeah.

Q. And we'll talk a little bit about the current form as well.

A. All right.

Q. But I'll go back to that at the end. So you have "Confidentiality", that's checked off. "Duty to Report", so what did you discuss with him regarding duty to report?

A. So I let people know about the limits of confidentiality, so that if there is an imminent risk to self or others, that we can disclose their information if it's in the interest of safety, including if there is risk reported to a minor, even if that is not ... so even if it's not their own child, in the course of what they tell me, if they tell me about

their granddaughter or grandson, that I have a duty to report that.

Q. And that was reviewed with Lionel Desmond?

A. Yes, it's kind of a standard, yeah.

Q. So rather than me try to paraphrase the next heading that says "Chief Complaint", and it's your writing, I'm wondering if you could read that in, without including the check mark boxes. We'll review those. But what is that saying?

A. "PTSD symptoms increasing - Interrupted sleep due to vivid dreams, nightmares, night sweats. Decreased appetite. Angry outbursts with aggression to objects. Paranoid ideation about wife. No trust. Isolating self to decrease stimuli."

Q. So this information here, was that information provided to you by Lionel Desmond?

A. Yes.

Q. Was some of it, that you recall, was any of it provided by Shanna Desmond?

A. Oh, possibly. They were both in the room, so ...

Q. And I'll just, before I get into breaking that down, when you're doing the assessment are you making the notes as you go along?

A. Generally speaking, no. It's hard to establish

therapeutic rapport and to be present and engaged with somebody if I'm looking at a piece of paper and writing down. That being said, sometimes I will document certain things, so list of medications or a doctor's name or something. Usually the things that are more narrative, I would wait for either a break in the interview or for the end of the interview.

Q. So the first thing it says, "PTSD symptoms increasing". Do you recall what sort of sense you got, what sort of symptoms were increasing?

A. Well, so the "Chief Complaint" section is, as much as possible, taken from the patient and what they're reporting, or the client. So what I document, actually most of what I documented after the little dash, after "PTSD symptoms increasing" are PTSD symptoms.

Q. Okay. And what were they?

A. "Interrupted sleep due to vivid dreams, nightmares, night sweats. Decreased appetite. Angry outbursts with aggression to objects. Paranoid ideation about wife, no trust. Isolating self to decrease stimuli."

Q. And there was the sense that all of those were increasing?

A. Yes.

Q. Did you get a sense of ... Down below you see the text "Mood" and then there's a handwritten note by you. What does that say?

A. "Anger and depression and anxiety increased since approximately one month."

Q. So did you get a sense of how long these symptoms had been increasing, since when, I guess?

A. I don't recall specifically what my sense was at that time. I can only go by what I've written.

Q. So based on what you wrote ...

A. They were ... he was reporting ... And, again, with two people present, that if one contradicted the other, I would note that. So he or they were reporting that it was about a month of symptoms of anger, depression, and anxiety being worse.

Q. And were you able to tell by your note or your recollection if sort of the interrupted sleep, nightmares, decreased appetite, outbursts, if they had also been increasing over the last month?

A. I did not document the exact period of time. no.

Q. In terms of vivid dreams and nightmares, did he get into particulars as to what they were?

A. I don't recall.

Q. Did you get a sense of how frequent they were?

A. I don't recall.

Q. There's a note, it says, "Angry outbursts. Aggression to objects." Do you recall ... You sort of talked about that a little bit earlier but did he give examples or did she give examples of what angry outbursts there were?

A. My only recollection around that is the one I already shared.

Q. Do you recall if there were any more than the one that you recalled?

A. I don't recall.

Q. And aggression to objects, you used an example about the table but do you recall if there were any other discussions?

A. I don't recall.

Q. Then there is, you said "paranoid ideation about wife".

A. Yes.

Q. What was that all about?

A. So, again, this would be ... in this section this would be partly ... mostly what they were reporting.

Q. Yes.

A. So they would have reported that he was having

paranoid ideas. A lot of people use that word "paranoid" quite frequently.

Q. Yeah.

A. And so from what I've written, I would say that they probably shared that he had some paranoid ideas about his wife.

Q. Do you recall what they got into when they discussed that he had paranoid ideas about Shanna Desmond?

A. So I do not recall. I've heard lots since, so I can surmise, but I don't recall from that moment, no.

Q. You just know that there were sort of paranoid ...

A. I know now.

Q. ... ideas directed towards her?

A. Yeah.

Q. Were you able to get a sense at that point when he had, when you noted sort of paranoid ideas about his wife, whether they were sort of over-exaggerated or irrational, sort of over-reactive?

A. So ... no. I know that I would have documented delusional ... or delusions if I had have felt that it met the criteria for delusions, whatever, maybe not in that section but in some section I would have written that. That's significant with mental status. And if they were ... if they used the term

paranoid, which I'm guessing they did, if I wrote it there, but that I don't recall specifically what my sense was at the time. But usually people use that to mean that it's something that's out of the ordinary or unusual.

Q. Did you get a sense whether they ... that paranoia towards jealousy was something that was frequent or a one-off?

A. I don't recall.

Q. The note that you have "no trust" or "zero trust", what was that referring to?

A. They would have disclosed that he didn't trust.

Q. Did they reference who he didn't trust?

A. I would have documented if there was a specific, but again my sense of, from the documentation and from what I know is that it was sort of a general distrust.

Q. Just a general distrust for almost everyone, you mean, or ...

A. I don't recall specifically.

Q. And you have "Isolating self to decrease stimuli".

A. Yes.

Q. What's that?

A. Specifically, or from ...

Q. I guess, literally, did they use the words "isolating

self to decrease stimuli" or is that ...

A. Actually, they might have ... Well, they might have used the word stimuli. Some people are quite ... Or they might have given ... they might have given some examples of noise and chaos and lots of people and I might have shorthanded it to stimuli.

Q. So what sense did you get in terms of isolating self, is that in the sense of him removing himself from a situation?

A. Avoiding things, avoidance.

Q. So avoiding things, people, what was that?

A. Stimuli.

Q. So ...

A. I don't recall specifically. I know what I meant likely was ... Yeah. I don't recall.

Q. Decreased appetite, did he elaborate further that you recall?

A. I don't recall.

Q. Any comments about his concentration?

A. So when I asked questions about concentration and memory his response would be, I have none, or, No. That there's no concentration and no memory. That would be ...

Q. So his ...

A. Yeah.

Q. So in the sense of, I can't concentrate? Is that what he's saying?

A. Yeah. Yes.

Q. So we see that sleep is checked off and it says, "Interrupted"?

A. Yes.

Q. No appetite?

A. Decreased.

Q. Or decreased appetite. No concentration.

A. Mm-hmm.

Q. And memory, no memory, you indicated.

A. Mm-hmm.

Q. And then you described mood.

A. Mm-hmm.

Q. And that is information that came from him?

A. Yes.

Q. So in addition to the report of PTSD symptoms increasing, did you get a sense of ... and I realize that some mental health disorders can kind of overlap with others. But did you get a sense of if there was any elements of depression in there?

A. I don't recall.

Q. Anxiety?

A. I documented anger, depression, and anxiety. So I don't recall any specific recollections other than what I documented.

Q. So below that there's "History of Presenting Crisis". What are some of the things you're looking for there? Generally.

A. So if a crisis in the moment is related to mental health - which usually it is if I'm seeing people - then we would look for any past history that would seem relevant. So we ask people about things like trauma, abuse, contact with mental health providers, substance use, that kind of thing. And sometimes, because we don't have a lot of room to ... or a lot of different domains, just in general for people to tell us sort of about their history and the significant times in their life and that kind of thing, yeah.

Q. So I'm not going to try to interpret your writing.

A. No.

Q. So I'm wondering if you can read into the record exactly what you wrote here under "History of Presenting Crisis".

A. Military ten years. Significant trauma in combat. After tour, trouble adjusting on base to being out of combat. Alcohol, anger. Went to AA. Diagnosed with PTSD in 2011. Occupational stress injury group, mental health. Discharged home. Discharged and home June/July of 2015. Trouble adjusting. Medication intermittently helpful. Conflict with wife. Ste. Anne's treatment centre, Montreal, June to August. Very brief stability and then problems getting worse since then.

Q. So there seems to be quite a bit there. So I'd like to sort of break it down. Is it fair to say that from your assessment with Desmond on this date, and in this note, that he was having sort of struggles moving from a military context back to his regular civilian life?

A. From what I've documented, that's what I ...

Q. Did that appear to be a recurring theme with him?

A. I'm not sure what you mean.

Q. Did he bring up that sort of concept multiple times?

A. I don't recall.

Q. Did it appear as though that transition was causing him some stress?

A. I don't recall, but I believe that I've documented that it was.

Q. So the fact that you documented it is suggestive that it was causing him problems?

A. I believe so. From reading over my assessment, I believe that that was one of the things that they ... yeah.

Q. Do you remember if he used any examples of sort of the struggle with the transition?

A. I don't recall.

Q. You noted that ... I'll get to that in a moment. So did you get a sense from here, from Lionel Desmond, that his struggles had been recurring for some time? His mental health issues?

A. Again, I really don't recall specifics outside of what I've said. So it's just from sort of reading the assessment that I can try to ...

Q. So based on what you reported and assessed ...

A. Yeah. Right.

Q. The person that you reported and assessed about, Lionel Desmond ...

A. Right. Yeah.

Q. ... is it suggesting here that he had been struggling with mental health-related issues for a while?

A. That he had had PTSD since 2011, that he had struggled with some alcohol and anger issues before he returned to Nova Scotia, and that he was at Ste. Anne's. So, yeah, so I would infer that, yes.

Q. And you also noted ...

A. Yes.

Q. You said, "Very brief stability", and then, "Problems worse since".

A. So Ste. Anne's treatment centre in Montreal from June to August, very brief stability and then problems getting worse since. The way that I document that is sort of in a chronological kind of a fashion.

Q. So the way in which you document it is saying that since his time in Ste. Anne's ...

A. Yeah.

Q. ... he's had very brief stability and then it's been getting worse.

A. Yes.

Q. So I guess you understood that to be since Ste. Anne's

and to the time he's presenting to you on October 21st that it's getting unstable.

A. That symptoms have been getting worse.

Q. Yes.

A. Yes.

Q. When we say stability aspect of his mental ... when we say "stability" ... when you write "stability" ...

A. Mm-hmm.

Q. ... are you referring to his mental health?

A. Yes. Yeah, and ...

Q. And I know stability can be a broad context.

A. Mm-hmm.

Q. But as you're writing it here, stability in what sense?

A. I would say in mental health and perhaps relationally and just in general.

Q. And would that include how he was adapting to sort of living out in the community?

A. I'm not sure.

Q. You note ... there's a reference to him being in AA?

A. Mm-hmm.

Q. I'm assuming that's for addiction to alcohol.

A. Yes.

Q. Was that discussed with him?

A. I don't recall besides what's documented.

Q. Did you recall how long he had been in AA?

A. No.

Q. I notice that this form appears to be pretty restrictive in the amount of space that it allows you to fill things out.

A. Yeah.

Q. Because the form is restrictive in such a way, is that part of the reason why, perhaps, you didn't expand on some of these areas?

A. There's never going to be the ability to expand on, or to write, all the details of everything on any form, and when I document on this form, again, it's thinking about somebody with a mental health lens, looking at it or it being that way. And I think that writing in point-form and using some of the terminology that we use and that would communicate to somebody in the mental health program. They would be able to get enough of a picture from what's written here.

Q. And you also ...

A. Yeah.

Q. ... noted, "Conflict with wife". So you're referring to Shanna Desmond.

A. Yes.

Q. What sort of conflict?

A. I didn't document specifics.

Q. And again my question is, when you, as a mental health crisis clinician ... and you're trying to be thorough and comprehensive as to what is happening with a person and why.

A. Mm-hmm.

Q. Conflict with a wife is a pretty broad term. Would you agree?

A. Yes.

Q. Would it be helpful, perhaps, to expand on what that is?

A. So, again, keeping in mind that I'm sure we had a discussion around it. What I document would be ... So would it be helpful, I guess, to whom and how, is the question. And I'm not sure ...

Q. I guess to you and perhaps the treatment plan.

A. But I would have the information. Just because I didn't write it doesn't mean that I didn't have it.

Q. We talked about the concept of circle of care.

A. Yes.

Q. Which is listed in the new policy.

A. Yes.

Q. And what is "circle of care"?

A. Circle of care includes people who are involved in a person's life, I guess, is a good ...

Q. And we talked about sharing information with other people that are going to be engaged in, perhaps, treatment.

A. Yes.

Q. So presumably, this document, at some point maybe ... maybe not in 2016 but in today's terms is going to be shared with someone else. If there's a plan put in place for treatment would you not share this information?

A. Within our mental health and addictions program you mean? Or I'm not ...

Q. If he has a ...

A. Oh.

Q. ... clinician that's treating him for ...

A. If he did have.

Q. ... jealousy with his wife.

A. Okay.

Q. Or trauma ...

A. Yes, then they may view this form, yes.

Q. So if there's the plan put in place to treat someone of jealousy as it relates to their wife ...

A. Right.

Q. ... would it be helpful to perhaps elaborate on "conflict with wife" in a little further detail?

A. I assume that they would explore that with him anyway. Writing that would be enough for them to delve into that with him and ask for clarification if they want.

Q. But do you think it's beneficial for somebody that's going to be handed off Lionel Desmond to know more information about Lionel Desmond and the particular issues that he's having expanded upon? I realize that ER is very busy.

A. Yeah.

Q. Do you see the benefit in that?

A. I understand the question you're asking, and I understand that if I say no, it sounds ... but the people that he would be seeing for mental health would be doing their own assessment anyway. Should be doing their own assessment anyway. And I would think that sort of honestly hitting the highlights and that kind of thing in a crisis assessment would be enough for that person to have things to be curious about or to kind

of, you know, delve into specifics more. So nobody's going to read all of my assessment and not re-ask things anyway and do their own assessment.

Q. When you're doing an assessment have you had an occasion where you looked at a previous assessment?

A. Yes, yes.

Q. Did you find ...

A. Yes.

Q. ... looking at the previous assessment helpful and insightful?

A. Yes, to look for differences and changes maybe. Yes.

Q. And would you say the more information provided in the previous assessment is helpful to you making a determination on your new assessment?

A. Not necessarily, no.

Q. Okay.

A. Yeah.

Q. So "Previous Health History" on page 8 of the report. What did you note for previous health history?

A. "Back injury 2007/2008." Which must mean that there was some question over which year. "Head trauma times three with loss of consciousness, the last one 2007/2000-(something.

I can't read, apologies.) 2011, diagnosis of PTSD. Query depression. Ste. Anne's treatment centre, Montreal, June to August 2016."

Q. And during this taking this assessment did you ask Lionel Desmond who maybe other healthcare providers were that he had been seeing and what for?

A. I would have asked about treatment history or history of being seen by mental health professionals.

Q. So at this point would you have asked, perhaps, Do you have a social worker or a case manager in the community assisting you with your affairs?

A. I'm assuming that whenever it was in the course of our conversation that they discussed Veterans Affairs I would have asked what the status of his situation was with Veterans Affairs.

Q. Did you get any sense of him being in Nova Scotia who, if anybody, he was seeing to deal with his PTSD symptoms?

A. Based on my documentation. I don't recall, like, in my memory. But based on my documentation, he said that he didn't have service in Nova Scotia, is what they said.

Q. Did you recall asking if he was seeing anyone in Nova Scotia for his symptoms?

A. I don't have specific recollection but I would normally ask that, yes, yeah.

Q. "Medications". You listed a number of medications here.

A. Mm-hmm.

Q. I won't get into the details. We've sort of reviewed what they were. So this information about the medications, where does it come from?

A. In 2016 ...

Q. '16.

A. ... it would have either come from the client or their family. So from whoever is presenting. If they have a medication list. Or some people bring in the actual medication bottles or if they disclose what pharmacy they use, then I could get a list from the pharmacy if they weren't certain what they were on or didn't have a list or bottles.

Q. And the practice today, does it differ in any way?

A. Now there is something called the Drug Information System, or DIS, which is basically a repository, I guess, of prescriptions filled. I believe it's anywhere in Nova Scotia in a certain timeframe. So oftentimes now it's a matter of somebody in the Emergency Department. I don't know if it's

triage or a clerk or somebody automatically usually prints out the DIS, and so that's usually on the chart by the time I see the person and then I would review that with the person to make sure it was accurate.

Q. Okay. His family history. So what are you asking about here?

A. Generally speaking, if there's a history of any mental health or addiction problems or concerns or suicide, people who might have died by suicide in the family.

Q. And what was noted, if anything? I can't ...

A. Paternal side is question mark for substance issues.

Q. So what does that mean? What are your ...

A. It generally means sometimes when we ask people this question they are not sure if things have been diagnosed in the family but they think that their relative has something. So it would have ...

Q. So ...

A. It would have meant that they thought maybe some substance issues on the paternal side of the family.

Q. In Lionel Desmond's case they thought there might have been?

A. Yes.

Q. Okay.

A. That's what that would mean, yeah.

Q. So in terms of social history, what are you looking for in terms of social history when you're doing your assessment?

A. A bit of a general context. So their work, their family supports. Yeah, just sort of their social as opposed to their medical kind of history.

Q. So I'm wondering if you can read it rather than me trying to interpret your writing ...

A. Yeah.

Q. ... what it is you noted in Lionel Desmond's assessment chart?

A. Raised predominantly by grandparents. Graduated Grade 12. Odd jobs. Started a relationship with current wife. Enlisted in the army. Spent time in New Brunswick and not much concentrated time with wife until discharge from military. Has ... (looks like I put two-and-a-half-year-old daughter at home. I know that's an error) Still trying to get connected with Nova

Scotia GP and other supports. Not sure how to live as a civilian. Trouble navigating Veterans Affairs system and worried about what they will offer and what they will cover. Waiting for Veterans Affairs case manager in Nova Scotia. Transfer not complete.

Q. So I take it from your note, again sort of a recurring theme with Lionel Desmond and this concept of he's trying to get care and he's trying to get it lined up and it just doesn't seem to be happening?

A. That they're having some trouble navigating the system and they were worried about what would be offered and if they would have to pay or not.

Q. And was there any sense that all of this ...

A. Mm-hmm.

Q. ... was adding to sort of acting as a bit of a barrier to Lionel Desmond or triggering his symptoms or anxiety?

A. I couldn't say.

Q. And normally is that something you're looking for to see what the stressors are someone has in their life?

A. Yes. I'm assuming this is a stressor, but as to the

weight it had, so I don't know.

Q. So at the time when you wrote this and at the time you ...

A. Yes.

Q. ... evaluated Lionel Desmond you noted, "Still trying to get connected to ... in Nova Scotia. Not sure how to live as a civilian. Waiting for Veterans Affairs." Would these have been stressors to Lionel Desmond?

A. Yes.

Q. And could these have played into risk factors when you're evaluating suicide risk, someone that ...

A. So not being connected with clinical supports can be a risk factor, yes, yeah.

Q. So how significant is it in your opinion as a mental health crisis worker when you're trying to assess risk and come up with a plan ...

A. Mm-hmm.

Q. ... when you have a patient such as Lionel Desmond telling you he was in a clinic, there's been periods of instability.

A. Mm-hmm.

Q. Then he says ... essentially, that he tells you that

he's trying to get connected with a family physician or a GP.

A. No.

Q. He can't ... he's having trouble living as a civilian.

A. Mm-hmm.

Q. And he's having troubles navigating a system that's there to offer him help. Is that concerning?

A. Yes, yes. That would be one of the things that we would be trying to support in order to help remediate the crisis, yeah, and to modify as far as risk is concerned, yes.

Q. And without going to the end ...

A. Mm-hmm.

Q. ... what sort of plan ... he was ultimately assessed as low risk for suicide.

A. Mm-hmm.

Q. In October. I know there were other follow-ups. But sort of what steps, if any, were taken by you for someone in an ER setting to sort of start to tackle these things? Not to say it was your responsibility but ...

A. So it would ... well, it would be my responsibility to think about those, absolutely, and so I would have recognized that the .... so the symptoms worsening and some of the symptoms he was having, that maybe might be responsive to medication.

And I can't prescribe. And that the not being connected would be a conversation that we would have and that I think I documented at the end in the document. They were waiting for a phone call and et cetera. So I consulted there. I called Psychiatry to get the support of the psychiatrist, yeah.

Q. And the concept that he was a military veteran and he makes a point of saying specifically he's not sure how to live as a civilian.

A. Mm-hmm.

Q. Was that significant to you in any way?

A. I'm not sure what you mean.

Q. So he's a man who was in the military and then he says, I'm not sure how to live as a civilian. What does that mean to you when he said that?

A. I'm not sure exactly what it meant to me at the time because I don't recall, and I don't recall if we explored that what came out of that. But now in general if somebody said that to me I would be thinking of, I guess, trying to look at how to support that person in reintegrating into civilian life. So by connecting them with a therapist and by talking to them in my role, talking to them in the short-term about, like, routines and things that would help to decrease anxiety and that kind of

thing. So I don't know.

Q. So when you're doing this did you get a sense that Lionel Desmond was a little transient and that he was kind of moving from place to place?

A. I don't recall having that sense, no.

Q. Did you get a sense of where he was from or where he was living?

A. My recollection and from what I documented is that he had spent a lot of time in New Brunswick after he left combat and then he just recently returned to live in Nova Scotia.

Q. Do you recall where it was in Nova Scotia?

A. I know now. I don't recall if I knew it then. I don't ...

Q. Okay, but at the time would you have sort of ...

A. Right, and I would know the address. So ...

Q. So at the time would you have considered ...

A. Is that ...

Q. ... whether or not he was from a rural area?

A. Again, I usually look at the address. I usually have a sense from people, again, the whole interview being more than what's documented here, about what their context of their life is. So I usually would have a sense of whether it was rural or

not, but I don't recall.

Q. So back when you assessed Lionel Desmond on October 24th, 2016 ...

A. Yeah.

Q. ... and he revealed those things to you, did you turn your mind to the fact that, Okay, he's not living downtown Antigonish, he's not living in an urban setting, he's in a rural area and there may be limits to resources he can access? Did you have any consideration of that?

A. I don't recall, but I'm assuming that if it was applicable I would have. So I don't ...

Q. And did you suggest to him places where he could attend to access certain services?

A. Beyond what's documented or ...

Q. Yes.

A. I don't recall aside from what's documented. Likely not.

Q. Did he give you any examples or elaborate as to the difficulties he was having? You said, "Difficulties navigating Veterans Affairs." Was he specific? Did he give examples of what he was running into?

A. Honestly, I don't recall if there were specifics.

Q. Did he give you a sense of it's a transfer not complete. So a transfer of what?

A. To case manager in Nova Scotia.

Q. So he was waiting for a case manager in Nova Scotia was your understanding?

A. That would have been my understanding at the time, yeah.

Q. Did he give you a sense of what his expectations were of what he was waiting for, what sort of treatment plan he had been waiting for?

A. I believe, from referring to my notes, that it was that he wanted therapy. They were looking for therapy or connection to a therapist.

Q. So you got the sense that he was waiting for somebody to put that in place for him.

A. Again, from the documents, and what I glean is that they were waiting for a phone call from somebody about getting connected with a private therapist that would be covered by Veterans Affairs.

Q. I'm wondering, Your Honour. It's 10 to 1. The witness has been going fairly steady for a while. If it's appropriate to break now.

THE COURT: Yes. We can break for lunch. We'll take an hour, thank you. We'll come back at 5 to 2. Thank you.

COURT RECESSED (12:57 HRS)

COURT RESUMED (14:02 HRS)

THE COURT: Thank you. Mr. Russell?

MR. RUSSELL: Yes, Ms. Wheaton, where we left off, it would be Exhibit 67, page 9. You made a number of notes with respect to "Substance Use and Addiction History". I'm wondering if you could indicate what those were.

A. He was using medical marijuana until February 2016. "Found it made symptoms of depression and panic worse. No alcohol since 2016."

Q. As well, you did a mental status exam, and there's a pretty detailed note in there. I wonder if you could read into the record what your notes were as it relates to the mental status exam.

A. 32 year old male, black, slightly unkempt, in sweat clothes. Angry outbursts that occur suddenly and are followed by return to low mood. Anxiety, paranoid thoughts about wife. General distrust of all people. Feeling tired and overwhelmed and unsure

about how to best get or receive help.
Suicidal ideation, no intent or plan.
Affect downcast and speech is tangential.
Wants to talk about his military
experiences.

Q. So what is it you're looking for when you're doing the mental status exam?

A. A collection of things, and actually the check boxes on the left, I guess, or the prompts on the left would cover most of them. So a person's appearance - in general, I guess, to describe a person's appearance, if there's anything noteworthy about it, so sort of slightly unkempt; what a person's mood is, what their affect appears like; what their behaviour is while you're with them, so sort of what you're seeing; anything to note about their speech or their voice, their thought processes, thought content - hallucinations, delusions.

Q. And this particular profile, if I may call it that, seems to have a number of elements to it, would you say?

A. Yes.

Q. So would you agree that his crisis profile is not exactly straightforward or limited to "I'm depressed"?

A. Correct.

Q. And it had a number of sort of moving variables, would you say?

A. A general mental health assessment includes assessing many different domains, I guess, or many different things.

Q. And in his case, Lionel Desmond's case, did it touch upon various domains?

A. It would have touched upon anything noteworthy about things like appearance, mood, affect, speech, thought process.

Q. So just when we get to in terms of ... you have "anger occurs suddenly". So what are you referring to there when you say occurs suddenly?

A. The angry outbursts that occur suddenly?

Q. Yes, sorry, yes.

A. I think as opposed to a sustained angry presentation.

Q. I sense that it comes and goes quite quick?

A. Yes. Yes.

Q. And did you get any sense in terms of the "anger occurs suddenly" that it ... I guess it's just that, it's pretty unpredictable, is that a fair ... I'm just trying to get your sort of understanding of when you put "occurs suddenly" what you're getting at.

A. Yeah. I think what I was getting at was that it would occur all of a sudden as opposed to build. So sometimes you can see people, you can maybe see that anger is building and they're getting more and more angry, you know, in their behaviour, their affect, their voice and tone and volume, and it's kind of a rising and then there might be, like, an outburst, like, oh, they almost swore, or whatever, you know, something like that. But I think what I was getting at was that it would occur more suddenly than that. There wasn't necessarily a period of which it would be observably getting more and more angry.

Q. And then you had "followed by return to low mood/anxiety". What are you referring to there?

A. Again, from my documents I'm assuming that what I mean is that he would have an outburst and then his mood would return to being sort of low or downcast, maybe with some residual anxiety.

Q. And the anxiety, is it connected to what his reaction was or ...

A. I don't know what it was connected to.

Q. And again we see "paranoid thoughts about wife".

A. Yes.

Q. So when you documented it earlier and you again document it here ...

A. Yes.

Q. ... are we to understand that it was brought up perhaps a second time?

A. Not necessarily, no.

Q. Okay. And here you had trust and no trust earlier, but here you made a specific reference to "general distrust of all people".

A. Right.

Q. So here you appear to have elaborated a bit further.

A. I guess so, yes.

Q. And would that be something he expressed to you, that he distrusts all people?

A. I would have gleaned that information from him or his partner.

Q. So as a clinician, in that context, and you have a sense, very clearly an indication of a patient who's in mental health crisis has a distrust for all people.

A. Mm-hmm.

Q. Are you evaluating how they're perceiving you in terms of sharing the information, whether they trust you?

A. Well, I'm working on developing a therapeutic relationship with the person and endeavoring to make the environment as comfortable and respectful as possible, hoping to increase their trust. But I recognize that for a lot of people meeting a stranger in an emergency room in the middle of a crisis is not going to be an environment that makes them likely to trust if they have general distrust, so I'm aware of that.

Q. Would you say that that could be a considerable stressor for someone who has a distrust of all people?

A. If what could be ...

Q. If somebody, I guess, is looking for help ...

A. Yes.

Q. ... and they're meeting with various people for help, but they have an underriding distrust of all people, could that be a significant barrier for someone in that situation?

A. It could be difficult for people who distrust to seek help, yeah.

Q. And is there any sort of therapeutic way or ability to sort of remove that barrier of trust before you can get to treatment? Is there an approach?

A. If somebody's not seeking treatment because they have a distrust?

Q. Or if they have trust issues, is that something you need to assess first before you can get to the real root of the problem?

A. I don't think it's necessarily something we need to assess first, but it certainly is something that we are mindful of in the sense that, in a lot of different ways, so in the sense that I wouldn't ask somebody that I just met who has a general distrust of people to tell me all about the trauma they experienced as a child in detail. I think I mentioned that earlier. I would talk to them about ... We often ... I often would talk to people about that distrust and how it might be showing up as a barrier for them. It would be something that we might dialogue about and about what would make it easier for them to connect. Some people have some ideas about that.

Q. The next note you had made, you had said "overwhelmed and unsure about how to best get or receive help".

A. Yes.

Q. And that was in what sort of context?

A. Again, I really can only go by my notes, but I believe it's back to the, what was documented earlier, which was that there was worry about having to pay for therapy, wanting therapy, wanting Veterans Affairs to pay for therapy, not having

a case manager in Nova Scotia yet, so this idea of being disconnected from help and not sort of knowing the best route how to get that help.

Q. Did you get a sense that that sort of theme was sort of a pressing concern for Lionel Desmond?

A. Well, I can only ... Again, I don't have a specific memory in that moment but I can go by my notes and say that it was a theme, it was a stressor.

Q. In terms of his speech you described it ... first, I guess, "his affect is downcast". What is that?

A. Sad, hanging head, sort of a downcast kind of a posture, sort of ...

Q. And that's something that you noted about Lionel Desmond?

A. Yes.

Q. And when you're describing his speech you refer to it as tangential.

A. Yeah, tangential.

Q. Tangential. So what do you mean by "tangential"?

A. That in conversation he would have sort of gone off on a tangent, so taken a piece of something that was talked about and kind of gone off on a tangent. And from my notes, I

say that he wants to talk about his military experiences, so I'm guessing that that was the content of his tangentialness, so if we were having a conversation about his time in the military, his time in combat or whatever, from my notes I would say he would go off on a bit of a tangent as far as describing something or talking about something.

Q. So did he appear to have any sort of difficulty staying on task, on topic?

A. Again, I don't have specific recall of that. People who are tangential can ... generally they come back to topic and they can be brought back to topic.

Q. But how was he?

A. I don't have specific recall.

Q. And you said "wants to talk about military experiences". Was there a particular reason why you would note that? Is that something that he kept sort of going back to, is that why you noted it?

A. I don't recall if he kept going back to it or not. I would note it probably because, if a person wants to talk about military experiences and he has a diagnosis of PTSD and has experienced trauma in the military, it's probably noteworthy that he actually wants to kind of talk about and process those

things out loud.

Q. The suicide risk assessment as it was then you had filled out, there were a number of boxes that were ticked, but, in particular, you checked off "suicidal ideation".

A. Correct.

Q. So that is suggesting that you noted that he had suicidal ideation?

A. So that would indicate that when I asked about thoughts about hurting or killing himself in the recent past - again this assessment is supposed to be recent, so here and now, in the past couple of weeks, that kind of thing - that he would have had, and I know from my documentation that there was no intent or plan, and I think I wrote "passive" somewhere. So it would mean that he had some type of a thought. So, for example, if a person says to me, Yes, there have been times in the past couple of weeks or whatever when I've woken up and thought I wished I just hadn't woken up, or, I wished I had have just died in my sleep, that kind of thing, I tend to check off "suicidal ideation" because I think it's noteworthy that a person's mind is starting to go there, to want to escape whatever they're experiencing, either internally or externally, by death. So I will usually check off "suicidal ideation" if those are recent

thoughts they're having.

Q. So, logically, when you're assessing suicide risk, the presence of suicidal ideation is relevant?

A. Yes.

Q. Thoughts of suicide are relevant?

A. Yes.

Q. Did you expand anywhere what those thoughts were in your report?

A. No, I did not.

Q. The fundamental purpose of suicidal risk assessment is to assess for suicide?

A. No, it's to assess ...

Q. No? Risk?

A. To assess for risk, yes, and then to work on modifying those risk factors.

Q. And if somebody speaks about, as in Desmond's case, thoughts of suicide of some degree, is there a particular reason why you don't note what they are?

A. There's no particular reason why, no.

Q. Would you normally note them up?

A. So if he had passive thoughts about wishing he were dead, with no intent or plan, I wouldn't necessarily note that

in this assessment. The new suicide risk assessment form has a place on the bottom where we can document specific to the things that are documented in the checklist, so I would now, given that space, be able to expand on those things.

Q. I just want to go over a few points in the suicide risk assessment as you've completed it, as it then was on October 24th, 2016. There's a box in there under "Interview Risk Profile" that has "hopelessness".

A. Mm-hmm.

Q. What is hopelessness? As a clinician filling out this tool, what is hopelessness?

A. Generally speaking, if a person does not have any hope that anything will ever change, anything being pertinent to that person's situation.

Q. So we have Lionel Desmond saying he's overwhelmed, he has a distrust of all people, he's worried about Veterans Affairs paying for treatments.

A. Mm-hmm.

Q. He's trying to find a doctor, he doesn't have one, doesn't know where to look for help. Would you agree that that is perhaps suggestive of somebody that has hopelessness?

A. No.

Q. Why not?

A. Hopelessness, by contrast, your description would be somebody who said, I don't think anything will ever change, I'm never going to get therapy, there's nothing I can do to get therapy, nothing is going to ever get better, that kind ... that sort of hopeless ... So he has, obviously, some frustration maybe, he was feeling overwhelmed, but he still wanted the help and was there taking steps to get the help, and there's nothing to indicate he was hopeless about it.

Q. As well, under that same heading, "Isolation" is listed. What is isolation in this context?

A. So generally speaking ... So specific to Corporal Desmond's situation, from my documentation and from what I know now, so he was isolating himself somewhat to avoid stimuli, but he wasn't isolated in the sense that he still had family, so he had contact with extended family and from ... and was with his own family at the time of the assessment.

Q. So are these concepts that are listed in the risk assessment tool, is there, are they listed anywhere what it is, are they defined anywhere, in any policy?

A. You mean the words, like, what ...

Q. Yeah.

A. Not that I'm aware of.

Q. Do the people that fill out this tool get training in terms of what these terms exactly mean, in what context?

A. People who fill out this tool are mental health and addictions practitioners or professionals, so they would have lots of training in mental health assessment and I think that most of this would be sort of self-explanatory to them.

Q. So something like isolation is a fairly broad concept.

A. Correct.

Q. It can mean isolation from stimuli, can mean isolation from friends and family. To your knowledge, is everyone on the same page filling out this form that they know what isolation means whether they check it off or not.

A. To my knowledge, as much as it is possible for people to be on the same page about that, people would be. The new form with the space underneath would certainly allow for, and often what will happen is somebody might ... In my clinical judgment, for example, I might think, well, he's kind of isolated but kind of not, and so, therefore, I might check it off and expand upon that in the space below where we can expand upon those things. But, generally speaking, we know what

isolation means.

Q. There's another one and it's listed as "Recent Dramatic Change in Mood".

A. Yes.

Q. And that wasn't ticked off, but what is recent dramatic change in mood to someone who's filling out this form?

A. Likely more recent, so likely not any gradual increase or decrease in symptomology but more recent dramatic change. So yesterday everything was fine, woke up this morning and something is dramatically different.

Q. So when you noted, "PTSD symptoms increasing past month, angers suddenly", that's not recent dramatic change in mood?

A. No.

Q. I notice "Recent Past Suicide Attempt" wasn't checked off, so, presumably, had Lionel Desmond told you about something you would have noted that?

A. If there was a recent past suicide attempt, yes, if he had, yeah.

Q. And just moving on to page 10, Crisis Coordinator Assessment and Plan, if you can indicate what the plan was for Lionel Desmond on October 24th, perhaps read it into the record.

A. You want me to read that section?
Q. Yes, if you don't mind, yes.
A. 32 year old male accompanied by wife, who was organizing much of his care. Experiencing an exacerbation of PTSD symptoms. Waiting for service through Veterans Affairs. Mood and functioning impaired. Relationship with wife and daughter are strained. Wants help and is worried that it will cost money and Veterans Affairs won't pay for it. Would like a therapist.
Dr. Slayter saw in the ER. Plan is to increase prazosin from two milligrams to four milligrams *h.s.* and to start trazodone 100 milligrams *h.s.* and to see Dr. Ranjini (which was his new family physician).
If the phone appointment with Veterans Affairs on October 28th is not leading to timely mental health follow-up, then make a referral for Outpatient Mental Health Crisis Service/ER as needed.

Q. So was there a referral to ...

A. So the plan here ...

Q. Yes?

A. ... was, they were waiting for a phone call that they expected should, and were hopeful would, result in connection with a private therapist, funded by, I guess, or paid for by Veterans Affairs. We said if that did not happen, if after that phone call they did not feel like they were going to get that timely support or whatever, that they could refer through our Mental Health Program and we would get them a therapist.

Q. So your role as mental health crisis clinician, is part of your role to see that this plan is ... to see this through?

A. Not necessarily. It depends on the situation. So in this situation, again he had somebody with him, too, that was sort of in a managing ... who was kind of managing care. I didn't have concerns about their ability to make phone calls, for example, or be able to do that. I would have given him ...

At that time we were still trying to provide, providing some phone support, so I would have at that time always give, we always gave the provincial mental health crisis number. It's on a card, they have, like, a business card, and then I would have

written the number to reach myself in the Crisis Service at St. Martha's on the back of that card, and we would have talked to them about the process for referral, like, that would have all been discussed. And I wouldn't, in that situation, have had any concerns about the ability of somebody to make those phone calls or to ...

Q. So after this plan is put in place and your assessment is completed, do you have any further involvement with Lionel Desmond?

A. No.

Q. Is there any procedure in place where you were to check in to see if the contact was made with the family doctor, to check in to see if he was followed up with that clinician that was spoken about?

A. Which clinician? Sorry.

Q. There was a reference to, earlier, that he wanted to see a clinician.

A. Oh, that he wanted .. he was looking for a therapist or he was wanting to see a therapist and the hope was that the Veterans Affairs phone call would result in that.

Q. Yeah, so was there any follow-up on you to see if that happened?

A. No.

Q. Was this ... I believe you spoke about it earlier, this risk assessment ever sent to Dr. Ranjini?

A. I'm not sure.

Q. Did you speak to anyone about perhaps sending it?

A. No.

Q. Did you share this assessment with anyone?

A. Dr. Slayter, the Mental Health Outpatient Department, in case he called for an appointment they would have had a copy of it.

Q. So your role today as mental health crisis clinician, I take it, as doing more than just doing an assessment in the ER, sharing it with the psychiatrist.

A. So part of what we do in the Emergency Room is not just an assessment. There's also an intervention piece. So, again, there's a lot of stuff that isn't documented or qualified there, but ... So when we see somebody in the Emergency Room we do an assessment and we do an intervention, so we try to modify the risk factors, we try to support people in - again, it's different for everybody - in problem-solving, in managing symptoms of their illness, and that could entail a variety of different approaches and different interventions.

Q. So would ...

A. And there would be an aspect of making a plan, so a management plan for when they leave the Emergency Department, if they're going to.

Q. And you're involved in that intervention?

A. That would be what we would do in the Emergency Room, that's what we do.

Q. So was there any intervention put in place here for Lionel Desmond in 2016?

A. The whole therapeutic interaction that I had and then Dr. Slayter had is an intervention of sorts. So the course of the conversation is again trying to build up a therapeutic rapport, try to, in this situation, try to modify some, again, like I said, for adjusting medication, for example, to try to target the most prominent symptoms that he was experiencing, and then talking to him about getting connected with somebody and making arrangements for that. They very much wanted the private therapy, and that was still their hope and their expectation from that phone call that they were going to be having.

Q. Did you offer any assistance in that or was there any way you could help facilitate that, find out ...

A. I don't think so ...

Q. ... any information?

A. ... because it was already a planned phone call that was going to ...

Q. Did they say what the phone call was? Who they were expecting it from?

A. I don't recall if they said.

Q. Did it ever cross your mind where ... you refer to Shanna Desmond as very much sort of ... you used the term "manager" of ...

A. I don't ...

Q. ... sort of his affairs and his plan.

A. Yeah.

Q. Did it ever cross your mind that there might be a little bit of a concern in that she was also managing his affairs and his primary support but, yet, she was very much heavily the subject of his complaint and his concerns?

Did you ever consider, perhaps, how fragile his plan might be going forward if she were to be removed from it?

A. So I ... your words there about how she was very much heavily involved in his complaint, that was not my assessment on that day.

Q. I guess ...

A. Yeah.

Q. ... I can back up.

A. Yeah.

Q. So he had talked about jealousy as it relates to his wife ...

A. Yes.

Q. Her. He had talked about anger outbursts and arguments with her.

A. No, not necessarily. It was angry outbursts but there was .. it wasn't necessarily in arguments with her. It was just angry outbursts, frustration when ... again, my sense of that part of things which when ... afterwards when I was processing around the ... what I was hearing about domestic abuse and violence, part of what I was processing was those angry outbursts weren't presented as necessarily relating to arguing. It was somewhat the stimuli. So my ... was that if there was a lot of noise and chaos in the household or if they were trying to look at documents or papers and work things out that he would ... that he would become frustrated and he'd bang the table..

Q. Did you get any sense that the relationship between Lionel Desmond and Shanna Desmond was strained in any way?

A. Yes. Yes, that it was strained and that they were having some conflict. But, like I said, it wasn't necessarily related to that angry outburst.

Q. So I'll ask my question another way.

A. Yeah.

Q. So you recognize that the relationship was strained. There was some conflict ...

A. Uh-huh.

Q. ... and it was directly as it relates to her. And when he left the ER, he was ... she was sort of the manager, as you say, about his ...

A. Right.

Q. ... connecting and support. Did that cause you any concern about the viability of that plan?

A. It did not because he was still very much a part of the intervention, the assessment, and the conversation in the Emergency Room. It wasn't just her. I would have ... for example, if I gave that card with the phone number ... I always give it to the individual who's there for assessment or who is in crisis. Sometimes give another one to the family or get them to write it down separately kind of thing. It's always ... the plan is always made with the individual. I would say it just

... she was seeking help for him, as well. So she was sort of a partner in it, I guess, at that time.

Q. Did you get any indication that he was having difficulties, you know, personally trying to navigate the system of care, trying to get help and was having a difficult time doing it?

A. I just recall that he ... yes, that he said he was feeling frustration and having, yes, difficulty with ...

Q. So was Dr. Slayter present during your assessment?

A. So I would have done ... I would have had a conversation with them and done my assessment, again not necessarily the documentation of the assessment, but done the assessment. And then I would have called Dr. Slayter when I knew I was going to need some support with something that I could not provide.

Q. And did you have an opportunity to sort of share what you had found out about Lionel Desmond, and his circumstances, with Dr. Slayter?

A. Yes. I would always, whether it was on the phone or when he arrived would depend. It's usually a little bit of both. So I would call him, give him a brief rundown and then when he arrived in the Emergency Room, I would speak with him

again. And then we would go in together to see the person.

EXHIBIT P-000113 - CRISIS RESPONSE SERVICE MENTAL HEALTH/RISK ASSESSMENT

Q. And, finally, I'm just going to show you a document, Exhibit 113. It says, "Crisis Response Service Mental Health/Risk Assessment". Do you recognize that document?

A. Yes.

Q. Is that the new form you're referring to?

A. Yes.

Q. And is it different in substance at all from the old form?

A. I'd have to compare them side by side to really know for sure. I believe there are some differences as far as space and organization.

Q. I noticed if we look to the last page of that form, page six, it seems to indicate the treatment plan off to the left and it sort of spells out what the treatment plan is, "Referrals completed" ...

A. Uh-huh.

Q. "Physician involvement". Is that something that's new compared to the old form?

A. That page is new. Yeah.

Q. Where it says "Other - Reviewed home safety, weapons, dangerous objects", is that something that's new, as well?

A. This page is new.

Q. The whole page.

A. Yeah.

Q. Okay. No further questions, Your Honour.

EXAMINATION BY THE COURT

THE COURT: Ms. Wheaton, just before I call on counsel, I have a question. If you could look ... it's Exhibit 67 and it was the last ... page ten, right at the bottom of the page.

A. Mm-hmm.

Q. Left-hand side, there's a field there that says, "Sent To" and it gives you a variety of people or locations that you can send that to.

A. Oh, sorry. Uh-huh.

Q. And so one of the boxes says, "Family Physician".

A. Uh-huh.

Q. It includes a variety of others, Child Youth and Mental Health, can go to them. Adult Outpatient Services, Inpatient Mental Health Services, Addiction Services, family

physician. So if you would not normally send it to a family physician, if it was ... what would be the purpose of the box? If you're not making ...

A. Just ...

Q. If you're not making decisions about sending it to people.

A. Yeah. So sometimes it might be sent to people. In this situation, when Dr. Slayter saw and made changes to treatment, that information would have been sent to the Emergency Room ... I mean ...

Q. Oh!

A. ... to the family physician from ...

Q. So that's for him as much as it is for you then?

A. No. I probably could have ... should have checked that off, I suppose. It's just that I wasn't physically the one doing it so, therefore, it didn't prompt me. So when Dr. Slayter came to ... and often when a psychiatrist comes to the Emergency Room, when they do their piece, they ... so back in 2016, electronically we didn't have access to these ... this part of their Emergency Room visit. So back then if Dr. Slayter came to the Emergency Room and saw somebody and there was a chance they were going to come to the Outpatient Department or

they were going to come and see him or a therapist he would take the information to the Outpatient Department. So I wouldn't be sending it there.

Q. Oh, I see.

A. And, likewise, if there ... somebody is in the Emergency Room and a physician writes on the Emergency Room record that there was a visit and a plan and things happened, then that information is sent, but not by me, to the family physician.

Q. Right.

A. Yeah.

Q. Thank you.

A. Yeah.

THE COURT: Ms. Grant?

MS. GRANT: Thank you.

CROSS-EXAMINATION BY MS. GRANT

MS. GRANT: Ms. Wheaton, my name is Melissa Grant and I'm representing the Attorney General of Canada in this matter and the various several entities that Lionel Desmond had interaction with.

Earlier, you said that typically you might review some documents that you had prior to seeing someone in the ER.

A. Uh-huh.

Q. Okay. So you said that you might review some records before you see someone. So I just ... I'm asking you to think about a typical day in your life. So at any given time the ER is a busy place. Correct?

A. Uh-huh.

Q. And might you have more than one person waiting to be seen?

A. Yes.

Q. And those people would be because you're involved in a mental health crisis situation.

A. Yes.

Q. And part of what you were explaining earlier is that you don't only assess but that part of your job is to intervene and so that if there's somebody in crisis who is suicidal, you want to try to stop that from happening.

A. Yes.

Q. So is it fair to say you want to see people as quickly as you can?

A. Yes.

Q. So you also mentioned earlier that, generally speaking, you don't have an ongoing therapeutic relationship with patients.

A. Correct.

Q. So in light of all that, I want you to consider a situation where you have unlimited access to records. So my friend was asking you a lot of questions about the kind of records that you have available, kind of records that are not available. So you have access to family physician records, you have access to every hospital that a person went to, every private therapist that they went to. Practically and realistically in your job on a daily basis, how much time could you devote to reviewing those records before seeing a person in the ER?

A. Timewise, I suppose I could choose how much time I wanted to spend at the expense, perhaps, of somebody waiting longer. Practically, if I had at my disposal all of that information, I would likely only look at recent contacts and that's because my role in the Emergency Room is very much crisis intervention in the here and now and sort of making plans for where to go from here but not to do a full sort of historical review of records. Yeah.

Q. Thank you. Those are all my questions.

THE COURT: Thank you. Ms. Lunn?

MS. LUNN: No questions for this witness, Your Honour.

THE COURT: Okay. I've lost my order now. Mr. Macdonald? Sorry.

MR. MACDONALD: Thank you, Your Honour.

CROSS-EXAMINATION BY MR. MACDONALD

MR. MACDONALD: Good afternoon, Ms. Wheaton. So my name is Tom Macdonald. I'm the lawyer for Shanna Desmond's mother and father, Ricky and Thelma Borden, her brother Sheldon Borden, and share co-counsel with Ms. Miller of Aaliyah Desmond.

Have you ever discussed this matter with Dr. Rahman? This matter being what I'll call the "Borden incident".

A. I think he might have been the person who first told me after it had happened. My recollection is vague but I think he might have been but ...

Q. So that would have been in 2017?

A. Yes. After ... yeah.

Q. Since then, have you ever discussed the matter with him?

A. Not really, other than in passing, Are you going to the Inquiry, that kind of thing. I don't see him on a regular basis.

Q. When is the last time you would have had the short "not really" conversation?

A. Maybe a couple of weeks ago just in ... and I think it was ... or I think it was something about the weather delaying the Inquiry or something like that.

Q. So ...

A. It wasn't ... sorry. Go ahead.

Q. No, no. So did you have any substantive discussion with him ever about the evidence that he would give at the Inquiry?

A. Oh, about that? No.

Q. Okay. Never?

A. I don't see him. No.

Q. Okay. Did you know Shanna Desmond?

A. No.

Q. So you know that she trained ... or went to university at St. FX for Nursing?

A. I think I've heard that now ... Now I know she was in Nursing but ...

Q. Yes.

A. ... I didn't know then.

Q. So would you ever have encountered nursing students ... or do you ... from St. FX in your job? Do they ever rotate through you for a day of training, a practicum? Do you ...

A. Yes, they do.

Q. ... ever give a lecture or anything like that?

A. They do rotate through sometimes and spend time.

Q. Do you know whether she ever rotated through with you?

A. I had never met her before.

Q. Okay.

A. Yeah.

Q. On the form ... I don't know that we need to go to it, the one that Mr. Russell was taking you through. And that's the one you filled out on October 24th. There is a section about confidentiality and that's the duty to report. Do you know ...

A. Uh-huh.

Q. ... the section I'm talking about? Can you explain to the Inquiry what the "duty to report" means?

A. So I can breach or share confidential health information about a person if there's an imminent risk to themselves or another person and the information sharing would

result in increasing safety.

Q. So are you speaking about contacting RCMP, for example?

A. It could be contacting RCMP or could be contacting even a family member. If an 18-year-old is there and they have, you know, moderate to high risk and they're talking about suicide, I would tell their person, whoever that might be, or people that are close to them, if it would help increase their safety.

Q. So given it's the 18-year-old example ...

A. Just ...

Q. ... what other triggers are there for you when you're interviewing someone in the ER who is in crisis? Just let me finish the question, please.

A. Uh-huh.

Q. ... who is in crisis. What are the triggers that would compel you to report?

A. Report ...

Q. In terms of the confidentiality box on the suicide risk assessment form.

A. Are you asking, though, report ... you mentioned RCMP. Do you mean ...

Q. Well ...

A. ... specifically to RCMP or just ...

Q. ... report to anyone.

A. To anyone? Yeah. If there was ...

Q. Just let me rephrase my question, please.

A. Uh-huh.

Q. So I'm talking about the box that you fill out in 2016, but also there's a new form today.

A. Uh-huh.

Q. So that part of the form that deals with reporting ...

A. Uh-huh.

Q. ... what are the triggers that would cause you to report?

A. Imminent risk to ... of harm to self or others.

Q. Okay. So based on something somebody tells you when you're intervening with them?

A. It could be based on something that they tell me or it could be based on something that they tell me combined with other risk factors.

Q. Any other triggers?

A. I don't think so. If I understand your question correctly, I don't think.

Q. So is there a part of the question you don't understand, though, ma'am?

A. No. I think I understand it but ...

Q. Okay. When you met with the Desmonds on October 24th, 2016, Shanna Desmond didn't tell you she was abusing Lionel, did she?

A. No.

Q. And Lionel didn't tell you that Shanna was abusing him, did he?

A. No.

Q. And you didn't fill out any report that either of them were abusing one another on that day, did you?

A. No.

Q. So, ma'am, when, earlier this morning in response to Mr. Russell, you made a comment that when you heard the news ... and tell me if I'm phrasing it incorrectly. When you heard the news, you thought which one was the abuser or who was the abuser. Do you remember making that statement ...

A. Correct.

Q. ... this morning?

A. Yes. Yeah.

Q. You don't have any evidence to support that statement,

do you, that Shanna could be the abuser somehow?

A. No, but keeping in mind that was back then when all I really knew of him or her was from that one-hour interaction in the emergency room. And I ... so when I was hearing about domestic violence or domestic abuse, part of my job is to not make assumptions and not assume. And men do ... are victims of intimate relationship abuse and violence. So I just remember having a thought about, I wonder what that's about? Who was abused? Was it a physical violence? I didn't know. I didn't have that information.

Q. So three years later, today, you have a lot more information.

A. Yes, of course. Yes.

Q. Yeah. So why ...

A. Yes.

Q. ... did you make that statement this morning?

A. Because I think somebody had ... I don't recall exactly, but I think somebody had asked me what my thoughts were or what my ... at the time or if I had any thoughts once I found out what happened or if I changed anything about what I do. So I was just sharing my thoughts at the time.

Q. So that we're clear though, today, you have no

evidence that Shanna ever abused ...

A. No.

Q. ... Lionel, do you?

A. No, I do not. No.

Q. No. Thank you very much. Those are my questions.

THE COURT: Yeah. And I believe ...

A. I'm sorry.

THE COURT: ... the witness is correct. You were asked about your thoughts, not about ...

A. That was ...

THE COURT: ... what you might have as evidence.

A. Right.

THE COURT: It was what ...

A. What ...

THE COURT: ... hearing of the event caused you to ...

A. Yes.

THE COURT: ... consider, for whatever reason it came up ...

A. Yes.

THE COURT: ... in your own thinking.

A. I guess.

THE COURT: Yeah. Thank you

A. Yeah.

THE COURT: Ms. Bennett? Who's next?

MR. ROGERS: I think that would be our witness usually going last, Your Honour. So I think we would be bouncing to Ms. Miller, if I'm recalling the order.

THE COURT: All right. Ms. Miller?

CROSS-EXAMINATION BY MS. MILLER

MS. MILLER: Ms. Wheaton, my name is Tara Miller. As you've heard, I'm the lawyer representing Brenda Desmond, through her personal representative, and also sharing representation with Mr. Macdonald of Aaliyah Desmond.

I just want to start with some questions about your charting. Mr. Russell covered in detail the intake sheet or the crisis sheet that you would have completed on October 24, 2016. I'm a little ... I'm not clear on when Dr. Slayter would have joined you and what role he would have played during that assessment. We know from your notes that you started the assessment around 3:30 and that you indicate you stopped around 4:30. Dr. Slayter, did he complete any part of this document, the crisis assessment?

A. No. He doesn't document on that document.

Q. Does he document somewhere else?

A. He would document somewhere else.

Q. He would ... there should be records or ... of him having documented his interaction that day somewhere else?

A. He would document what he ... if there was anything that he wanted to add or clarify or anything that he specifically was doing on the Emergency Room record, I think.

Q. Okay. Would he have come in at some point during that hour or would he have come in at 4:30 ... or, sorry, 3... 4:30, yes, when you left?

A. So in this situation, I stayed. So I'm guessing that the time ... if you're wondering about the time, I'm guessing that that time was when we both completed.

Q. So the time that you're guessing in terms of you both completed ...

A. So like 4- ...

Q. ... would be 16:30?

A. 16:30. Yeah.

Q. So 4:30?

A. Yeah.

Q. So he would have come into the room at some point

after you started at 3:30 and you're ...

A. Yes.

Q. You're guessing that it's 4:30 you both would have left the room.

A. Yes.

Q. Okay. You noted that ... well, you did check off suicidal ideation and you explained to Mr. Russell that that was because Lionel would have indicated having passive thoughts about killing himself but without an intent or a plan.

A. Yes.

Q. I mean you didn't chart the specifics of that. Did that indication that he had had passive thoughts trigger any kind of questions about access to lethal weapons which would have included a gun?

A. I actually don't recall specifically in this situation. Usually it is something, but without having documented it, I can't say with certainty. Yeah.

Q. Is it your practice if someone says ... if you do ask about access to guns and they tell you ...

A. Yes.

Q. ... they either have them or they were taken away or they still have guns, would it be your practice typically, if

you asked about it, to record that detail?

A. Typically, yes. Yeah. Yeah.

Q. And so is it reasonable to infer or assume, Ms. Wheaton, that because there is no detail about guns in your crisis assessment of that day that you likely didn't ask about that?

A. I would say yes except there is ... where the assessment was low risk and his ideation was passive, if I had have asked if there were guns in the home and they had said no, I might not have documented the ... like the absence of that being ... yeah.

Q. If ... and I appreciate that you're casting your mind back and ...

A. Yeah.

Q. ... guessing what you might have done. But if it had been shared with you by either Corporal Desmond or Shanna that there had been guns and the guns had actually been removed by the police because of mental health concerns within the last 12 months, would that have been something that you would have noted?

A. I would have documented that.

Q. Yeah. And ...

A. Yeah.

Q. ... would that have ... something that would have played a relevant criteria in assessing the risk?

A. Not necessarily because, again, the suicide risk that we're assessing there is in the now, sort of. It's more about right now, so not what happened previously. And, always, we would be looking at trying to modify risk factors. Even for somebody who is low risk, we'd be looking at that, knowing that that had happened. Now if it was yesterday, maybe. I certainly would delve into it a little bit more. But if it had have been months previous, I don't know that it would have affected the low risk assessment in that moment.

Q. One of the changes ... and I appreciate you weren't taken through the changes between ...

A. Yeah.

Q. ... old risk assessment and the new one that came out in the summer of 2017. I believe it's Exhibit 105. But we do know from earlier evidence, one of the changes in that risk assessment tool is a specific reference to canvassing whether or not the patient has access to lethal weapons.

A. Okay.

Q. Do you know ... do you know or are aware that that is

a specific change in terms of what was in place then and now?

A. No, because I would have had familiarity with a form very similar to the new one when I worked in Capital Health.

Q. Okay.

A. So it would always be in my mind.

Q. But you'd agree it would be helpful in terms of going through checklists if there's a specific reference to canvassing presence of lethal weapons and/or guns.

A. Particularly helpful as far as documentation.

Q. Yes.

A. Yeah.

Q. Okay. You were asked questions about your charting and specifically about recording detail, the specifics of the detail of the incident that Corporal Desmond and Shanna relayed to you around his angry outburst and hitting the table and the fact that Aaliyah was present for that. And you indicated that that would have triggered a conversation with you with the couple about making sure things like that didn't happen and a plan for preventing that.

A. Yes. And I ...

Q. Was that because of the fact that Aaliyah was present during that outburst and experienced and viewed that or it's

just the general nature of that?

A. Probably would have ... it would have been a little bit more a conversation about it because there was a child present. He was not able to make ... yeah ...

Q. So it would have been more ...

A. ... decisions.

Q. ... concerning, the situation that was ...

A. Yes.

Q. ... described to you because it was not just two adults but it included a child.

A. Yes.

Q. Okay.

A. Yes.

Q. You were asked about why you wouldn't have included the specifics of that encounter.

A. Right.

Q. And as I understand your evidence, it effectively was that you noted that there had been some conflict but you wrote that down as a trigger for other people. You would expect them ... other people that he would be seeing would or should be doing their own assessment, anyway, and they would drill down further with respect to that detail?

A. Yes. And because, after reviewing it, I didn't have, in that moment, any concerns about safety for Aaliyah particularly because there was nothing to indicate that her mother wasn't able to protect. And there was a sense of her doing that and her recognizing that that was important. So, yeah. So I wouldn't document every single thing. Yeah. So ...

Q. Could you see some value, Ms. Wheaton, in ... particularly when there's a child involved in recording those types of details when you're trying to address and identify some indications of potential domestic intimate partner violence? And particularly in the case where you're trying to build something that other clinicians down the road can use as a benchmark to track changes and see if things are escalating to see if the severity is increasing, intensity, the frequency of that kind of behaviour is increasing? Would you agree that it would be helpful to have captured that detail around that particular incident involving Aaliyah so that future clinicians would have that as a benchmark for tracking any kind of escalation?

A. Just give me a moment just to ...

Q. Yeah.

A. As a benchmark for tracking any ... Actually, I don't

know if it would be or it wouldn't be.

Q. Okay.

A. Really, again, there's a sense of when a ... more detail isn't necessarily always helpful. A person should do their own assessment of a situation. Then they think ... and could even ask about what was going on at that time. I'm not sure. I really don't know.

Q. I appreciate that your charting is not meant to be, again, a verbatim transcript of what happened.

A. Yeah.

Q. So that's why I'm focusing specifically in on things that involve children ...

A. On ... okay. Children.

Q. ... and domestic violence and harm around partners and children.

A. Yes.

Q. So I'm not suggesting this level of charting for other things, but particularly around that issue, when other clinicians may pick up this record and be delving in on their own but not having the contemporaneous benefit of your charting around the details that would establish a benchmark at that time, in October, for what was going on. Do you think there

would be some value, you know, in the context of a domestic piece?

A. I'm conscious that I say "I'm contrary", but I don't know. I have to think about it a little bit in reverse. If I was seeing somebody and there was something. I'm not sure. Child safety, in the moment, is either ... there's a confidence that there is some safety or there's not that confidence. And so I'm not sure how sort of tracking it would be helpful.

Q. Would you agree with me, though, that, you know, domestic violence involving partners and children is never a one-off. There's usually a ...

A. No, that's true. Yes.

Q. ... progression, an escalation, a deterioration.

A. That's right. Yes.

Q. And so we can't just look at one episode in isolation.

A. Right.

Q. And what may have been initially not a real safety concern, but taken in a total picture over a course of several months, to track the change in behaviour, the frequency of behaviour, the escalation. If that could be helpful.

A. So I guess possibly if what the person is assessing for is for an escalation of domestic violence, but when I'm

doing that assessment in the emergency room, the focus is on psychiatry and risk, not necessarily "let's look at creating a benchmark to see if" ... yeah. So I don't know.

Q. But you're looking at risk and psychiatry.

A. Yes.

Q. But I also understood you're looking at harm to self or others.

A. In the moment. Is there a risk of harm to self or others?

Q. In the moment.

A. Yeah.

Q. And if we're looking at accessing records, you know, collectively, to get a better picture of what's going on in a situation, which I think you've agreed, it would be helpful to have some access to those other sort of contemporaneous records.

That was my point, that with respect to the evolution and deterioration of behaviour around domestic violence, it would be helpful to have more specifics of incidents that you noted, at least in a very broad way, in your assessment form involving a child.

A. Mm-hmm. Somebody might find that helpful. Yeah.

Q. Okay. The intake form on page 9 also talks about

recent past suicide attempts. That is under "Individual Risk Profile". That's on page 9 of Exhibit 67.

A. Yes.

Q. What would qualify, in your clinical experience, as a recent past suicide attempt? Would that be an actual attempt or a threat of an attempt?

A. An actual attempt.

Q. Okay. So if someone had threatened to commit suicide within the last year, that would not have caused you to mark that off. Okay.

"Mental illness and addiction" is also listed on "Individual Risk Profile".

A. Yes.

Q. "Addiction" is self-evident, but "mental illness", does PTSD qualify?

A. It does, yes, and they probably should've checked that off.

Q. And the other question I had about this sheet was "clinical intuition" which is under "Interview Risk Profile".

A. Mm-hmm.

Q. Can you describe for us what "clinical intuition" is?

A. So I believe that is there partly to encompass

situations that maybe people have alluded to in which there may be a perception on the clinician's part that there's something not being said, something not being disclosed, for example. Or there's just ... there might not be a lot of checkmarks or a lot of things to check off, but there's just a gut feeling based on, yeah, experience.

Q. So it's not really a clinical definition, it's more like a "spidey sense" or an intuition that there might be something else.

A. It is, but built on clinical experience of ... yeah.

Q. Mr. Russell was asking you about the reality of how people present to you versus how they may present when the psychiatrist comes in.

A. Mm-hmm.

Q. And I think you said that usually what happens, if the difference in presentation is more in manner and demeanour versus the content, that they would present differently with you as the initial person they interact with about ... how their mannerism, their demeanour versus the information that they give you.

A. Yes.

Q. In your experience, has a patient ever told a doctor

more than they share with you when the doctor comes into the room?

A. If the doctor asks different questions, you know, than maybe I have asked. And, I mean, like when you're asking questions of me today, I may expand on something if somebody else asks it. So in that sense, yes.

Q. Okay.

A. Not so much in a ... not necessarily in an intentional sense. But there's lots of things that factor into that. So, you know, about the change in demeanour. It could that their ... they've settled somewhat after talking out things and so they have less to say.

Q. Okay. With respect to Lionel Desmond, you told us earlier that, you know, you would've started this intake assessment and then Dr. Slayter came to join you within that hour. What was your sense? Did Lionel's manner and demeanour change when Dr. Slayter came into the room?

A. So it does say "crisis assessment".

Q. Sorry.

A. There is something called an ... and it's a different document.

Q. Sorry, I apologize. Yeah. "Crisis assessment".

A. Yeah. But, yeah, I don't really have ...

Q. A memory of it?

A. No, I don't.

Q. So you can't say whether his demeanour and manner changed when Dr. Slayter came into the room?

A. I don't recall that.

Q. And you don't recall, is it fair to say, if he offered any new information to Dr. Slayter when he came into the room?

A. I don't recall that, no.

Q. Is it fair to say that if he did offer new information and you observed a change of his mental presentation, you would've ...

A. I would've ...

Q. ... noted that in your crisis assessment?

A. Yes.

Q. Okay.

A. Yes.

Q. I want to also go into Exhibit 67. I'm going to take you to page 22 of that. And this is an Emergency Room visit and this is from December 1st, 2016. So we know that after seeing you on the 24th, Lionel came back into the Emergency Room on December 1st.

And as I understand your evidence and evidence of others before you, at that time the crisis team at St. Martha's was effectively you?

A. Mm-hmm.

Q. And you worked from 8:30 to 4:30, taking the last referral at 4:00?

A. I think at that time, yes.

Q. And that would only have been Monday through Friday. Not holidays, not weekends?

A. Correct.

Q. And not after hours, obviously.

A. Yeah.

Q. Okay. So this is a December 1st ER form, and we know from the calendar that December 1st is a Thursday. So is it reasonable to assume that this would've been a day that the crisis intake ... the crisis assessment team ... sorry.

A. That's okay.

Q. The crisis assessment team, i.e. you ...

A. Yeah.

Q. ... would've been present to provide that service?

A. Yes. Unless I ... I can't speak to whether or not I was off ill or anything like that, but, yeah.

Q. We can see here that Lionel registered 11:28. The triage time is noted at 11:44 and it looks like at 3:10, he's no longer in the waiting area. So we don't have a sense of when he would've left, but I take it from this, should this have triggered, if you were working that day, should this have triggered a referral to your crisis assessment? Because this wasn't a point in time where an ER physician had to see the person.

A. Yeah. Unless by December, they did. I actually am not sure when that piece of things changed as far as the Emergency Room physician having to see somebody prior to consult. I'm not exactly sure when that changed.

Q. Okay. Assuming it hadn't changed by December 1st of 2016.

A. Yes. I would've expected somebody would've called us but I don't ...

Q. Okay.

A. Yeah. I can't ... I don't know what the ...

Q. And you don't know if you were working that day, but if you were working that day, you don't know if you received a call.

A. Or if I was already seeing people in the ER. I don't

know.

Q. So we see a handwritten note. It says, "15:10. Not in waiting area" with some sort of initial there. Do you have any sense of who would've been responsible? Would that have been you who would've gone into the Emergency Room to call Lionel?

A. No, that's not ...

Q. No, that's not you.

A. No. I ...

Q. Okay, and you don't know who that is?

A. No.

Q. Okay. But in any event, there's no evidence that he was seen by you on that day.

A. He was not seen by me on that day.

Q. No, okay.

A. No.

Q. But based on what you've explained to us in terms of the role of the crisis team is that if you had been working, it would've been reasonable to expect that he would've ended up back with you on that day.

A. I would expect that.

Q. And you may not know the answer to this, Mrs. Wheaton,

but how often is it that people leave the Emergency Room for mental health issues when they're waiting?

A. I ...

Q. You don't know?

A. I really wouldn't know. My sense is not often. I have a sense that, or a thought that, if that happened, they'd tell us or, you know, somebody in the Emergency Room mentions it to us. There's not very many days that we're not there seeing somebody, but I really don't know for sure. I don't.

Q. Okay.

A. Yeah.

Q. Is there any follow-up that happens when someone comes to the Emergency Room? They're noted to be there for a mental health issue but then they're not there when someone goes to gather them for further treatment?

A. I can't speak to what their processes or procedures are. Like I'm not sure if there's something standard.

Q. Okay.

A. Yeah. I'm not sure.

Q. I'm going to follow-up on a question that His Honour asked you and it was with respect to the new suicide assessment risk tool, and follow-up seems to really only be triggered if

somebody is rated as a moderate or severe suicide risk in terms of providing a management plan.

A. No, that's not true.

Q. Well, I'm just going to ...

A. Sorry.

Q. Yeah.

A. The policy states that it must be.

Q. Right.

A. But we do ... anytime we see somebody in crisis in the Emergency Department, there is some type of plan.

Q. Fair enough.

A. Yeah.

Q. But there's more significant follow-up when somebody has been classified as a moderate or severe risk of suicide. I think you said most people who are severe are actually admitted.

A. Most people who have high risk are admitted. Most, yeah.

Q. Yeah.

A. Yeah.

Q. And the moderate risks, that could be either/or, but there ...

A. Could be either/or depending, yeah.

Q. There's usually a plan put in place.

A. There would be, yes.

Q. Yeah.

A. And the policy would dictate that. Basically, we'd document what that is.

Q. Yeah.

A. Yeah.

Q. And maybe if we can bring up Exhibit 105 because there was one thing I wanted to take you to. There's the last page of that document which is the suicide risk assessment and intervention tool under "Management Plan". It's on the right-hand corner at the very bottom. It says, "Removal of lethal means as part of the management plan." Can you explain for us, first of all, what that means, and then what would trigger, under a management plan, to remove lethal means?

A. So if somebody had access to lethal means. Gun. Oftentimes, it's medication. And, basically, in the situation where part of the management plan was to remove lethal means, then we would check off there that it was. Again, this is a documentation that ...

Q. To confirm that that's been addressed and actioned?

A. Yes.

Q. I thought you had said to His Honour that everybody is effectively a low risk for suicide?

A. Everybody we see, yes.

Q. Everybody you see?

A. Yeah.

Q. And depending on the risk assessment categorizes them into the different categories of moderate or high risk?

A. Mm-hmm.

Q. But my thought was that, you know, Lionel as a military veteran, we certainly know from the statistics that he's at a greater risk of suicide just by virtue of that group that he's in as a military veteran, would you agree with me in that?

A. Yes.

Q. And the fact that he had had three ER visits within two and a half months. He was at the ER on October 24th, he was at the ER on December 1st, and he was at the ER on January 1st, 2017. I think your evidence was there's obviously an increased risk for people who have multiple presentations in hospital so ...

A. It's a risk factor, yes.

Q. That's a factor?

A. Yes.

Q. An increased risk?

A. Yes.

Q. So three visits to the ER within a two and a half month period, that's an increased risk as well?

A. It's a risk factor, yes.

Q. It's a risk factor. And the fact that he had PTSD on top of all that, that's another risk factor?

A. Yes.

Q. And then you are able to look at the totality of what was going on over that two and a half month period from October 24th ...

A. Yes.

Q. ... to January 1st?

A. Yes.

Q. So further, of course, the helpfulness of clinicians such as yourself, mental health workers, having access to a complete and total picture of what was going on in that two and a half month period would have been valuable?

A. Well, knowing that he had attended the Emergency Room, which I think that information was available or that he was diagnosed with PTSD and I think that information was available.

Q. We heard from Dr. Slayter yesterday that even though Lionel had attended the Emergency Room on December 1st, he didn't believe he would have known that because it wouldn't have been scanned into the records by the time he saw him for the intake consult?

A. Oh, in his office?

Q. So there appears to be some gaps in those people at St. Martha's who are seeing him on the ground in the moment certainly by January 1st, he had been there three times in the Emergency Room, and you're without a complete picture with record sharing of what was going on, how he was presenting, and it isn't something you need to necessarily comment on but you saw him at the front end of that.

A. Yeah, it was my understanding that everybody along the way knew he was diagnosed with PTSD. How they came to know that might have been through his verbal, you know, but ...

Q. But not knowing what other treatment he was receiving privately through that period of time, these are all things that we've talked about and there are silos of information as His Honour said.

A. Correct.

Q. All right. Thank you, Ms. Wheaton, those are my

questions. I appreciate you time.

A. Okay.

THE COURT: Mr. Rodgers?

CROSS-EXAMINATION BY MR. RODGERS

MR. RODGERS: Thank you, Your Honour. Ms. Wheaton, I'm Adam Rodgers and I'm representing Corporal Lionel Desmond through his personal representative. I just have a few questions, my colleagues have been good and thorough with your questions. First, I see according to your *CV* you've got lots of experience in this field, in mental health crisis work identification through the Nova Scotia Hospital, Capital Health, and now St. Martha's. So I guess I wanted to ask you, during that time you would have seen hundreds or maybe thousands of people in a mental health crisis or presenting as a potential mental health crisis?

A. I would have seen a lot, yes. I don't know the numbers.

Q. During that time can you think of ... has there been other situations where you've seen somebody and then within the next few months they've committed a homicide?

A. No.

Q. This is the first one, same as Dr. Slayter. I had 40 years he said.

A. More than.

Q. Yes. I wanted to ask you, Ms. Wheaton, about particular training you have. I see on your *CV* and there's lots of continuing education and education earlier than that, but I don't see anything but I'll ask you about training particular to military personnel and military veterans and their potential idiosyncracies or distinctiveness in terms of mental health.

A. No specific training, no.

Q. Is that something that has been available and you've not done it or just hasn't been presented to you as an option for continuing education?

A. I don't recall it ever being presented to me as an option.

Q. You may be particularly now but is it something as you reflect on this incident and this scenario that you think might be helpful to people in mental health crisis positions?

A. Again, I would never say no to more education or to being offered information but in the moment in assessing crisis and in recognizing that PTSD is a risk factor, I'm not sure how

having more information would necessarily make a difference in the moment to that sort of assessment in the moment but I'm not sure if it would.

Q. Can you think of any other professions, RCMP officers, first responders, and many others who have PTSD ...

A. Yeah.

Q. ... or potentially present with PTSD, are there things that you can think of from a military perspective or military personnel from their mental health that might form part of an educational program particular to their mental health idiosyncracies?

A. So I think if I were a practitioner who was going to be seeing somebody who had PTSD related to combat-type experience and I was going to be seeing them in a role of providing some therapy and some ongoing, then I might be looking for that kind of education and looking for that.

Q. Just thinking you're the frontline and, you know, you're seeing whoever comes through the door, there's going to be military veterans occasionally coming through there, I'm just wondering if there were other particular things that you might see as valuable to learn about their circumstances?

A. Again, I don't want to say that I don't wish to learn

more about what people might be struggling with, lots of different issues including that or lots of different things people have experienced that I don't have first-hand knowledge of, but I think a lot of the ... for my role in what I do, a lot of the symptoms of PTSD are similar or the same and in a crisis, our approach to trying to support people with a reduction of those symptoms or a resolution of crisis, I don't know that more information would be helpful. I wouldn't say no to it if it was given to me but I don't know that it would be ...

MR. RODGERS: Thank you. Those are all the questions I have for you.

THE COURT: Mr. Rogers or Ms. Bennett-Clayton or no, Mr. Hayne, sorry, I'll go to Mr. Hayne.

MR. HAYNE: Thank you but no questions, Your Honour.

THE COURT: Thank you.

MS. BENNETT-CLAYTON: No questions, Your Honour.

THE COURT: Thank you. I have some questions but I think they'd be probably be better put to another witness.

A. Okay.

THE COURT: Mr. Russell, do you have any follow-up questions?

MR. RUSSELL: Nothing in follow-up re-direct, Your Honour.

THE COURT: All right, thank you very much. Ms. Wheaton, thank you for your time, we appreciate you being here today and the other day as well.

A. Thank you.

THE COURT: So you're free to go.

WITNESS WITHDREW (15:24 HRS)

THE COURT: Mr. Murray or Mr. Russell, do you have another witness?

MR. RUSSELL: We do, Your Honour, yes, Nurse Lee Anne Watt. Her former name was Graham, Your Honour, I'm going to clarify that.

THE COURT: All right, thank you.

LEE ANNE WATTS, affirmed, testified:

DIRECT EXAMINATION

MR. RUSSELL: Good afternoon, Ms. Watt, is it?

A. Watts.

Q. Watts with an "s"?

A. Yes.

Q. I apologize.

A. Okay.

THE COURT: Ms. Watts, if we were to look at your name in some of the documents, would it be Watts or would it be?

A. Graham.

THE COURT: Graham?

A. Lee Anne Graham, yeah.

THE COURT: And your first name, I'm sorry?

A. Lee Anne.

THE COURT: Lee Anne? Thank you, Ms. Watts.

MR. RUSSELL: Just to help you out there, anything we present will be either on the screen in front of you or in the binder so you can look at either.

I'm going to start by just asking a little bit about your

background so what is your full name?

A. Lee Anne Marie Watts.

Q. And what is your occupation?

A. I'm a Registered Nurse.

Q. And how long have you been a nurse?

A. For four years.

Q. So you would have graduated 2000-?

A. 15.

Q. Thank you. And your career as a nurse, what sort of departments have you worked in?

A. So I was ... my whole time as a nurse I've been at St. Martha's. I started in what was called the float pool so I was a float nurse for about two and a half years and now I'm currently working in the Emergency Department for about a year and a half.

Q. So what exactly is a float nurse?

A. So a float nurse is basically you float to different units in the hospital kind of where the need may be for that specific shift. So as float nurses, we would call in before every shift to see where we are basically.

Q. So January 1, 2017 which sort of position did you hold, I guess, or which units did you work on? Were you a float

nurse then?

A. I was a float nurse then. I was only out for about 11 months at that time and so the departments or units I would have floated on would have been the Progressive Care Unit, the Geriatric Rehab Unit, Stroke Med/Surg Unit and the Observation Unit.

Q. And the Observation Unit, I understand, is part of the ER at St. Martha's?

A. Yes, yeah.

Q. We heard earlier, and you wouldn't have had the benefit of it, but Dr. Clark talked about physicians have to do a sort of training or an orientation prior to, the newer physicians anyway, before they can work in the ER. Is there a similar sort of orientation or training for nurses before they can work in the ER which includes observation?

A. So there would be specific training to the Emergency Department, the actual working on the floor in Emergency, which would be a longer type of orientation that one would get to the Observation Unit.

Q. And during your career and over the four years, have you had any sort of experience or training as it relates to mental health or mental health nursing?

A. Over the last four years?

Q. Yes.

A. Any specific training? I wouldn't say any specific training but there was a mental health education day that I did take part of just this last October so that was kind of a moreso education day rather than training.

Q. So if we go back to January 1st of 2017, you're working in the ER and working in Observation. Outside of sort of your Nursing degree, would you have had any training as it relates to patients with mental health?

A. No.

Q. Do you recall what your normal shifts were around the time of January 1, 2017, so your start and finish, how that worked?

A. So usually 7 to 7, 7 a.m. to 7 p.m, 7 p.m. to 7 a.m.

Q. On January 1st specifically of 2017, do you recall what your shift was?

A. It was 7 p.m. to 7 a.m.

Q. And I just want to sort of touch on this before we really get started. I understand that you have some knowledge, other than what you've heard after this, who Shanna Desmond is?

A. Mm-hmm.

Q. How did you know who Shanna Desmond was?

A. I worked maybe a shift or two with her at St. Martha's.

Q. So and we'll get to the details of you had some involvement in treating Lionel Desmond on January 1, 2017. At that time were you aware that he was married to Shanna Desmond?

A. I can't recall if I knew that at the time or not.

Q. Just a little bit about, and I appreciate that it's been three years, was there anything when you're looking back that stood out that was abnormal or unusual about the flow of the ER or observation on that particular shift of January 1, 2017?

A. I can't recall.

Q. I wonder if we could bring up Exhibit 67 and, in particular, if we could turn to page 33.

THE COURT: Ms. Watts, it's going to come up on the screen in front of you but it's also available to you in the binder if you wanted to look at a paper copy of the same exhibit, it's your choice.

A. Okay.

MR. RUSSELL: So if you see that there, it's an emergency care record, St. Martha's Hospital, it says January 1, 2017?

A. Yes.

Q. Do you recognize what that is?

A. Yes.

Q. And is that in relation to Lionel Desmond's attendance at St. Martha's on that date?

A. Yes.

Q. So I'm just wondering when you're working and prior to your contact or starting your shift on that particular date, would you have reviewed the emergency care records as they were completed, as much as it was completed at the time, prior to starting your shift?

A. I can't say that I specifically remember reading this but that's part of my process is that I do read through the chart and that would be one thing that I would look at.

Q. And you indicated that you were assigned to Observation in the ER?

A. Mm-hmm.

Q. What is Observation in the ER?

A. So the Observation Unit is kind of a four-bed unit that is within the Emergency Department and so patients who are staying as observation, they could be admitted and there's no bed in the hospital for what we call CDU patients, they could be

in that unit with the four beds. And so they are kind of the four beds that are separated by half walls and curtains and so it's in the Emergency Department but kind of enclosed with one nurse that would tend to those patients.

Q. And as a rule is there a limit as to how many patients under observation can be assigned to one particular nurse?

A. My understanding is that it's four, the most I would or somebody would have in the Observation Unit would be four.

Q. And to the best of your recollection on January 1, 2017, if you recall the number that's fine, but did it exceed four patients?

A. I can't recall how many patients I had, no.

Q. And, I guess, what were the most patients you would have had under observation at one time?

A. Four would have been the maximum.

Q. In your entire career?

A. Yes.

Q. So my understanding is you would not have been involved in the triage of Lionel Desmond?

A. No.

Q. So when you're in Observation, do you document times you have contact with a particular patient who is under

observation?

A. Yes.

Q. And are you trained to sort of do that on every interaction?

A. Not necessarily, no.

Q. Is there an importance to documenting time?

A. It just shows at that specific time what was going on with their vital signs or what was happening at that time and then kind of compare from your shift onward back to those times to kind of compare any changes.

Q. And during the course of your time on Observation and with a patient, is there anything in particular you're looking for?

A. It would all depend on why the patient is there so assessments that are pertinent to why they're there, that's basically ...

Q. Is there a set sort of schedule as to how often you may check on a patient?

A. We're expected to check on our patients hourly, that's just a standard for nurses.

Q. And as a rule do you always sort of comply with the hourly?

A. Yeah.

Q. And are there times when you may check up on them more often than hourly?

A. Yeah.

Q. And ...

A. If needed.

Q. All right. And someone that is, well, I guess we'll get into Lionel Desmond in particular. And if you look at page 34, this is a document called emergency care record. What's the purpose behind this particular document?

A. So this document would be what the nurses would, how we would chart, that would be our charting record.

Q. And do you recognize up there it says "Lee Anne Graham", I take it that's your writing?

A. Yes.

Q. And throughout here there's a number of times and a number of things written.

A. Yes.

Q. Would that be your notes?

A. Yes, up until where I have the line and it says L.G.

Q. So just above there's a time, in the margin it says 7:10 and the writing after it, is that your writing?

A. No.

Q. So up until that point it is your handwriting?

A. Correct.

Q. Are there times when a patient is under observation that it's necessary maybe to consult an ER doctor to come back in?

A. So I had mentioned before about CDU so there can be the option of the patient as CDU, which I think stands for clinical decision unit. In that case that means the Emergency physician takes care of the patient while they're there for the whole time. For Observation, like in this case, Dr. Clark had consulted Dr. Rahman and Dr. Rahman held him for observation in his care. So technically when they're in Observation they are under the care of another physician other than the Emergency physician.

Q. So in the case, what was your understanding of why Lionel Desmond was in the hospital that particular evening? I guess how did he ... your understanding of why was he in Observation overnight at St. Martha's?

A. The only thing I remember, just from my memory, was that he had a history of PTSD, that's really all I remember but now I know more as to why he was there.

Q. So if we look at page 33, this is again the emergency care record and you indicated that that's something you would normally review?

A. Mm-hmm.

Q. If we look at the triage assessment in the middle of the page it says: "Patient dealing with PTSD since 2011, had a bad day today, argued with partner, walked a lot to try and calm down, feels he's not coping well, is looking for admission, speaking quietly." Would you have looked at that note the night that you were assigned to Observation with Lionel Desmond?

A. I would have, yes. I don't specifically remember but I would have, it would be part of my practice.

Q. So on that particular evening you would have been aware that was the triage assessment as it related to Lionel Desmond?

A. Yes.

Q. If we could turn to page 34 again. So there's a time that indicates 19:10. I'm wondering if you could read into the record what that note says?

A. So 19:10, "Patient assessed by Dr. Clark."

Q. Is this the first note you made as it relates to Lionel Desmond?

A. It appears to be, yeah.

Q. And 19:10, would this have been your first ... were you present for the assessment done by Dr. Clark as it relates to Lionel Desmond?

A. No.

Q. No? So where did you get the information of patient assessed by Dr. Clark at 19:10?

A. So I could have either seen Dr. Clark go in to assess him at that time or it could have came from the emergency sheet where he charted that he seen him at that time.

Q. So did you have any conversations with Dr. Clark as it related to Lionel Desmond?

A. Not that I can remember.

Q. The next entry is 20:00 hours, I wonder if you could read what that says?

A. So 8 o'clock, "Patient assessed by Dr. Rahman."

Q. And so were you present for the assessment that Dr. Rahman had done with Lionel Desmond?

A. No.

Q. And, again, what I'm wondering is you made the entry of 20:00 hours. What's the significance of the 20:00 hours?

A. So like I said, it could have been when I seen him go

in or I could have realized at that point that he was in the room with him, I'm not sure exactly.

Q. So do you have a recall as to which one it might have been? Was it when ...

A. I don't recall, no.

Q. So the next entry is 20:15 and then you can read in what it says there, what that entry is.

A. So: "Plan to keep patient overnight in Obs. Patient transferred to Obs bed two. Orders received and carried out. Patient settled to bed. Patient calm and cooperative."

Q. So at 20:15, is that when you're made aware of what the plan was?

A. Yes.

Q. And who advises you of what the plan is as relates to Lionel Desmond?

A. In this case I'm not sure, it could have been another nurse or it could have been a physician.

Q. So are you involved in transferring or taking Lionel Desmond to Observation?

A. I can't recall if I was involved in that.

Q. So when do you first sort of ... what's your first involvement with Lionel Desmond?

A. From what I remember or?

Q. Yes.

A. I don't recall really but basing my notes I would have been in Obs bed two where he was and settled ... kind of get him ready for bed or if he needed anything before he went to bed and just kind of do a general assessment.

Q. So it says: "20:15 - plan to keep overnight, transferred to Observation." It says: "Two orders received and carried out. Patient settled to bed. Patient calm and cooperative." So are you able to sort of estimate when you say "patient settled to bed", is that ... are you involved in that, getting him ready for bed and putting him in the bed?

A. Well, I mean he would have been able to ...

Q. Yeah.

A. ... but I would have been in the room. If I say he was settled to bed then I would have been in the room when he was getting ready.

Q. And would that entry, then, be close to that event, I guess, occurring based on your notes, of him getting settled to bed, would that have been close in time to 20:15?

A. I would assume so, yeah.

Q. So you had a description of patient and you're

referring to Lionel Desmond I'm assuming?

A. Mm-hmm.

Q. Calm and cooperative?

A. Mm-hmm.

Q. And is there a particular reason why you would note sort of his disposition when you're having contact?

A. So, in general, with any mental health patients, that's something you would kind of observe, like their behaviour, how they present themselves, and so that was just my general assessment of what I observed of him.

Q. And at that time did there appear to be anything alarming or out of the ordinary with Lionel Desmond?

A. From my notes, no.

Q. And you indicate two orders received and carried out. I guess, first, who gave the orders and; two, what were they?

A. So the 2, it refers to Bed 2.

Q. Okay.

A. Like Obs Bed 2, and so orders received and carried out, so the orders would have been from Dr. Rahman.

Q. So if we could look at page 36, so here we see prescriber's order sheet. This is from the same overall chart from January 1st?

A. Mm-hmm.

Q. And then there's a note here, with a signature. Do you know who made that note?

A. The signature at the bottom?

Q. Yeah, whose signature is that?

A. Dr. Rahman.

Q. And when you refer to orders received, are the orders contained in this note?

A. Yes.

Q. And what were the orders?

A. Did you want me to read them?

Q. I guess or tell us what they were.

A. So the observation, so the patient, "Observation under Dr. Rahman in ER, DAT (is diet as tolerated), AAT (activity as tolerated)."

Q. So I'll stop you right there. So diet as tolerated, what does that mean?

A. Basically, just a regular diet, so he didn't have any restrictions as to sodium or anything like that.

Q. And AAT is what?

A. Activity as tolerated.

Q. And what does that mean?

A. So he could be up and about.

Q. Okay. Maybe continue with the next.

A. "Off unit unaccompanied, routine checks. Prazosin 4 milligrams *p.o.* at *h.s.*, quetiapine 25 milligrams *p.o. t.i.d. p.r.n.*, quetiapine XR 50 milligrams *p.o.* at *h.s.*, trazodone 100 milligrams *p.o.* at *h.s.*, and Tylenol Extra-Strength 1000 milligrams *p.o.* every four to six hours *p.r.n.*

Q. So I guess in terms of the medication, there was sort of instructions as to perhaps when he was to take it?

A. Yes.

Q. And what was that in, I guess, regular terms as opposed to ... What is *p.o.*?

A. So *p.o.* is orally, by mouth. *T.i.d.* would be, like ... So *q.h.s.* would be at bedtime or in the evening.

Q. And *t.i.d.*?

A. *T.i.d.* would be three times a day, and *p.r.n.* is as needed.

Q. So we'll get into the administration of those drugs and when they took place at some point. So back to page 34, so we have a note here from 21:10, what does your note indicate?

A. "Patient up to bathroom, ambulatory, no voiced concerns at present."

Q. So when you indicated no voiced concerns at present, are you interacting with Lionel Desmond or ...

A. For me to have written that, I would have had some sort of interaction, communication with him, but what was said I can't recall.

Q. So I guess it was just almost, is it fair to say it was sort of uneventful, I guess, in the sense that somebody got up, Lionel Desmond got up, went to the washroom, didn't voice any concerns?

A. At that time whatever was said, yes, there was no concerns.

Q. So your next entry occurs, it appears to be a few hours later, at 1:45. It says 00:45, that's 1:45 a.m., 12:45 a.m.?

A. 12:45, yeah.

Q. So what is you entry here?

A. "Patient stating unable to sleep, medicated as per *p.r.n.* orders."

Q. So you made a note of "patient stating unable to sleep".

A. Mm-hmm.

Q. Now is this something that normally ... I guess, do

you recall if Lionel Desmond had initiated that to you or did you initiate that conversation with him?

A. I can't recall.

Q. So normally, I guess, if a patient is sleeping in Observation, as silly as this may seem, do you go in and wake them up and say, How are you doing?

A. No, not if they ... If they appear to be sleeping, I'm not going to wake them up, no.

Q. Or I guess, in another scenario, you do your routine observations, if you go in and they're awake do you sort of just engage them in a conversation?

A. Yeah.

Q. So obviously some sort of conversation must have happened between you and Lionel Desmond at 12:45 a.m.?

A. Yes.

Q. And it was clear to you that you say: "Unable to sleep." So would he have voiced that to you?

A. He could have. Stating, so I say stating, so, yeah, he would have stated that.

Q. So: "Medicated as per *p.r.n.* orders." Do you recall what medication ... If you could turn to page 40. We see a series of medications listed on page 40 here, and we see times

that appear to be on the right-hand side. Do you see those?

A. Yes.

Q. And I guess if we turn to page 41, we see a similar sort of drug-date entry and the initials "LG".

A. Yeah.

Q. So are these your notes?

A. Yes.

Q. And it's your notes as it relates to medications?

A. Yes.

Q. And medications administered to Lionel Desmond?

A. Yes.

Q. Do you see noted in there anywhere where you said, your entry was at 12:45, "medicated as per *p.r.n.* orders". If you take another look at that do you see the entry as to 12:45?

A. On the medication administration...

Q. Yes.

A. It says 12:30.

Q. 12:30.

A. Mm-hmm.

Q. So what drug did you administer at that time?

A. Quetiapine.

Q. And what was that for?

A. So it would have been to help him sleep.

Q. And would you have had to consult Dr. Rahman to administer that drug?

A. No. It was already on the order sheet, so I had the order to give it.

Q. All right. So if we go back to page 34, the next entry you make in your notes, 1:50 a.m., so approximately an hour later, an hour and five minutes later, what entry do you make, if you could read that into the record.

A. "Patient stating still unable to fall asleep, asking for his usual sleeping pill that he didn't bring into hospital with him. Medication unavailable in hospital at present. Warm blanket provided. Will continue to monitor."

Q. So do you recall anything about that particular interaction?

A. I don't recall, no.

Q. But you have noted here that he was still unable to fall asleep.

A. Mm-hmm.

Q. So again could this have been part of your routine checks, you go in and observe him and he's still awake?

A. It could have been or he could have told me.

Q. And there's a discussion or appears to be that he's looking for his usual sleeping pill and it's ... he didn't take it into the hospital with him. So was there any different medication that was administered?

A. At this time did I ...

Q. Yeah, I guess what was this discussion about, he's looking for his usual medication ...

A. Mm-hmm.

Q. Were you able to find what, did he say what that usual medication was?

A. So I don't recall, I can't remember, but for me to have written "medication unavailable in hospital at present", I would have either asked him or he would have told me what the medication was and then I would have looked into it. So first of all, looking at the orders to make sure that it wasn't on there, and then we do have, like, where we have our medications in Emergency, they're stored in our omnicell it's called, so we sign in and pick our patient and take medication out that way. And in the omnicell there is an option to do, like, a global search and that would search every omnicell in the hospital. So for me to say "unavailable in hospital at present" I'm assuming that I did that search but, ultimately, I would need a doctor's

order to give that pill.

Q. And in this case there was no doctor's order?

A. There was no order, no.

Q. And so from all of this, we can presume that Lionel Desmond wasn't administered the drug that he was looking for that he normally took?

A. Yeah.

Q. So your next entry ... so you indicated, sorry, before we move on. "Warm blanket provided and continue to monitor."

A. Um-hmm.

Q. So it looks as though you might have taken sort of additional steps, I guess, by giving him a warm blanket to try to assist with his sleeping?

A. Um-hmm, the best I could do, yeah.

Q. So the next entry, it doesn't appear as though any notes that you documented from 1:50 in the morning, but at 6:35 you made another entry. What does it state?

A. "Patient states had poor sleep. Checked on hourly. No voiced concerns at present. Will continue to monitor."

Q. So we're into the next morning at that point, at 6:35, so you obviously have some sort of communication with

Lionel Desmond.

A. Mm-hmm.

Q. And did he initially offer that information to you?

A. I can't remember.

Q. You don't remember if it was you asking, How did you sleep or him saying, By the way ...

A. I can't remember.

Q. But either way, I guess, he did state that he had poor sleep?

A. Yes, yeah.

Q. And after that you had indicated "checked on hourly".

A. Mm-hmm.

Q. So are you referring to hourly between your last entry of 1:50 and the entry of 6:35?

A. So checked on hourly just means I checked on him hourly throughout the night, so from when I came on shift til I'm ending shift.

Q. So do you recall if there were any issues with sleep other than the ones you noted?

A. I don't recall, no.

Q. And is it fair to say that if there was anything of particular note between 1:50 a.m. and 6:35 a.m., you would have

noted that in your chart?

A. Yes.

Q. And it appears as though there was some consistency, I guess, in you saying, when he indicated he was having difficulty sleeping.

A. Mm-hmm.

Q. So if he had have expressed it or you had have learned that between 1:50 a.m. and 6:35, would you normally have noted that?

A. If he were to state it again?

Q. Yes.

A. More than likely, yes.

Q. And this, you indicate: "No voiced concerns present." What are you referring to in terms of no voiced concerns?

A. So whatever communication was had, he didn't have any concerns that he brought to my attention or that I had seen, noticed.

Q. Do you recall what time your shift ended that particular day?

A. It would have been around 7 a.m.

Q. I can't remember if you answered this or not, but

were you present during Dr. Rahman's assessment of Lionel Desmond?

A. No.

Q. No. That particular evening, I guess your understanding today, if someone is held overnight for mental health-related reasons, do they typically stay in Observation in the ER?

A. Not typically, no.

Q. Where do they normally stay?

A. Usually up on the Mental Health Unit. It all depends, though, on the patient situation or ... It all depends.

Q. And your recall of January 1st, did anything stand out to you as were you ever informed as to why he was in Observation and not on another unit?

A. I can't recall from that evening, no, that night.

Q. Your general observations of your time with Lionel Desmond in the number of interactions you had with him throughout that evening and into the morning, were you able to sort of observe his demeanour or affect?

A. I would have observed it. I can't recall what exactly, but just going ...

Q. And normally... No, go ahead. Sorry.

A. No, just because I can't recall, so I'm just going off my notes.

Q. And normally if you had have had interactions with him and noticed that he was aggressive or if he was manic or if he was depressed, those sort of clinical terms, would you have noted that normally in your notes?

A. Yes.

Q. So if we could turn to page 40, I'm just going to ask you what drugs and when they were administered to Lionel Desmond while he was, I'm going to say under your care, when you had him in Observation.

A. Um-hmm.

Q. So I guess we'll start at the top, I guess.

A. So prazosin 4 milligrams, I would gave that at 20:40. Trazodone 100 milligrams was given at 20:40, and quetiapine Extended Relief 50 milligrams at 20:40.

Q. And if we turn to the next page, page 41, and what one is that?

A. Quetiapine 25 milligrams at 12:30.

Q. And just below that, if we could scroll down, there's a reference to Tylenol.

A. Mm-hmm.

Q. But there's no date, no time, no initial.

A. So I wouldn't have gave that.

Q. And was there a particular reason why you didn't administer the Tylenol?

A. If, unless he requested, if maybe he was having pain or anything like that I would have given it, but there was no indication for it.

Q. So if we turn back to page 34, if we look down towards the bottom, the text says "Time: 20:35, Medication: quetiapine".

A. Mm-hmm.

Q. And I know earlier when I asked, your entry had been ... I guess my question is are you documenting that quetiapine was administered at 20:35 there?

A. Um-hmm, yes.

Q. Is there a particular reason why this drug administered at this time is listed in this location and not listed in the other section?

A. So this quetiapine order came from Dr. Rahman, which is on the emergency care record, and I believe he ordered that as a stat dose. This is something I just know because I've reviewed the documents. I don't recall this from that night.

So with him ordering the stat dose, that's where we would put our medications. So if they're on, like, the Emergency side they would, we would document medications here. We have to print off what are called medication administration record sheets, so our MARS, which is where the other medications are documented. So I wouldn't have had those MARS printed off and filled out at that time, so I decided to write it on the bottom of the emergency care sheet.

Q. Okay. And if we go back to page 34, just by me looking at it, in your, roughly, 10 lines of notes with respect to Lionel Desmond ... Are these notes shared with the treating or psychiatrist or ER doctor that the patient is under their care, are they shared with the doctor?

A. I wouldn't say they're shared with them but they, it would be accessible to them.

Q. So they could look, obviously, if they wanted to see?

A. Yeah, yes.

Q. So I note four times in those 10 lines you noted some reference to either poor sleep or "Lionel Desmond unable to sleep" on four separate occasions. So in your opinion as a nurse in Observation would you say he slept well?

A. Well, I have that he stated he had a poor sleep, but

for me to say that he slept at all or slept well, I couldn't say that.

Q. And, in fact, he told you he had poor sleep?

A. Yes, he stated ... "Patient states had poor sleep."

Q. So your impression, I guess, if you were just asked, Take a look at these results, you documented them, did he have good sleep or poor sleep?

A. Poor sleep.

Q. I note on the same page that you indicated, if we go just above the 7:10 mark in the left margin, after the word "monitor" there's a line and then there's an initial "LG", and I'm assuming that's your initial again?

A. Yes.

Q. If we can just scroll down a little bit, so that's the last of the notes you made?

A. Yes, yeah.

Q. So prior to your shift change, I guess, or you're off, are you familiar with a nurse by the name of Maggie MacDonald?

A. Yes.

Q. And do you recall if she was working on January 2nd when you were getting off?

A. I don't recall but she was, yes.

Q. So would you have normally ... I'm guessing the way this works is that a nurse comes to cover your shift.

A. Mm-hmm.

Q. And would you have any communication with that nurse advising, giving them an update, I guess, on each patient?

A. Yes, we would give verbal report.

Q. So you would have given a verbal report to the incoming nurse?

A. Yes.

Q. That morning?

A. Yeah.

Q. Throughout the evening and during that morning, other than seeing Dr. Rahman go into the room with Lionel Desmond to start the assessment or at some point during the assessment, did you see Dr. Rahman down near the Observation area?

A. Not that I recall.

MR. RUSSELL: No further questions for the witness, Your Honour.

THE COURT: Ms. Grant?

MS. GRANT: No questions, Your Honour. Thank you.

THE COURT: Ms. Lunn?

MS. LUNN: No questions for this witness.

THE COURT: Mr. Macdonald?

MR. MACDONALD: Thank you, Your Honour.

CROSS-EXAMINATION BY MR. MACDONALD

MR. MACDONALD: Ms. Watts, I wanted to make sure about the "s", so I had to put my glasses on. I'm Tom Macdonald. You were here this afternoon, I won't go all through it, you know who I represent, I'm guessing, if you were listening today.

A. Yeah.

Q. Have you ever had occasion to discuss this matter or your evidence or his with Dr. Rahman since January of 2017?

A. No.

Q. Okay. Thank you very much.

THE COURT: I can pass on Mr. Rogers for ...

MS. MILLER: No questions.

THE COURT: Ms. Miller has no questions. Mr. Rodgers?

MR. RODGERS: No, Your Honour.

THE COURT: No questions. Mr. Hayne?

MR. HAYNE: No questions.

THE COURT: Mr. Rogers?

MR. ROGERS: Just a few questions.

CROSS-EXAMINATION BY MR. ROGERS

MR. ROGERS: You indicated, Ms. Watts, that there are four beds in the Observation area. I think the Inquiry heard yesterday earlier evidence that there were six beds. Are you certain as to how many beds that are in the Observation area?

A. There's four.

Q. Okay. And the Observation area, I know you described it as being an area slightly separate and distinct from the Emergency Department, is that correct?

A. Yes.

Q. You also made reference to the CDU, or the Clinical Decision Unit, are those beds shared with the Observation area?

A. Yes.

Q. So the four beds that you've described can be occupied either in what the hospital calls the Observation area or as Clinical Decision Unit or CDU beds?

A. Yes.

Q. And then is there always one nurse who is assigned to those four beds, whether it's Observation beds or CDU beds?

A. Yes.

Q. And lastly, you indicated that you recently had some education dealing with mental health issues, is that correct?

A. Correct.

Q. Can you generally describe who that training or education was provided to?

A. So that was specific for Emergency nurses. It was a mandatory education session for Emergency nurses.

Q. The course you took was for St. Martha's-based Emergency nurses?

A. Yes.

Q. Very generally, what was the nature of the topics that were covered in that training session?

A. So they reviewed communication techniques, how to have a therapeutic relationship, what kind of communication to have with patients. There was bits on substance use disorders and trauma-informed care as well.

Q. To your knowledge, was that a course and training that was rolled out just to St. Martha's Emergency Room nurses or was that part of a broader provincial-wide program?

A. I believe provincial but I'm not sure.

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

THE COURT: Do you know if Mr. Desmond had a phone with him when he was in the Observation area? Did you ever see him with his phone?

A. I can't recall.

THE COURT: You can't recall. Thank you. Those are all the questions we have for Ms. Watts?

MR. RUSSELL: That's all the questions, Your Honour, yes.

THE COURT: Ms. Watts, you're free to go. Thank you very much for your time.

A. Okay. Thank you.

WITNESS WITHDREW (16:11 HRS.)

THE COURT: We're at 4:10. Do you have a short witness?

MR. RUSSELL: I think there's only one witness here, it would be the nurse Maggie MacDonald. I would anticipate she'd be no longer than the last witness, which would be anywhere between a half hour and 40 minutes. I'm sort of mindful of two things, Your Honour, I guess, courtesy to the witness, courtesy to the lawyers. I'll leave you decide.

THE COURT: Well, if everyone's prepared to stay on a bit longer, we can deal with Ms. MacDonald today.

MR. ROGERS: I think that would be great. I know we're

expecting some weather tomorrow and the fewer people we could have coming in from Antigonish, the better, so I'd be pleased to proceed with Ms. MacDonald.

THE COURT: I think so, too.

MAGGIE MARY MACDONALD affirmed, testified:

DIRECT EXAMINATION

MR. RUSSELL: Good afternoon, Ms. MacDonald.

A. Good afternoon.

Q. So I wonder if you could state your full name for the Court, please.

A. Maggie Mary MacDonald.

Q. And Ms. MacDonald, how long have you been a nurse?

A. I would have graduated in the year 2016, so three and a half years now.

Q. And I understand that you ... are you currently working at St. Martha's?

A. I am, yes.

Q. So have you spent your whole nursing career at St. Martha's?

A. Yes.

Q. And what sort of areas of the hospital did you work since May of 2016?

A. So I am ... I started off as a float nurse and I am still currently a float nurse, so I do float to multiple floors.

I call Staffing about a half hour in advance and, based on the need, I go wherever they tell me to go. So that could be Progressive Care, GARU - Geriatric Assessment Rehab Unit, Stroke floor, and Emerg Observation.

Q. And I understand that on January 2nd, 2017 - we're going to get to the particulars - you were still a float nurse at that time?

A. Yes.

Q. Obviously. And you worked in Observation?

A. I did, yes.

Q. And that's a part of the ER as it relates to St. Martha's Hospital?

A. Yes.

Q. In terms of your career since 2016, have you had any training or educational sessions as it relates to mental health?

A. The only education that I would have had would have been in my Nursing degree, would have been a mental health course; other than that, no.

Q. While you were an employee of the Nova Scotia Health Authority you wouldn't have had any sort of training as it relates to mental health nursing?

A. No.

Q. Any training as it relates to domestic violence issues or risk factors?

A. No, I have not.

Q. And what about orientation to the ER at St. Martha's, would you have received any sort of orientation or training with respect to that?

A. In regards to the Emergency Observation area we do receive a day and a night of training, just it's a little bit different, a lot of it's paper charting, so one day and one night, and then after that you're working on that Emergency Observation area, not the Emergency floor, but the Observation area by yourself at that time.

Q. And I understand that nursing in different areas can be somewhat specialized at times, is that fair?

A. Yes.

Q. So if you're a nurse on the maternity ward, things you're exposed to and need to know about may be very different than if you were a nurse in the ER.

A. Correct. Yes.

Q. Is your understanding of being a nurse in a mental health setting somewhat specialized as well?

A. I don't have any mental health, like, specialty

training, so I wouldn't have any speciality in that area. Yeah.

Q. Okay, that's fair.

So on January 2nd, 2017, do you recall when your shift would've started and ended?

A. Yeah. 07:00 to 19:00 on January 2nd.

Q. So 7 in the morning to 7 at night?

A. Mm-hmm.

Q. And I understand, as part of your training as a nurse, is it fair to say you learned the importance of taking detailed notes?

A. Yes, that would be correct.

Q. And documenting times?

A. Yes.

Q. Which would include interacting with patients?

A. Mm-hmm.

Q. And the patients' interactions with different health care professionals?

A. Correct, yes.

Q. And you indicated that you had just graduated in May of 2016?

A. Yes, I had.

Q. So it would've been fresh in your mind, I guess, when

you were early on in your career?

A. Yeah. I would've been seven months out so ...

Q. So I'm just going to look at Exhibit 67.

THE COURT: And Ms. MacDonald, there's an electronic copy as well, but there's a paper copy if you want to have a look at it.

A. Thank you.

Q. Just for ease of reading, if you like.

MR. RUSSELL: If we could turn to page 33. So, Ms. MacDonald, this particular date on January 2nd, what was your role, I guess, in Observation as a nurse that morning?

A. So my role as the Observation nurse would be to monitor any current status changes in any acute patients. So if I noticed something that was a red flag to me, I would call the doctor and notify them. Yes. I'd monitor any changes.

Q. And part of your duties in observations, are you looking for any sort of changes or notable signs or things that stand out to you with respect to a patient?

A. In regards to Mr. Desmond?

Q. Well, we'll get to that, but in general.

A. Yeah. If any status change from what I received in report and then when I go on to assess the patient, if I noticed

that something was different that would be alarming to me, I would make it a point to call the doctor and receive orders from there.

Q. So in terms of your knowledge of Lionel Desmond, when you start that morning, do you recall if you reviewed any sort of charts or history as it related to Lionel Desmond? Kind of why he was in Observation that particular night, overnight?

A. I just recall that he needed a place to stay that night and that he had some difficulty with his spouse and that he was just looking for an area to relax and have a quiet night's sleep because I knew that he didn't have any other place to go, from my understanding.

Q. So if we look to page 33. Sorry, 34. If we go down the page, on the left-hand side, it says "7:10". So 7:10 in the morning, there's a note here. Is that your handwriting?

A. Yes, it is.

Q. So that's a note that you made?

A. Correct.

Q. And this is on the emergency care record?

A. Yes.

Q. And would this emergency care record have applied to Lionel Desmond?

A. It did, yes.

Q. So what was your note that you made at 7:10?

A. So I would've came on shift and I would've received a report from Lee Anne, and from that point on, I'm assuming the responsibility of Mr. Desmond. And then ...

Q. So ... go ahead.

A. And then from there, I would've taken the time to review the charts. That's what I do on a standard basis. And from there, I would go and assess my patients after that.

Q. Do you recall how long this report ... when you say, "report received from Lee Anne", was it a verbal report?

A. Yeah. It's a conversation about how the patient's night went, if there was anything concerning that the nighttime nurse feels that, you know, we should relay to the physician. And just a conversation on how their night went overall. Any specific medications that they needed to receive.

Q. And do you recall having that conversation with Lee Anne?

A. Not specific points, but a general conversation of his night and it being uneventful.

Q. Okay. And were you familiar with ... at the time of starting your shift and you received the report from Lee Anne

Watts, would you have seen her note, as listed above? Those ten lines?

A. Yes.

Q. And you would've reviewed that.

A. Correct.

Q. And so there's a note here at 8:30 a.m. What is that?

A. That would've been when I would have seen him, laid eyes on him, and I did a set of vitals on him by the looks of it there. And I would've had a conversation with him about his overall night, anything concerning, how is he feeling.

Q. So what were his vitals?

A. His vital signs were 36.7. That's his temperature. Heart rate would've been 78. His respirations, 18. His blood pressure, 109/62, and that is left semi, and "semi" just means the type of position he was in. So he would've been on a bed in a 30-degree angle. And 95 percent on room air. So he didn't require any oxygen.

Q. So is there anything notable or concerning about his vitals as they were at 8:30?

A. No. All of his vitals were stable.

Q. And 8:30, does that note sort of your first contact with Lionel Desmond?

A. Yes.

Q. And then it went on to continue. It says, "Patient stated restless tonight."

A. That is "throughout". Sorry.

Q. Oh, it's "throughout".

A. "Throughout the night." Yeah.

Q. "Throughout the night." Do you recall having that conversation with Lionel Desmond?

A. I did go in. I asked him how his night was and he did state that he had a restless night but he wasn't currently restless. So he did mention that, you know, he didn't sleep the greatest.

Q. And after that, you have noted "flat affect".

A. Yes, I did.

Q. So "flat affect", is that a clinical term? A medical term, I guess?

A. Yes. I knew he was some ... he was a mental health patient so as a new nurse I was doing my best to incorporate some kind of mental health perspective, and so that involved his demeanour, how he was looking at me, and from what I noticed, he was very pleasant and calm but he just had an emotionless look to his face.

Q. And ...

A. And that's what I mean.

Q. ... what is "flat affect", I guess?

A. That's what I would say "flat affect" is.

Q. Okay.

A. I mean if you were to say "hi" to someone, you might give them a smile. In this case, he was pleasant but there was no emotion to his words.

Q. And was there sort of a purpose of why you would've noted that in your nurse's notes of your first contact with him? "Flat affect", specifically?

A. Mm-hmm. That was me thinking from a mental health perspective and trying to incorporate my best practices.

Q. So you're looking for active observations of the patient.

A. Yeah. Any change in mental status and ... yes.

Q. And it says, "No pain concerns."

A. Yes. I ...

Q. So is there some discussion about his level of comfort, I guess, physically?

A. Yeah. I would've asked him, How are you feeling? Is there anything you need me to relay to the doctor? Do you have

any concerns at all? And his response, he said, No, that he was just waiting to be discharged and to be seen by the doctor.

Q. And at any time during the time that Desmond is under your observation, do you administer any drugs?

A. I would if they were scheduled. In his case, he had no scheduled daily morning medications. He just had nighttime pills and then medication as needed.

Q. So 8:30 we have, "Vitals, restless tonight, a flat affect, no pain concerns, and awaiting discharge." So all of this takes place in the conversation you have with Lionel Desmond at 8:30?

A. Yes, correct.

Q. And "awaiting discharge", what do you recall about that?

A. Yeah. So he did just make a statement saying that he was just waiting to be seen by the doctor and so I took that that the plan was for him to be, I guess, assessed again and then discharged if there was no change in his status when he currently came in.

Q. So if we can look at page 36. So if you look down - it's on the left side of the page, right there - it'll say "January 2nd, 2017" and 11 (audio blip).

A. Mm-hmm.

Q. Who made this particular entry or note?

A. I did.

Q. And so there's an initial right at the very end. Is that your initial?

A. "M. MacDonald, RN." Yes.

Q. Yes, okay. Oh, the "RN".

A. Yeah.

Q. So below that, whose signature is that?

A. That would be Dr. Rahman's.

Q. So 8:30 you have noted a conversation with Lionel Desmond where he's asking about discharge.

A. Mm-hmm.

Q. About leaving the hospital. Between 8:30 and 11:00, I guess, do you have any further conversations with Lionel Desmond?

A. He did ring the call bell once, I believe it was around 10:30, just inquiring about when Dr. Rahman was going to be in to assess him. I don't typically know the specific times when the doctors come in. I try to give them a little time because I know that they have other patients to see. So I told Mr. Desmond if he could just wait a moment, I would call him and

see if I could get in touch with him to clarify his status and if he could go.

Q. Did Lionel Desmond indicate as to why he wanted to leave or if he had a place to be or anything like that?

A. He did mention that he had an appointment that he had to attend to. I didn't inquire about what that appointment was.

Q. Okay. So your note at 11:00, what does it say?

A. "Discharge patient for appointment with psychiatrist. Telephone read back order from Dr. Rahman to M. MacDonald."

Q. So I take it this is you referencing a conversation you had with Dr. Rahman?

A. I did, yes.

Q. And is this conversation in person?

A. No, this conversation was via telephone. That's "TRBO". Telephone read back order.

Q. Okay, and what's a "telephone read back order"?

A. A "telephone read back order" is when you make a phone call to the attending physician and you receive an order from them to which you verbally give that order back to the physician to make sure it's the correct order and you write that down on the paper.

Q. So as a nurse in Observation, do you have the

authority to discharge a patient?

A. I don't, no. A psychiatrist that attending day would have.

Q. So was it you that reached out to Dr. Rahman that morning?

A. I did, yes.

Q. And do you recall how you initiated that conversation?

A. Mm-hmm. So normally how I go about my conversations with the doctors, I say, Good morning. This is Maggie MacDonald. I'm calling from Emerg Observation area. I have a patient here that's under you. And I'd state the patient's name, Mr. Desmond. Are you aware of this patient? And then they would reply "yes" or "no" because sometimes hospitalists, certain doctors, can get mixed up with different patients. So I make sure that they are aware of the patient and, yeah, from there, I just give report from there.

Q. So in your experience, and as a relatively new nurse at the time, would you have introduced on the phone specifically who you were?

A. To my recall, yes. I can't say that with a hundred-percent certainty but I do normally state my name on most occasions, yes.

Q. Would it normally be a little more official than, Hey buddy, it's me?

A. Yes. I go about it in a professional way, yes.

Q. Okay.

A. Yeah.

Q. So, in your mind, was there any sort of ... was it in any way from your end of things unclear as to who Dr. Rahman was speaking to?

A. Not to my knowledge, no.

Q. And Dr. Rahman, I understand, gives you the instructions to discharge the patient?

A. Correct.

Q. And it says, "For appointment with psychiatrist." What was that?

A. So I did mention to Dr. Rahman that he was looking to get discharged and that he had an appointment and was he aware of this appointment and was he following up with him in Psychiatry? And that's when Dr. Rahman began to ask me, Oh, yes, I'm aware of this patient. How is he doing, is everything okay? And I stated that there was no change in his status. The only thing that I mentioned was that ... a restless sleep. But currently I didn't see any change in status and demeanour or

presentation and that I felt he was in stable condition in the morning.

And so from there he said, Yes, I'm aware of this patient. I am following up with him in Psychiatry and if he is feeling okay he can go home.

Q. And after that phone call at some point Lionel Desmond leaves the ER. Who relays that information to Lionel Desmond that he's being discharged?

A. I did.

Q. And do you recall how you did that?

A. It would have been a casual conversation. I would have went in there and just said, I spoke to the doctor, he knows about you and that he feels comfortable just letting you go. And then from there on I would have said that it was okay for him to leave.

Q. And do you recall approximately when that time was? If this phone call is 11 o'clock ...

A. Yes.

Q. ... how soon after you would have went to see Desmond and advised him of that?

A. Yeah, he didn't have any pending tests. Or he didn't have any IVs in him. So he would have just been sitting at the

bed and he would have been ready to go right away. So it would have been a couple minutes after.

Q. And do you recall seeing Lionel Desmond leave?

A. I do. He walked past me. The unit where my desk is at is ... if I'm facing forward he would have had to have walked past my left to get out of the unit.

Q. Is there a particular reason why you recall him actually leaving?

A. No particular reason, no. I just remember saying, See you later, and I think I just recall it given the circumstances as to what happened after the fact.

Q. And when he's leaving where are you at in the Observation Unit?

A. I would have been at my desk charting, reviewing meds, receiving orders.

Q. And do you remember how many patients that morning you had sort of under your observation?

A. I believe I had three. I can't say that with a hundred percent certainty, but I remember it being a busy day and I remember receiving a patient right off the bat in the morning. So there would have been a patient over in the Emerg side that I would have received almost right after report and I

would have had to get them settled into our Observation side. So I would have had a total of four patients, I believe.

Q. So the Observation desk. Can you see the patients in the Observation area?

A. I would have to turn my chair behind me ...

Q. To see.

A. ... to see them.

Q. So if they were having a conversation or talking could you hear them?

A. Most likely not, no.

Q. And if somebody is in one of the Observation beds and you're at the Observation desk, for someone to get to the patient would they have to have gone past you?

A. Yes, yes.

Q. There was no sort of back door or side door kind of thing?

A. There is a side door and that's connected to the Emergency floor. But there's only one main entrance, I guess, on the left side of me that family members ... they would have to come to that front area and we would have to push a button to let them in. So unless there were family members already there they could go through that side door from the Emergency side,

but in most cases they would have to ring the buzzer and we would have to allow them in from the main area ... main entrance.

Q. Approximately how soon after you let Desmond know that he was discharged and leaving to you seeing him walk past, are you able to estimate?

A. It was relatively quick but I would be just guessing on the number, I guess, but it was within 10 to 15 minutes I would say.

Q. Do you recall seeing Dr. Rahman at all that morning?

A. I do not.

Q. And do you recall if Lionel Desmond had been interacting with anyone after you went and delivered the news that he was being discharged?

A. I don't recall any of his family members or ... being in the room with him at that time or even within the unit that day.

Q. And typically you've been in situations before where a doctor gives you an order to discharge a patient.

A. Yes. Correct. Yes.

Q. Is it common for a doctor to give you an order over the phone to discharge a patient and then come down to see a

patient?

A. Yeah. I mean I do get orders, as Observation patients, to discharge them and sometimes they do pop down right quick just to say goodbye, basically, just to give an eye-to-eye look at the patient.

Q. Okay.

A. Which doesn't take very long to do. But yes.

Q. Okay. And your understanding that morning from looking at Lee Anne Watts' note of the night before, and in your conversation with Lionel Desmond where he indicated that he didn't sleep well ...

A. Mm-hmm.

Q. ... was there ever any impression that he, in fact, slept well to you?

A. No. I was going off of what I received in report and he did make a comment saying that he didn't sleep the greatest. So that's what I was going off of, his word and the report from the other nurse as well. And what, yeah, he told me.

Q. Do you recall how he seemed, how Lionel Desmond seemed as he was leaving?

A. Very calm and friendly. He didn't seem to be showing signs of agitation or aggression. He was very patient even when

I made the phone call to Dr. Rahman. He didn't seem to, you know, ring the call ball too many times because he was getting agitated. He was very patient in that way.

Q. Okay. No further questions for the nurse, Your Honour.

THE COURT: Thank you. Ms. Grant?

MS. GRANT: No questions, Your Honour.

THE COURT: Ms. Lunn?

MS. LUNN: No questions for this witness.

THE COURT: Mr. Macdonald?

MR. MACDONALD: Thank you, Your Honour.

CROSS-EXAMINATION BY MR. MACDONALD

MR. MACDONALD: Good afternoon, Ms. MacDonald. I won't go through who I am because you were here and you heard.

A. Mm-hmm.

Q. So my standard question. Have you discussed this matter with Dr. Rahman since January of 2017?

A. He did have one conversation with me. I'm not sure how long ago but he didn't know who I was. So I believe I was working on the Stroke floor on one random day and he just wanted

to see who I was and, Oh, you're the nurse that was working that day. Because he couldn't put a face to a name. So yes.

Q. Would it be your recollection that his was a purposed visit, in other words, seeing you that day for the purpose of finding out who you were for lack of a better word?

A. Yeah, he did seem to be confused as to who I was and he didn't know my face to the name. So he wanted to come see my face and, yes, introduce himself.

Q. And do you recall why he was introducing himself, why he wanted to come and see your face?

A. Well, yeah, when that time happened we heard, everyone heard of the Inquiry happening. So he mentioned like, Oh, you were the nurse working that day, weren't you? And I said, Yes.

Q. Is it possible that that visit, let's call it, was in 2019?

A. No. 2019?

Q. Right.

A. No.

Q. So just last year.

A. It was moreso recent of when the incident happened.

Q. Okay.

A. Yes.

Q. So fair to say maybe 2017?

A. Yes, more along ...

Q. Okay.

A. Yes.

Q. Do you remember Dr. Rahman on the day that Lionel was discharged coming to see Lionel at all before the discharge while you were on the duty on the floor?

A. I did not have an in-person contact with Dr. Rahman.

Q. Okay.

A. All my orders were via telephone read back order to him. So I did not see him face to face.

Q. Okay. Do you know of anyone who did see him on the floor speaking with Lionel that day?

A. I was never told by any other nurse, no. I can't answer to that specifically, but I know that my contact with him wasn't in person.

Q. Okay. Those are my questions. Thanks very much.

A. Okay.

THE COURT: Thank you. Mr. Rogers? You're going to defer, are you? Ms. Miller?

MS. MILLER: I have no questions. Thank you.

THE COURT: Mr. Rodgers?

MR. RODGERS: Just a couple of very brief questions, Your Honour.

CROSS-EXAMINATION BY MR. RODGERS

MR. RODGERS: Ms. MacDonald, when you leave the Emergency unit how do you get out of the hospital? Could you walk us through that process?

A. Like from the Observation area?

Q. Yes.

A. So when people come in to get triaged they have to go ... There's a front desk there, and from there they'll go straight into the ... whatever room they choose in the Emerg floor.

Q. Yeah.

A. And then from there the Emergency Room physician will see them and then they get transferred over. If need be, they'll go over to the Observation side, which is right near the main entrance. So right to your right as soon as you walk past those doors to enter the Emerg floor, right to your right would be the Observation area.

Q. Okay, so when Corporal Desmond leaves the Observation

area you see him walk past you. He's presumably going to the parking lot or somewhere to get outside.

A. Yes.

Q. What's his route? Does he have to go up or downstairs or out the door?

A. No.

Q. How far does he have to travel?

A. He's right there at the entrance there. He just took a left and would have pushed the doors, those two main doors to get out.

Q. Yes?

A. And then from there I wouldn't have seen which direction he would have went. If he went halfway down the hallway, he could have took a right to where the ambulance enter and he could have went out that way or he could have went down the hallway into the main entrance of the whole hospital and he could have exited there.

Q. If he went to the main entrance, and that's the longer route for him to take ...

A. Yes.

Q. ... is it not? But that's the entrance or the exit that takes you to the main parking lot. Is that ...

A. Correct.

Q. ... correct? Can you give us an estimate of what distance that would be for him to walk down the hall?

A. From the time he leaves the Emergency Room area to ...

Q. Yes.

A. To the main entrance of the hospital?

Q. Yes.

A. A hundred feet?

Q. Okay. and your recollection is that you gave Corporal Desmond the news that he was free to leave and he was basically ready to leave and left a few minutes later?

A. Mm-hmm.

Q. I think you said 10 to 15 minutes later. May it have been less than that or more than that?

A. Yeah. I'm going to say up to 15 minutes but definitely no more than 15 minutes because it was just a verbal thing I had to say to him. And I didn't have to take anything off him. He had no monitors on him. He had no x-rays to be done or anything like that. So he would have been sitting at the bed ready to go.

Q. Okay. Okay. Those are all the questions I have. Thank you.

A. Okay.

THE COURT: Mr. Hayne?

MR. HAYNE: Yes, just a few questions.

CROSS-EXAMINATION BY MR. HAYNE

MR. HAYNE: Ms. MacDonald, I'm Stewart Hayne. I represent physicians in this matter including Dr. Rahman. I just have a few questions. You did say, and correct me if I'm wrong, that you do have instances where a physician will give a verbal order for discharge but then subsequently to that come down and see the patient after the order has been provided. Correct?

A. Yes.

Q. And I think you said something along the lines of, Maybe have a quick eye-to-eye with a patient.

A. Mm-hmm.

Q. Something that doesn't take very long to do. Correct?

A. Yes.

Q. Okay, and your evidence also was that on January 2nd you had between three and four patients in the Observation area?

A. Correct.

Q. And you characterized that as a busy morning?

A. Yes, typically four patients. That's a full load. And then depending on their acuity as well.

Q. Right, and the Observation area, I think it was your evidence that said that the patient beds are divided by a half-wall and a curtain? Is that right?

A. Yes.

Q. Okay. And so in the time from providing the verbal ... receiving, rather, the verbal order from Dr. Rahman to seeing Mr. Desmond depart the Observation area, would you agree with me it's possible that if you were dealing with another patient or some other event, that Dr. Rahman could have come in to see Mr. Desmond and you may not have seen that yourself. Correct?

A. Yeah. There is a chance that that could have happened as well. I could have gone to the bathroom and he could have went in and seen him while I was down the hallway but ... there is a chance.

Q. Okay.

A. And it was a telephone read back order, not a verbal order.

Q. Right, but conveyed verbally by the telephone.

A. Yes.

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

THE COURT: Mr. Rogers?

MR. ROGERS: Thank you, Your Honour. I have no questions and do want to thank Your Honour and Inquiry personnel for sitting late and getting Ms. MacDonald finished. I appreciate that.

THE COURT: All right. That's fine. Ms. MacDonald, I don't have any questions for you either. So ...

A. Okay.

THE COURT: ... you're free to go. Thank you for your time.

WITNESS WITHDREW (16:46 HRS.)

THE COURT: All right. Thank you. So what we'll do is we'll adjourn for the day. I know we started at 10 o'clock this morning. My inclination is to start at 10 o'clock tomorrow as well. I'll start earlier if you like, but just anticipate the roads may be ... they were good this morning as it turns out.

MR. ROGERS: Your Honour, I just checked again weather forecast, because I know that three of our nurses are coming from the Antigonish area and the last forecast hourly I saw has snow heavy at times running through to 8 a.m.

DISCUSSION

THE COURT: Mm-hmm.

MR. ROGERS: And I think they're talking about 10 to 15 centimeters in total over the night.

THE COURT: Mm-hmm.

MR. ROGERS: So I raised with Inquiry counsel as to whether it might be possible to bump the start time to 11 or 12 and run through just with the chance of roads improving a little bit from Antigonish. So I appreciate that I'm in Your Honour's hands, but that might be a little better for the driving conditions.

THE COURT: I think what we'll do is we'll adjourn for a few minutes and we can have a discussion. All right. Thank you.

COURT RECESSED (16:47 HRS.)

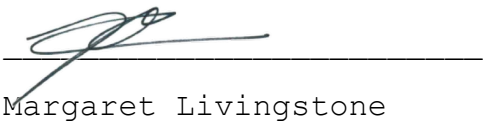
COURT RESUMED (16:52 HRS.)

THE COURT: So just for scheduling purposes, I think we'll adjourn until tomorrow morning 11 o'clock. Thank you.

COURT ADJOURNED (16:53 HRS.)

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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