CANADA

PROVINCE OF NOVA SCOTIA

IN THE MATTER OF THE

FATALITY INVESTIGATIONS ACT

S.N.S. 2001, c. 31

THE DESMOND FATALITY INQUIRY

TRANSCRIPT

HEARD BEFORE: The Honourable Judge Warren K. Zimmer

PLACE HEARD: Guysborough, Nova Scotia

DATE HEARD: February 3, 2020

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INDEX

Page

DR. JUSTIN CLARK

Direct Examination by Mr. Russell 5

Cross-Examined by Mr. Macdonald 102

Cross-Examined by Mr. Rogers 110

Cross-Examined by Ms. Miller 124

Cross-Examination by Mr. Rodgers 141

Cross-Examination by Mr. Hayne 146

Cross-Examination by Mr. Macdonald 151

Examination by the Court 152

EXHIBIT LIST

Exhibit	Description	Page
P-000066	*Curriculum Vitae* of Justin Clark	5
P-000067	St. Martha's Regional Hospital - Emergency Chart - January 1, 2017	30

1 **February 3, 2020**

2 **COURT OPENED (13:36 HRS)**

3

4 **THE COURT:** Mr. Russell.

5 **MR. RUSSELL:** Yes, Your Honour. This afternoon we'll call

6 Dr. Justin Clark.

7 **THE COURT:** Okay. Dr. Clark.

8

9 **DR. JUSTIN CLARK, affirmed, testified:**

10

11 **DIRECT EXAMINATION**

12

13 **MR. RUSSELL:** Good afternoon, Dr. Clark.

14 **A.** Hi.

15 **Q.** Thanks for coming. In front of you as discussed,

16 you're going to see, we'll look at, I guess we'll just pull up

17 exhibit number 66.

18 **EXHIBIT P-000066 - *CURRICULUM VITAE* OF DR. JUSTIN CLARK**

19 **Q.** So Dr. Clark, there will be a binder in front of you

20 as discussed, on the desk, that will have exhibit 66. You can

21 either look on on paper format or on the screen, whatever you

22 prefer.

1 **A**. Okay.

2 **Q**. And if at any point you need time to sort of get
3 caught up with where I'm looking, just let me know.

4 **A**. Okay.

5 **Q**. So, Dr. Clark, I guess what is your full name and
6 occupation?

7 **A**. Justin Dale Clark, I'm an emergency room physician.

8 **Q**. And how long have you been a physician in general?

9 **A**. Since 2016. Sorry, since 2013.

10 **Q**. All right. And, Doctor, if you could look at exhibit
11 66 which appears to be your *CV* outlining your qualifications, I
12 just want to take you through that and I'll have a few
13 questions. I guess starting first with your education, I'm
14 wondering if you could outline for the Court what your education
15 is, starting I guess in 2007 through 2016.

16 **A**. Okay. So I went to St. FX, I did a Science degree
17 there for four years. Then I went to medical school at Saba
18 University and that's another four years. I did two years of
19 family medicine residency after that and then I did an
20 additional year in emergency medicine training. The family
21 medicine residency was in Ottawa at the University of Ottawa and
22 the emergency medicine training was at Dalhousie.

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

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

1 finished residency.

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

3 **A.** Yes.

4 **Q.** In terms of you outlined that you worked at St.
5 Martha's, Dartmouth, and Truro primarily in 2016, would that
6 apply to early 2017 as well?

7 **A.** Yes.

8 **Q.** My question, I guess, is are you able to estimate, and
9 I know it probably varies, how many days a week would you work
10 at each different location?

11 **A.** So I would do about 14 shifts a month so eight of them
12 will be in Truro, two to four at St. Martha's, and two to three
13 at the Dartmouth General Hospital.

14 **Q.** And your shifts would normally, I guess ... your ER
15 doctor shifts would typically be between what hours?

16 **A.** They could be any hours, so it's basically shift work,
17 so they could be morning, evening or overnights. I currently
18 work more evenings and overnight shifts. In 2016/2017 I
19 probably had an equal distribution.

20 **Q.** So typically when would be the starting hour and sort
21 of completion hour?

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

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

1 listed a couple but one in particular that I'm interested in is
2 a membership with the S.R.P.C. which indicates Society of Rural
3 Physicians of Canada. So what is that organization and what
4 sort of topics, I guess, do they get into?
5 **A.** So basically when you sign up you get a medical
6 journal that comes out, I believe four a year, and it's just
7 looking at things specific to rural physicians. So looking at
8 specific skills, learning new skills, looking at issues that
9 they may face in a smaller community department.
10 **(13:45:57)**
11 **Q.** So in your experience, are there actual differences of
12 being sort of an ER doctor in a rural region as opposed to a
13 central region such as, say, Dartmouth or Halifax?
14 **A.** For sure, there's a lot less resources. In rural
15 areas you may not have an ophthalmologist or a plastic surgeon
16 or an orthopedic surgeon to help you deal with things so it's
17 important to be proficient in dealing with some things like
18 that.
19 **Q.** And are there sort of limitations as it relates to
20 resources or access to, say, a psychiatrist for mental health
21 consults for an ER physician?
22 **A.** In rural areas, most rural areas don't have a

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

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

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

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

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

1 to cry, you might think that they're hiding something but, I
2 mean, you have no way to know for sure.
3 **Q.** Would having access to those other medical records
4 that we've referred to, private clinics, family practitioners,
5 other ER visits perhaps recent in other provinces, would that
6 information be helpful in sort of testing sort of the honesty or
7 validity, I guess, of what the patient is telling you in the
8 moment?
9 **A.** It could be beneficial for sure.
10 **Q.** And in what way, do you have sort of an example?
11 **A.** Well, if a patient's telling you certain details of
12 their life and events that have happened and you see the same
13 information from multiple sources, then that kind of helps you
14 when you're assessing whether or not you think the person's
15 being truthful.
16 **Q.** In terms of, again, hospital charts and records that
17 an ER physician has access to, do you know typically what format
18 they come in? Do they come in paper format, digital format,
19 does it vary?
20 **(13:56:01)**
21 **A.** The record I would document on as a physician.
22 **Q.** No, the records you might review if you had to have

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

1 they all have it?

2 **A.** So every hospital I work in outside the Central Zone
3 has MEDITECH. I've never been working in the Central Zone, for
4 example in Dartmouth, and tried to sign into MEDITECH so I don't
5 know, I would assume it's on the computer there.

6 **Q.** And say a patient such as Lionel Desmond, we know and
7 we'll get into later, that he had a consult with Dr. Slayter in
8 the clinic, not in an ER, presumably that record is held
9 somewhere. As an ER doctor, would you be made aware of where to
10 look to see that yes, okay, Lionel Desmond attended a clinic
11 that was operated by and assessed by Dr. Slayter? Do you know
12 where to look for that as an ER doctor?

13 **A.** I would look in MEDITECH or SHARE and if it's not
14 present there, I'm not aware of anywhere else to look. We would
15 have to contact the specific office to get the records.

16 **Q.** Okay. Have there been any other occurrences where, as
17 an ER physician, you had to look other places other than
18 MEDITECH for information when you're assessing a patient?

19 **A.** In terms of health records?

20 **Q.** Yes.

21 **A.** I have had records faxed from various places in the
22 past.

DR. JUSTIN CLARK, Direct Examination

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

DR. JUSTIN CLARK, Direct Examination

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

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

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

1 ultimately know presented to you with a form of situational
2 crisis, we know that he had, previous to that, been taken to an
3 ER, you may not be aware, in New Brunswick, for example. Having
4 access to that information, would it have been helpful to you as
5 an ER physician to have access to that information?
6 **A.** Yeah.
7 **Q.** And why?
8 **A.** Again, more information is always better. It gives
9 you a better picture of the patient and their history and it can
10 help you to determine again if they're being truthful or it can
11 help you decide on which way to go with management.
12 **Q.** And we'll get into it in a bit of detail, the concepts
13 of suicidal ideation and homicidal ideation. I guess probably
14 now is sort of the best time to sort of define those. So what
15 is "suicidal ideation"?
16 **(14:05:42)**
17 **A.** So it's sort of a general term that encompasses ... so
18 I would ask a patient specific direct questions. Have you
19 thought about killing yourself? Have you considered killing
20 yourself? Do you have a plan to kill yourself? And suicidal
21 ideation encompasses all those aspects.
22 **Q.** And "homicidal ideation"?

DR. JUSTIN CLARK, Direct Examination

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

DR. JUSTIN CLARK, Direct Examination

1 significance depending on what it is you're assessing at the
2 time?
3 **A.** Yeah.
4 **Q.** And why is that?
5 **A.** Well, some things would be pertinent for how you
6 diagnose and manage. Using a cut finger as an example, an
7 otherwise healthy person with a cut finger, their past medical
8 history means little to nothing. But someone with a cut finger
9 who is getting chemotherapy and is prone to infection, that
10 would be a relevant part of their history in that specific case.
11 So you always have to consider other issues that ... medical
12 problems that a person has when you're treating the current one.
13 **Q.** I'm going to ask you a little bit about the
14 particulars of January 1st of 2017, basically the reason ... one
15 of the main reasons why you're here. So you were working at St.
16 Martha's Hospital in Antigonish on that date?
17 **A.** Yes.
18 **Q.** Do you remember what hours your shift was that
19 particular day?
20 **A.** My shift was 2 p.m. to 8 p.m.
21 **Q.** In terms of the flow of the ER that night, workload,
22 was there anything significant or notable or different on that

1 particular evening?

2 **A.** I don't recall. It's typically busy during those

3 hours but ...

4 **Q.** But nothing ...

5 **A.** ... I don't recall that specific day.

6 **Q.** So is it fair to say nothing stands out to you to make

7 it sort of abnormal in any way?

8 **A.** That's correct.

9 **Q.** I'm sure you can probably recall ... if I took you to

10 a certain time, you may recall if that was an abnormal day or

11 different in its operation?

12 **A.** Yes.

13 **Q.** Okay. But there was ... so there was nothing notable

14 or different with this one.

15 **A.** That's correct.

16 **Q.** And at that point, January 1st, how long, as an ER

17 doctor, had you been covering shifts at St. Martha's?

18 **A.** Approximately six months.

19 **Q.** And how long had you been an ER physician at that

20 point?

21 **A.** So approximately six months.

22 **Q.** And do you recall the names of any sort of nurses that

1 might have been ... I realize you probably work with a lot of
2 staff in a lot of different hospitals, obviously, but do you
3 recall the names of any particular nurses you might have worked
4 with that evening?
5 **A.** No.
6 **Q.** Going to ask you about ... before going back to that
7 date, something called "triage screening". Are you familiar
8 with triage screening?
9 **A.** (No audible response.)
10 **Q.** I notice you're nodding. We'll have to get you saying
11 ...
12 **A.** Yes.
13 **Q.** Yes. Okay.
14 **A.** ... I'm familiar.
15 **Q.** What is triage screening, I guess? I'm not going to
16 hold you to a detailed, I guess, account, but your understanding
17 as an ER doctor what it is.
18 **A.** So it's a scoring system from one to five. So,
19 basically, a one would be a patient that is a true emergency and
20 needs assessment immediately, something like a cardiac arrest or
21 a seizure. And then it's sort of a spectrum all the way to
22 five, which may be something that is very minor, a twisted ankle

1 or something.

2 **Q.** And what sort of effect does it have ... and so, I
3 guess, before we get into that, who does the triage screening
4 and scoring?

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

6 **Q.** And what's the purpose behind giving each patient a
7 triage number, I guess?

8 **A.** So the lower the number would be the higher severity
9 of the medical problem. And it's basically to get them seen
10 sooner.

11 **Q.** And so from an ER perspective ... an ER doctor's
12 perspective, you're given a chart with a description of the
13 details. And we'll go through what a triage nurse provides you
14 in those details. And on that same form, you're giving a triage
15 score. From an ER doctor's perspective, are you looking at the
16 score ... the triage number of any significance? What are you
17 interested in?

18 **A.** So I do look at the score. In St. Martha's, in
19 particular, the charts are organized in bins. There will be a
20 bin for the scores of three and a bin for the scores of four and
21 five. So I am aware of the score. For me, it's the vital signs
22 and the actual details of the triage notes are more important

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

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

1 **A.** Yes. That would be on the chart, as well.
2 **Q.** In terms of this emergency care record, are you able
3 to comment whether or not this document is the same throughout
4 all of the ERs that you've worked in throughout the province?
5 **A.** It's not the exact same form but all the components of
6 the form are the same.
7 **Q.** So when you say "the components of the form", what do
8 you mean?
9 **(14:16:00)**
10 **A.** So a section for the patient's information, a section
11 for vital signs, a section for medical history, allergies,
12 discharge instructions, those sorts of things.
13 **Q.** So is the content blocks the same? Is that what
14 you're saying?
15 **A.** (No audible response.)
16 **Q.** And it's just the format is a little different?
17 **A.** Exactly.
18 **Q.** When you were working at St. Martha's that particular
19 date, January 1st, 2017, do you recall how many separate ER
20 rooms were available for patients or how it was sort of divided
21 up?
22 **A.** So St. Martha's has approximately 10 to 12 rooms where

1 we assess patients in the Emergency Room and then two additional
2 rooms, which we call interview rooms, which don't have an
3 examination table. They have more of like a couch, a
4 comfortable place to sit. Sometimes they're called a "family
5 room". Family members may be waiting in one of those rooms or
6 we may use it for a mental health interview as well.
7 **Q.** Are you able to recall how many or approximately how
8 many actual beds there were in the ER Department around that
9 time?
10 **A.** So 10 to 12 beds in the ER Department. There is an
11 area called the "observation area" which is in the same area as
12 the emergency room with five or six beds with curtains between
13 them. It's where patients are kept for observation or if
14 they're admitted to the hospital waiting for a bed to go
15 upstairs, they would be in that area. It's not an area where
16 patients are initially assessed by the emergency room physician.
17 **Q.** So this area of five to six beds, is this over and
18 above the 10 to 12 you indicated or ...
19 **A.** Yes.
20 **Q.** It is over and above.
21 **A.** Yes.
22 **Q.** And if a patient is sort of either formally admitted

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

1 hospital, do they typically stay in the ER in an ER bed or do
2 they normally go elsewhere?
3 **A.** No. They would normally go elsewhere.
4 **Q.** And where in St. Martha's would they normally go?
5 **A.** There's a psychiatric ward that they would go to.
6 **Q.** Do you often see, in your experience, patients that
7 are either admitted overnight or kept overnight for mental
8 health- related reasons in St. Martha's? In your experience, do
9 you typically see whether or not they are kept in an ER bed? Is
10 that usual, unusual, frequent, unfrequent?
11 **A.** So they would usually not be kept in an ER bed. And
12 so I guess what I would call an ER bed is the 10 to 12 beds
13 where, as an Emergency physician, I'm seeing patients.
14 **Q.** Okay.
15 **A.** Like I said before, there's another area called the
16 observation area, that five to six rooms with curtains. So I'm
17 not sure if you're referring to the ...
18 **Q.** I guess either/or.
19 **A.** So I wouldn't call those emergency room beds. That's
20 an observation area. Physically, it's very close to the
21 emergency room. It's right beside it. And then there's the
22 wards in the hospital which would be on, usually, different

DR. JUSTIN CLARK, Direct Examination

1 floors. So, typically, a patient with a mental health issue
2 that was staying overnight for any reason, whether it just be to
3 stay overnight or if they're admitted, they would typically go
4 to the psychiatric floor.
5 **Q.** Which is separate and apart from those additional beds
6 off to the ...
7 **A.** Yeah. Apart from ...
8 **Q.** The observation ...
9 **A.** ... the observation area.
10 **Q.** ... beds, you call them?
11 **A.** Yes.
12 **Q.** And when you first examined Lionel Desmond on January
13 1st, where did that examination occur? Which of those ER rooms,
14 I guess.
15 **A.** So it took place in one of the interview rooms, which
16 is sort of down the hall, in a more quiet area. And there's a
17 room that has a couch in it.
18 **Q.** Was there a particular reason why that room might have
19 been used for Lionel Desmond as compared to one of the rooms
20 with the beds in it?
21 **A.** That would be a typical room that we would assess
22 someone in a situational crisis in the absence of physical

1 symptoms.
2 **Q.** So we're going to look to Exhibit 67, page 33. We're
3 going to go into some details. So at the top, Doctor, as we
4 identified as the emergency care record, we see a date of
5 January 1st, 2017. And do you see that in a registered time of
6 18:51?
7 **A.** Yes.
8 **Q.** And mode of arrival, it says "Walk-In".
9 **A.** Yes.
10 **Q.** So that information, is that completed by you?
11 **A.** No.
12 **Q.** Do you know who, as a rule, that's completed by?
13 **A.** I would say likely either the triage nurse or the
14 clerk at the front desk.
15 **Q.** And we see where it says, "R-E-G.time." What's the
16 significance of that?
17 **A.** That's the registration time. So during daytime
18 hours, there's a clerk that sits at a desk and they would
19 initiate this process and that would be the time they would
20 input when the person first presents.
21 **Q.** And this is pretty self-explanatory. Mode of arrival,
22 walk-in. I guess had somebody been brought in by the police or

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

1 it's already filled in.

2 **A.** Yes.

3 **Q.** And it says ... if you look back to the left, you see

4 "Complaint" listed there.

5 **A.** Yes.

6 **Q.** And what does it say?

7 **A.** It says "PTSD".

8 **Q.** What is ... I guess before I ask you what that is;

9 again, who would have entered this information? Do you know?

10 **A.** As far as I know, it would be the clerk. At certain

11 hours of the day, there's no clerk. So, at that point, it may

12 be the triage nurse entering it. I'm not sure.

13 **Q.** And, again, that's information that's completed on the

14 chart before it's provided ...

15 **A.** Prior to ...

16 **Q.** ... to you with the patient?

17 **A.** Yes.

18 **Q.** So what is "PTSD", I guess? And I recognize you're

19 not a psychiatrist, but you're a doctor obviously. What is

20 "PTSD"?

21 **A.** Post-traumatic stress disorder.

22 **Q.** Okay. And below that, we see a CEDIS code and it has

DR. JUSTIN CLARK, Direct Examination

1 MH.F41.9. And, there, it says, "Anxiety/situational cri".
2 What's that?
3 **A.** So that would be anxiety/situational crisis. It must
4 just be cut off.
5 **Q.** And that information was entered by someone else as
6 well?
7 **A.** Someone else as well.
8 **Q.** And provided to you at the time with the chart with
9 the patient.
10 **A.** Yes.
11 **(14:25:58)**
12 **Q.** So what is, I guess, "anxiety"? We all have a general
13 sense but is there a special clinical ...
14 **A.** I mean, generally, it's someone experiencing symptoms,
15 feeling worried. Some people can get physical symptoms like
16 their heart racing, palms sweaty. It's sort of a constellation
17 of symptoms that ...
18 **Q.** And what is "situational crisis"?
19 **A.** So that's sort of a non-specific term to describe when
20 someone presents in crisis in some way that's not a specific
21 physical symptom. So it's sort of a catch-all term.
22 **Q.** So a catch-all ... what does it capture, "situational

1 crisis", in your experience as an ER doctor? When you see that
2 entered, your mind goes to what?
3 **A.** To someone may have been in an altercation, they may
4 be brought in by police, they may have had ... you know, it may
5 be alcohol or drugs involved, just generally ... again, it could
6 be anything that's not a physical symptom. So people will
7 present for all sorts of different reasons; anxiety, depression,
8 fight with someone, altercation, arguments ...
9 **Q.** So it's a mixture of mental health-related matters.
10 **A.** Yes.
11 **Q.** And circumstance, I guess, related matters.
12 **A.** Right.
13 **Q.** So below that, we see triage date again, 18:51. And
14 then we see a number of things, "Lvi". What is that? It says
15 "LVI 2".
16 **A.** So that's a triage score, level two.
17 **Q.** And you indicated level one was cardiac arrest.
18 **A.** Uh-huh.
19 **Q.** Level two, in terms of the hierarchy, seems to be next
20 in terms of level of significance?
21 **A.** Yes. Two would be next.
22 **Q.** And realizing that you haven't ... you didn't score

DR. JUSTIN CLARK, Direct Examination

1 Lionel Desmond as a level two, but as an ER physician, when you
2 looked at that what, if anything, was that telling you?
3 **A.** So level two is, generally, you want to try to see
4 them as soon as possible.
5 **Q.** Does it suggest some sort of maybe urgency or ...
6 **A.** Yes, it does suggest urgency.
7 **Q.** And then you see ... it looks like temperature; HR,
8 heart rate. AA?
9 **A.** RR, respiratory rate.
10 **Q.** And BP, blood pressure. And O2, oxygen?
11 **A.** Yeah.
12 **Q.** So these are the vitals you had referred to?
13 **A.** Correct.
14 **Q.** And what were his vitals?
15 **A.** I would call those normal vital signs.
16 **Q.** So temperature, heart rate, respiratory, blood
17 pressure, oxygen.
18 **A.** They're all within the normal range.
19 **Q.** So those numbers, did they cause you any ... warrant
20 any sort of concern or ...
21 **A.** No. None.
22 **Q.** Below that it says ... under "Allergies" ...

1 **A.** Uh-huh.
2 **Q.** See that where it says "Medical History"? What does
3 it say there?
4 **A.** "PTSD. Post-concussion disorder."
5 **Q.** So that information, as well, was that entered by you?
6 **A.** No.
7 **Q.** So someone else. And you indicated ... would it be
8 the same person, presumably the triage nurse?
9 **A.** Yes.
10 **Q.** And that's information that's entered and provided to
11 you prior to or just as you see Lionel Desmond.
12 **A.** Yes.
13 **Q.** And below that it says, "Triage Assessment". I wonder
14 if you could indicate whether that triage assessment was entered
15 by you or someone else.
16 **A.** It was entered by someone else.
17 **Q.** And again a similar person?
18 **A.** The triage nurse.
19 **Q.** Okay. And entered in advance of you seeing Lionel
20 Desmond?
21 **A.** Yes.
22 **Q.** So I wonder if you could indicate what the triage

1 assessment was for Lionel Desmond.
2 **A.** To read it?
3 **Q.** Yeah.
4 **A.** "Patient dealing with PTSD since before 2011.
5 Patient had a bad day today. Argued with partner. Walked a lot
6 to try to calm down. Feels he's not coping well and is looking
7 for admission. Calm and speaking quietly."
8 **Q.** So you would have reviewed that, I guess, prior to
9 seeing Lionel Desmond?
10 **A.** Yes.
11 **Q.** So I guess we have that information or you have,
12 you're equipped with that information going into this. So is
13 there any sort of particular process that's happening in your
14 mind as an ER doctor being presented with this information?
15 What is your plan, I guess, if any?
16 **A.** So, initially, I would, I would look in MEDITECH to
17 get some background information prior to going to see the
18 patient and then after that I would go have a conversation, a
19 medical interview with the patient.
20 **Q.** Okay. So I guess step one would be looking at that
21 chart?
22 **A.** This chart, correct, yes.

DR. JUSTIN CLARK, Direct Examination

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

1 would that information have been relevant to you in assessing
2 Lionel Desmond that particular night?
3 **A.** Yes.
4 **Q.** If there had have been details about consults with
5 various health care professionals such as psychologists and
6 psychiatrists, would that have been helpful to you as an ER
7 doctor in your plan to assess Lionel Desmond that night? And
8 I'm keeping in mind, Doctor, that ultimately we're going to get
9 to the fact that you did ultimately consult a psychiatrist. So
10 the description in the triage assessment that described him
11 having a bad day, trying to calm down, not coping well, looking
12 for admission, "calm, speaking quietly, bad day, argued with
13 partner", is that consistent with this term of "anxiety
14 situational crisis"?
15 **A.** Yes.
16 **Q.** Do you recall when you looked at MEDITECH, do you
17 recall what, if any, documents you ... I know it's been a while,
18 obviously. Do you recall what, if any, documents you'd seen on
19 MEDITECH?
20 **A.** I don't recall.
21 **Q.** If we could look at page 3 ... Maybe it's page 2. My
22 numbering might be a little off. At page 2, this appears to be

1 a St. Martha's Regional Hospital Emergency Care record. Do you
2 see that?
3 **A.** Yes.
4 **Q.** And it's in the same format as the one from January
5 1st, 2017. There it talks October 24th, 2016, again related to
6 Lionel Desmond. Complaint: situational crisis. Do you see
7 that? I think we're on the wrong page here.
8 **A.** I don't think ...
9 **Q.** If we could ...
10 **A.** This looks like it says 1995.
11 **Q.** If we could look at page 3, maybe 4. Yes, we will
12 leave it on page 4, sorry. My numbering is one page off. So on
13 page 4, do you see that there, October 24, 2016?
14 **A.** Yes.
15 **Q.** "Lionel Desmond, situational crisis."
16 **A.** Yeah.
17 **Q.** So there's a chart there completed by ... There's a
18 signature down at the bottom, "attending physician", do you
19 recognize that signature?
20 **(14:36:00)**
21 **A.** I don't recognize the signature. I recognize the
22 handwriting, but I can't say which physician for sure.

DR. JUSTIN CLARK, Direct Examination

1 **Q.** Okay. And you recognize the handwriting. Who do you
2 believe that was? You can scroll up a little bit.
3 **A.** I can scroll up. Actually, I'm not sure.
4 **Q.** Okay.
5 **A.** I recognize the writing but I don't know specifically
6 which physician.
7 **Q.** Sure. But you would agree that this appears to be a
8 previous ER chart?
9 **A.** Yes.
10 **Q.** St. Martha's, predating January 1st when you had seen
11 him, outlining a situational crisis of Lionel Desmond?
12 **A.** Yes.
13 **Q.** And do you recall if you looked at that record on
14 that particular night through MEDITECH?
15 **A.** I don't recall if I looked at it.
16 **Q.** But, normally, would this document have been part of
17 MEDITECH on that date?
18 **A.** Yes.
19 **Q.** And I appreciate you can't recall if you looked at it
20 but is it typically something ... You seem very diligent in
21 wanting to go to MEDITECH to look up the history.
22 **A.** A recent ... I certainly would have. This would be

1 the first document I would open. A recent ER visit would be
2 very relevant and I would, typically, I would certainly look at
3 it.
4 **Q.** Okay.
5 **THE COURT:** In the normal course of events you would
6 expect to have read it even though you might not specifically
7 recall that today?
8 **A.** Exactly, exactly.
9 **MR. RUSSELL:** If we could turn to page 29, and, Doctor, I
10 just want you to take a quick look at that document. There are
11 three pages in total to it. And it appears as though, on the
12 first page, on page 29, it's a psychiatric consultation dated
13 December 2nd, 2016. He talks to clinician Catherine Chambers
14 and, ultimately, it appears to be signed, the detailed report,
15 by a Dr. Ian Slayter.
16 **A.** Um-hmm.
17 **Q.** Now this document, it says St. Martha's Regional
18 Hospital up at the top. Do you know if that document is
19 something that's uploaded and entered into MEDITECH?
20 **A.** I'm not sure.
21 **Q.** Okay. Do you recall if you had access to that
22 document on January 1st, 2017?

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

2 **Q.** So in the report, on the first page, Dr. Slayter is
3 indicating, do you see where it says, just above that, go up a
4 little bit. "I saw Lionel Desmond in consultation today at St.
5 Martha's Mental Health Clinic on referral."

6 **A.** Right.

7 **Q.** So were Mental Health Clinic documents accessible to
8 you as an ER physician on January 1st, 2017?

9 **A.** As far as I know, no. I don't recall ever seeing a
10 document from the Mental Health Clinic in the Emergency Room.

11 **Q.** Okay.

12 **A.** If a psychiatrist sees a patient in the Emergency
13 Room and does a consult, those documents are available.

14 **Q.** Much like the chart you had indicated earlier from
15 October?

16 **A.** Yes.

17 **Q.** Do you think such a detailed report from a
18 psychiatrist that occurred prior to your assessment and initial
19 encounter with Lionel Desmond on January 1st may have been
20 helpful to some degree?

21 **A.** Yes.

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

1 **A.** Again, the more information that you get about a
2 person, the better.
3 **Q.** If we could turn to page 37, we're back to the chart
4 of, just to orientate you, the chart of Lionel Desmond from the
5 night you had seen him, January 1st, 2017. This is one of the
6 documents you sort of identified. It says "Medication
7 Reconciliation"?
8 **A.** Yes.
9 **Q.** Is this a typical sort of form that goes with a
10 patient's chart in the ER?
11 **A.** Yes.
12 **Q.** And what's the significance of this particular form?
13 **A.** So it's a list of the patient's current medications.
14 **Q.** Okay. And the information of the patient's current
15 medications, do you know how that's typically gathered? Is that
16 gathered by you or ...
17 **A.** It's not gathered by myself. Usually, the nurses
18 will gather that information. It may be from the pharmacy, it
19 may be the patient may present with a bag of their medications
20 or they may present with a list of their medications.
21 **Q.** And you're provided with this information along with,
22 I guess, the first page of the chart, the Emergency Care Record?

DR. JUSTIN CLARK, Direct Examination

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

1 **A.** It's called trazodone.
2 **Q.** And what is trazodone?
3 **A.** It's a medication, it's generally used to help with
4 sleep.
5 **Q.** Prazosin?
6 **A.** Prazosin is also a medication used to treat sleep
7 disturbance.
8 **Q.** What's the next medication?
9 **A.** Quetiapine.
10 **Q.** What's quetiapine?
11 **A.** So quetiapine is an anti-psychotic medication that
12 can be used as ... I guess it's classified as an anti-psychotic,
13 but it can be used for various things, including sleep.
14 **Q.** And below that is another medication. What's that?
15 **A.** Quetiapine XR.
16 **Q.** And what is that and how is it different from
17 straight quetiapine, do you know?
18 **A.** So it would be a longer acting formulation of the
19 drug.
20 **Q.** And you normally would have reviewed that sort of
21 currently prescribed medication list?
22 **A.** Yes.

DR. JUSTIN CLARK, Direct Examination

1 **Q.** Did anything sort of cause you any concerns ... or
2 notable about that when you assessed Lionel Desmond on January
3 1st?
4 **A.** No. Those would be medications I would expect to see
5 from someone with his diagnosis.
6 **Q.** So in terms of your, I guess, approach as an ER
7 physician and, in particular, your approach to treating and
8 assessing Lionel Desmond on January 1st for mental illness, you
9 have him ... you're provided with information that it's
10 situational crisis, it's noted PTSD, it's also noted post-
11 concussion. What is your sort of approach ... what was your
12 approach to assessing Lionel Desmond, after you looked at
13 MEDITECH, you reviewed the chart, presumably you reviewed the
14 prior ER visit or what was available on MEDITECH, ...
15 **A.** Yes.
16 **Q.** You were diligent. What was your approach at that
17 point?
18 **A.** So I would go to the room where the patient is and
19 sit and have an interview. Typically, in the beginning, I would
20 allow the patient to describe why they're there in their own
21 words. So I would start with something like, What brought you
22 in tonight and I would let them describe their symptoms,

1 concerns, their story kind of in their own way.
2 **Q.** And do you have a recollection of interacting with
3 Lionel Desmond?
4 **A.** I do.
5 **Q.** And are you sort of assessing, in that initial
6 encounter, anything about body language or eye contact?
7 **A.** Yes, those would be included.
8 **Q.** And why are you sort of looking to those things?
9 **A.** So the goal of the interview is to get an overall
10 picture of what is going on. So there's a number of different
11 components that you'd look at when you're getting that sense,
12 and body language, eye contact, those would be a couple of those
13 components, for sure.
14 **Q.** And how would you describe Lionel Desmond's body
15 language or eye contact during the time that you had met with
16 him in the ER?
17 **A.** So I recall that he was calm and polite and
18 cooperative with the interview.
19 **Q.** A little bit about your history, Doctor. And we're
20 going to go back to the details of your interaction with Lionel
21 Desmond. Up to January 1st had you had much experience in
22 dealing with patients in the ER setting related to mental

1 health- related concerns or issues?
2 **(14:46:07)**
3 **A.** Mental health related concerns, yes. It would be a
4 common presentation in the Emergency Department.
5 **Q.** And what about your experience directly with military
6 veterans presenting in some sort of mental duress or concerns?
7 **A.** I would say I don't have a lot of experience with
8 military veterans. The areas I practice don't have a big
9 military population. In my family medicine residency in
10 Renfrew, Ontario, there is a military base near there, so I do
11 recall seeing patients, young veterans there ...
12 **Q.** Okay.
13 **A.** ... from time to time in the Emergency Room but I
14 would say I don't have a lot of experience.
15 **Q.** And is there any difference or was there any
16 difference in your approach to your assessment of Lionel
17 Desmond, knowing that he was a military veteran with those
18 symptoms ...
19 **A.** Yeah.
20 **Q.** ... versus a civilian with the same symptoms? Is
21 there any difference in your approach, from an ER physician's
22 perspective, in the treatment, diagnosis, assessment?

DR. JUSTIN CLARK, Direct Examination

1 **A.** No. I would go through the same process.
2 **Q.** Is there anything different in terms of flags or
3 concerns that you might be sort of keeping in the back of your
4 mind due to the fact that he was a military veteran with those
5 symptoms as opposed to a civilian with those symptoms?
6 **A.** Yes. Because it's a specific patient demographic I
7 don't have a lot of experience with, that was one of the reasons
8 I chose to involve Psychiatry when treating him.
9 **Q.** And you indicated you consulted Psychiatry. Do you
10 remember which psychiatrist you had consulted that evening?
11 **A.** Dr. Rahman.
12 **Q.** And my understanding is Dr. Rahman may be the Chief
13 of Psychiatry for that region?
14 **A.** I'm not sure.
15 **Q.** We'll find out. Perhaps I'm giving him a title he
16 doesn't have but I think he is or was. In your experience as an
17 ER physician at the St. Martha's Hospital, in particular, during
18 the shifts, whether it's day or afternoon or night, is there
19 always a psychiatrist present in the hospital that's available
20 directly?
21 **A.** They're not always present in the hospital, no.
22 **Q.** And ...

DR. JUSTIN CLARK, Direct Examination

1 **A.** There's always a psychiatrist on call. They may be
2 at home.
3 **Q.** So if you're working a shift at 3 o'clock in the
4 morning in Truro or St. Martha's in Antigonish and you need a
5 psychiatrist to consult, is there one available to you by way of
6 call?
7 **A.** Yes.
8 **Q.** That was the case in January 1st, 2017?
9 **A.** Yes.
10 **Q.** And does that continue to be the case today?
11 **A.** Yes.
12 **Q.** In your entire time, I guess, 2016 to today, and I
13 know this is putting you on the spot a little bit, and I
14 apologize, and I know you haven't been tracking data, but just
15 to get a sense from your perspective as an ER doctor, are you
16 able to estimate how many patients as a rule present to the ER
17 with a mental health-related medical issue or concern versus a
18 physically ... purely physiological concern, whether it's a sore
19 back, sore neck, cut, or a combination of both, in your
20 experience, and I won't hold you directly to hard and fast
21 numbers, but I'm just trying to get a sense.
22 **A.** I would estimate around 10 to 15 percent of

DR. JUSTIN CLARK, Direct Examination

1 presentations would be primarily mental health-related concerns.
2 And then there would be a significant number of people who
3 present with physical symptoms where there's some component of
4 their mental health that's involved but not the primary reason
5 they're there. But the majority would be physical, purely
6 physical components.
7 **Q.** So I understand that as part of your ongoing
8 professional experience as a physician, I guess the College of
9 Physicians ... Is that the right term?
10 **A.** Um-hmm.
11 **Q.** Requires you probably to keep so many continuing
12 education hours?
13 **A.** Yes.
14 **Q.** And are there set areas in which each physician and,
15 in particular, an ER physician has to complete so many hours in
16 mental health crisis-related illnesses, physiological, or a
17 combination of both?
18 **A.** There's a set number of hours or credits that we need
19 to get of CME, continuing medical education credits, but it's
20 not specified in which areas. It's largely up to the physician
21 to be working on areas where they may not be as strong.
22 **Q.** So I guess you, it's left to the physician's

1 judgment, to determine where they want to spend their continuing
2 education hours?
3 **A.** Correct.
4 **Q.** Which could mean going to conferences, I guess, or
5 reading sort of literature, that sort of thing?
6 **A.** Correct.
7 **Q.** So is it conceivable that as an ER physician who may
8 routinely deal with someone presenting in a mental health
9 crisis, you could decide I'm not going to do any continuing
10 legal education in that area - legal education? I'm thinking
11 from where I am, continuing education in terms of medicine, you
12 could decide I'm not going to do anything as it relates to
13 mental health, I want to do everything as it relates to burns, I
14 guess?
15 **A.** Yes, you could decide that. There are ways that in
16 your everyday treating patients and looking up diagnoses and
17 management of conditions, you can use that as your CME.
18 **Q.** Okay.
19 **A.** For example, if you're working in the Emergency Room
20 and you look, there's an app where we can look up diagnoses and
21 management. You get CME credits for using that.
22 **Q.** In your time as, as a physician could you, do you see

1 more of an emphasis, I guess, and concern or an awareness of
2 mental health related medical conditions or concerns compared
3 to, say, earlier on? Has there been a rise in the awareness of
4 that from a doctor's perspective?
5 **A.** I mean I have, I've only been practicing a few years.
6 I haven't seen ... I guess, do you mean with respect to
7 presentation to the Emergency Room or just ...
8 **Q.** Yes, specifically as it relates to presentation to
9 the Emergency Room.
10 **A.** To the Emergency Room. I have not seen a rise in the
11 number of people presenting, no.
12 **Q.** And in your ...
13 **A.** But again I have no data. I guess, in my experience,
14 I haven't found that to be true.
15 **Q.** And in your experience as an ER physician, would you
16 say it's of a high or low level degree of importance to be sort
17 of well-rounded in terms of - I realize you can't know
18 everything, and we presume that you do - but well-rounded in
19 terms of knowing mental health issues, signs, symptoms, as well
20 as the physiological aspects of things?
21 **A.** I would say they're equally as important, they're all
22 very important.

1 **THE COURT**: I'm going to suggest we take a short break.
2 So let's try for 15 minutes or thereabout. Thank you.
3 **COURT RECESSED (14:54 HRS.)**
4 **COURT RESUMED (15:07 HRS.)**
5 **THE COURT:** Thank you.
6 **MR. RUSSELL:** So, Dr. Clark, we're now going to turn to
7 the details of the chart as it relates to the visit with Lionel
8 Desmond which is Exhibit 67, page 33.
9 So, Doctor, if we could go down to the page where I guess
10 the handwriting starts where it says "time seen".
11 **A.** Yes.
12 **Q.** We're looking at the chart of Lionel Desmond from
13 January 1st, 2017. I'm wondering if you could ... and that's
14 your handwriting, I presume?
15 **A.** Correct.
16 **Q.** I'm wondering if you could read that into the record.
17 I wouldn't dare try.
18 **A.** Okay. So "Time seen - 19:09. 33-year old. Ex-
19 military. History of PTSD. Diagnosed in 2011. Followed by Dr.
20 Slayter and Veterans Affairs. Issues at home. Has a wife and a
21 nine-year old child. Outburst tonight. Breaking furniture. No
22 harm to family per patient. Wife told him, 'Don't come back

DR. JUSTIN CLARK, Direct Examination

1 until tomorrow.'"
2 **Q.** Okay. I guess we'll stop right there. So the time
3 you would have actually seen Lionel Desmond would've been when?
4 **A.** 19:09. I would put the time ... write the time seen
5 immediately before going into the room.
6 **Q.** Okay. So this note here that you made, there's quite
7 a few details in that small amount of note. Would you have made
8 these notes at the time you're doing your assessment with Lionel
9 Desmond or would you have made them after or a combination of
10 both, I guess?
11 **A.** Yeah. Sometimes during and sometimes after and
12 sometimes during and after. I don't recall in this case. I
13 would say that most of the time I see patients with mental
14 health concerns, I wouldn't be writing while talking to them.
15 **Q.** And why is that?
16 **A.** So I would want to be observing them closely and the
17 details of our interaction. I guess non-verbal details are a
18 lot more important in that case than if someone had a twisted
19 ankle, for example.
20 **Q.** So we're going to talk about sort of the outward
21 demeanour, I guess, of Lionel Desmond. Are you able to recall
22 sort of the tone or inflection of his voice?

1 **A.** I recall that he was calm and polite and cooperative
2 answering questions.
3 **Q.** Was he able to sort of engage in a conversation? And
4 what I mean by that is sort of question-answer dialogue with
5 you?
6 **A.** Yes.
7 **Q.** Were there any sort of stumbling blocks or concerns in
8 trying to get a narrative from him?
9 **A.** Not that I recall.
10 **Q.** And you described how his eye contact was. How was
11 that?
12 **A.** I recall that he had good eye contact during the
13 interview.
14 **Q.** Did he appear, say, nervous or restless at all when he
15 met with you?
16 **A.** Not that I recall.
17 **Q.** What's that?
18 **A.** Not that I recall, no.
19 **Q.** Did he appear excitable?
20 **A.** No.
21 **Q.** Did he appear to have any sort of, I guess, what's
22 referred to as "flat affect"? Very basic ...

1 **A.** I don't recall.
2 **Q.** Did you note anything from his body language?
3 **A.** Like I mentioned to you, he was calm, seated on the
4 couch in the interview room. That's all that I recall really.
5 **Q.** Do you recall if he was forthcoming with you in
6 providing information as to why he was there, why he was seeking
7 assistance?
8 **A.** I don't recall.
9 **Q.** Was he forthcoming in describing his symptoms or
10 concerns?
11 **A.** I guess what do you mean by "forthcoming"?
12 **Q.** I mean willing to sort of engage you. Was he holding
13 back information from you that you had to pull out of him?
14 **A.** No. I would say no.
15 **Q.** Did he seem willing to you to talk about his symptoms,
16 what he was experiencing and why he was there?
17 **A.** Yes.
18 **Q.** Was there anything in your interaction, I guess, with
19 Lionel Desmond that he appeared to be guarded or resistant to
20 sharing information with you?
21 **A.** No.
22 **Q.** There were a number of times you said you didn't

1 recall in terms of appearing sort of in different states. If
2 there was anything of significance that you noted about his
3 outward demeanour, would you normally have noted that in your
4 chart?
5 **A.** Yes.
6 **Q.** So, for example, if Lionel Desmond had been in what's
7 referred to a "manic state" ...
8 **A.** Yes.
9 **Q.** ... would you have noted that?
10 **A.** Yes.
11 **Q.** If he was agitated or irritable, would you have noted
12 that?
13 **A.** Yes.
14 **Q.** If he was aggressive, would you have noted that?
15 **A.** Yes.
16 **Q.** In that note you say, "Ex-military, PTSD", and you
17 have "2011", I believe?
18 **A.** Yes. "Dx 2011." Diagnosed in 2011, yes.
19 **Q.** So "Military, Dx PTSD, Dx 2011"?
20 **A.** Yes.
21 **Q.** So do you recall where the topic of him being
22 diagnosed with PTSD in 2011, where did that information come

1 from? Did it come from Desmond? Did it come from the charts?
2 **A.** I don't recall.
3 **Q.** You just recall having that information.
4 **A.** Yes. I documented it so I suspect it was from the
5 medical record, MEDITECH, the online EMR.
6 **Q.** Do you recall any discussion with Lionel Desmond about
7 the particulars of his post-traumatic stress disorder, when that
8 might've first occurred, how long it's been there?
9 **A.** I don't recall that conversation.
10 **Q.** Did you get into any sort of discussion or details
11 about his military service?
12 **A.** I don't recall.
13 **Q.** You just it noted "military" and you don't remember
14 where you got that information from?
15 **A.** No.
16 **Q.** Did you ever discuss with him, I note in the chart, as
17 it was provided to you by the triage nurse, it said "post-
18 concussion disorder". Did you do any sort of analysis or
19 follow-up with Lionel Desmond about post-concussion disorder
20 symptoms, if he was experiencing any, do you recall?
21 **A.** I don't recall but that is something I would typically
22 do. Ask the patient about their medical history. In that

1 section, I would confirm the details that are already written
2 and I would either add to it or cross out things that he didn't
3 endorse to me. So the fact that I made no changes, I most
4 likely confirmed that those details were there.
5 **Q.** And at one point in your note, you indicated, "No harm
6 to family per patient."
7 **A.** Yes.
8 **Q.** So that note, do you recall the circumstances
9 surrounding what information you gathered enough to make that
10 assessment of "no harm to family per patient". Or what does it
11 mean? Is it him telling you that?
12 **A.** So it means, according to the patient, there was no
13 harm done to his family.
14 **Q.** So that's information directly from him.
15 **A.** Yes.
16 **Q.** And do you recall how that information came out in the
17 dialogue with him?
18 **A.** I guess I don't recall our specific conversation, but
19 based on reading my own note, he told me about being in an
20 altercation or an argument and breaking some furniture so,
21 certainly, I would probe into the details of that. And one of
22 the most important pieces of information would be that, did he

1 harm any of his family members or did he have any thoughts or
2 considerations of plans to do so.
3 **(15:16:57)**
4 **Q.** Because you indicated that one of the things you
5 would've been looking for is this concept of not only suicidal
6 ideation but also homicidal ideation.
7 **A.** Correct.
8 **Q.** Do you recall specifically what you asked him
9 surrounding that when you learned the information of the
10 distress, I guess, that was happening between him and his wife?
11 **A.** Again, I don't recall the specific conversation but I
12 typically ask in the same way every time. It's something I do
13 every day, multiple times a day. So I would ask, Have you had
14 any thoughts of harming anyone? Any thoughts of killing anyone?
15 Have you considered harming anyone or killing anyone? And do
16 you have any plans to harm anyone or kill anyone?
17 **Q.** Do you recall what his answers were to those?
18 **A.** His answers were "no".
19 **Q.** And I didn't see ... Normally, do you document that
20 you had asked those questions in your chart?
21 **A.** Yes. So where I document, down towards the bottom,
22 "No SI/no HI".

1 **Q.** Yes.
2 **A.** So "HI" is referring to those questions. Homicidal
3 ideation refers to those specific questions. Any thoughts,
4 considerations or plans of harming anyone or killing anyone.
5 **Q.** And this is flowing, as well, there's a comment,
6 "Issues with wife. Breaking table."
7 **A.** "Furniture", yes.
8 **Q.** "Furniture", sorry. Is that information you gathered
9 from him directly?
10 **A.** Yes.
11 **Q.** And did you understand that to be recent? Occurring
12 recently?
13 **A.** Based on my note, I believe it happened recently, yes.
14 I don't recall the details surrounding that, but based on my
15 note, I would suspect that's something I would write if it
16 occurred recently.
17 **Q.** Back to your note, you say, "No harm to family per
18 patient". Was there a particular importance or reason why you
19 wanted to document it that it was per his narrative?
20 **A.** Yes. I had no collateral information at the time. He
21 was alone, so there was no other family members or friends or
22 police or anyone else.

1 **Q.** So it's fair to say it wasn't your definitive view,
2 that "no harm to family", but that's according to him.
3 **A.** Correct. On my assessment, that's what he told me.
4 **Q.** When you're having this interaction with Lionel
5 Desmond and there's talk about sort of recent issues at home,
6 breaking furniture, his wife told him, Don't come back until
7 tomorrow, and you're assessing, trying to get a full picture,
8 did you, in this case, ask Lionel Desmond about whether he had
9 access to firearms or does the topic of firearms ever come up,
10 or weapons?
11 **A.** That would be a typical question I would ask. I don't
12 recall a conversation we had about that but that's a typical
13 question during this type of interview.
14 **Q.** And why would you ask that sort of question?
15 **A.** So, at some point, you do an assessment for risk, so
16 you look at risk factors and protective factors and you kind of
17 go through those things.
18 **Q.** So the question you typically ask around firearms, in
19 your practice, what would it normally be?
20 **A.** I guess, Do you have any guns at home, or, Do you have
21 any access to guns, I guess, more importantly.
22 **Q.** Do you ever ask, and this may be getting into too much

1 detail, whether you have a license or a means to access
2 firearms? Is that something you would ever ask or is that too
3 detailed?
4 **A.** I wouldn't ask about a license routinely, but I guess
5 "do you have access" is the question I would usually ask, and I
6 guess that would include if they have means to.
7 **Q.** That's fair.
8 **A.** Yeah.
9 **Q.** I was going to have a separate section on it but I
10 think it's more relevant here. In terms of those questions,
11 when you're asking and assessing homicidal ideation, suicidal
12 ideation, and assessing risk, I guess, to himself and others ...
13 **A.** Mm-hmm.
14 **Q.** ... those questions that you say you typically ask,
15 are they outlined anywhere in a guideline for sort of an ER
16 physician? Is there a set series of questions? Perhaps like a
17 "best practices" manual or guide?
18 **A.** I'm not aware of any specific guideline, but it would
19 be a list. Risk factors and protective factors are in every
20 textbook and we're tested on it multiple times throughout
21 medical school and residency. So any physician or medical
22 student, if you ask them to list a few risk factors for suicide

1 completion, they would be able to list those, and those are
2 generally the same questions we ask during the interview.
3 **Q.** And you say this is sort of medical school, you learn
4 this?
5 **A.** Yes.
6 **Q.** So post-medical school but in terms of day-to-day
7 practice for ER physicians across Nova Scotia.
8 **A.** Mm-hmm.
9 **Q.** And I got the sense from you that it's a very active
10 thing that you're assessing risk to harm himself or others.
11 **A.** Yes.
12 **Q.** Is there anywhere that an ER doctor can sort of take a
13 quick look and say, Okay, I think I went through this here. I
14 checked off what I should be looking for. Is there a resource
15 that you can consult?
16 **A.** Yeah, and like I said, any textbook would have those
17 in it. A lot of us use online apps and things like that.
18 **Q.** Okay. Are you aware of any sort of ... If I could
19 have one moment, Your Honour.
20 My understanding is that there's sort of a suicidal risk
21 protocol or list of factors ...
22 **A.** Okay.

1 **Q.** ... that have been prepared by various psychiatrists.
2 Are you familiar with the document?
3 **A.** I'm familiar with that concept. I don't know of a
4 specific document that you're talking about but lists such as
5 that would be, like I said, they would be in any textbook, any
6 ...
7 **Q.** Yeah.
8 **A.** Yeah.
9 **Q.** But if there had been something sort of worked on in
10 Nova Scotia that identified risk factors for suicide, risk
11 factors for homicidal ideation, as an ER doctor, are you aware
12 of any such document?
13 **A.** I'm not aware of a specific document.
14 **Q.** Okay. I don't want to get too hypothetical, but do
15 you think it would have any particular value to ER doctors to be
16 privy to that information if there is one?
17 **A.** I think it would be valuable. It's something that we
18 all do sort of every day, multiple times a day. So I guess it
19 depends what you mean by "valuable". I suppose you could have a
20 checklist as part of the chart. That would save a lot of time
21 rather than writing out specific things but those risk factors
22 are something that we're expected to know.

DR. JUSTIN CLARK, Direct Examination

1 **Q.** Okay. So I guess my question is, if there was a part
2 of psychiatry in Nova Scotia that had worked on devising a
3 series of risk factors for suicide, for example, and they were
4 confident in saying, These are the main sort of areas to assess
5 for suicide risk, do you think it would be valuable for an ER
6 doctor to be aware of that document?
7 **A.** Yes.
8 **Q.** And perhaps learn a bit about that?
9 **A.** Yes, but I mean we would already know a lot about that
10 but ...
11 **Q.** That's fair.
12 **A.** Yes.
13 **Q.** For sure. Some of it obviously may be routine
14 information.
15 **A.** Yes.
16 **Q.** In terms of the living situation of Lionel Desmond,
17 you have in quotes, "Don't come back until tomorrow." So I take
18 it that's a direct answer from him.
19 **A.** Yes.
20 **Q.** Or words from him? And so was there any sense from
21 you, in your conversation with Lionel Desmond, how long he
22 might've been out of the home? Had he just been kicked out of

1 the home? What was your understanding of that situation?
2 **A.** I don't recall having a conversation specifically
3 about that. Again, the sense I get from reading my chart was
4 that it was very recent that he left his home and immediately
5 came to the emergency room but I don't recall him telling me
6 that specifically.
7 **Q.** Was there any discussion that you can recall whether
8 Lionel Desmond had somewhere to stay? Whether there was a
9 discussion about staying with relatives or anything? Do you
10 recall anything?
11 **A.** Again, that's something I would ask but I don't recall
12 having that conversation.
13 **(15:27:02)**
14 **Q.** And do you recall any sort of specific requests from
15 Lionel Desmond about wanting to stay overnight in the hospital?
16 **A.** Yes. I believe he wanted to stay overnight in the
17 hospital because he didn't want to go home until the morning
18 because he wanted to follow what his wife had asked him.
19 **Q.** In this situation when you're dealing with Lionel
20 Desmond, does he come to the ER with anyone that you're aware of
21 that particular date?
22 **A.** No.

1 **Q.** To your knowledge, he was alone?
2 **A.** Yes.
3 **Q.** Now did that cause you to sort of evaluate things or
4 did you start to draw any inferences or any additional questions
5 as a result of him showing up alone?
6 **A.** I guess having collateral information is very helpful
7 in a situation like this. So I guess that contributed to my
8 decision of whether or not to manage him on my own or to involve
9 one of my colleagues in Psychiatry. So if I don't have any
10 collateral information as an emergency physician, someone's
11 alone, I'm much less likely to manage it on my own.
12 **Q.** So I understand that there's rules on patient-doctor
13 confidentiality. Would there ever be any sort of discussion
14 with, say, Lionel Desmond in this situation of saying, Are there
15 any supports of people you can talk to? Would you ever have
16 that conversation with him?
17 **A.** Oh certainly. And often I will specifically ask
18 someone if I can call their friend or family member to speak
19 with them. I don't recall, in this particular case, if I did or
20 not, but that's something I would routinely do because sometimes
21 they'll be just fine with that.
22 **Q.** And is there a reason why you would sort of ask the

1 patient, in Lionel Desmond's situation, Look, is there somebody
2 I can call? Speak to?
3 **A.** To get collateral information. Just to ... more
4 details to verify what he's saying like that. But if he says no
5 to me doing that, I can't.
6 **Q.** Obviously.
7 **A.** I can't call someone for confidentiality reasons.
8 Yeah.
9 **Q.** Clearly. But in a circumstance where, if somebody had
10 said to you, I am going to go home and I'm going to do this to
11 my wife, threaten violence, does that lift your veil of
12 confidentiality?
13 **A.** Yes, in that situation, yes.
14 **Q.** Okay. But there was no indication of that here.
15 **A.** No.
16 **Q.** There's a reference in these notes, as well, by you.
17 It says, "Followed by Dr. Slayter/Veterans Affairs." Do you
18 know, the reference to Dr. Slayter, do you know where that comes
19 from? Does that come from Lionel Desmond or does it come from
20 your exploration of MEDITECH?
21 **A.** I don't know for sure. I suspect it is from
22 MEDITECH.

1 **Q.** In terms of drugs or alcohol, just if I look at the
2 right side of your report, you see the line that says "Time
3 Seen"?
4 **A.** Yes.
5 **Q.** "Time Seen" and then all the way over to the right of
6 the page there is two, looks like zeros with lines drawn through
7 them.
8 **A.** Yes.
9 **Q.** What is that?
10 **A.** That mean no. So no ETOH, no alcohol.
11 **Q.** Yeah.
12 **A.** And no illicit drugs.
13 **Q.** So you would have specifically asked ...
14 **A.** Yes.
15 **Q.** ... Lionel Desmond? And would you have also sort of,
16 there was that self-reporting aspect, but would you have also
17 sort of, as a trained physician, look to see if there was any
18 sort of visible impairment?
19 **A.** Yes, certainly.
20 **Q.** And to your recollection, was there any sort of
21 visible impairment?
22 **A.** No.

1 **Q.** If we look down below the note that said, "Wife told
2 him don't come back until morning ... until tomorrow," we see,
3 it looks like an O/E and what appears to be an NAD. What's
4 that?
5 **A.** So O/E is objective slash ... like I guess it means
6 what you're seeing, what you're observing, that section.
7 **Q.** Okay. And what is, is it "NAD"?
8 **A.** NAD. No acute distress.
9 **Q.** So what's the significance there, I guess, what are
10 you ...
11 **A.** So I guess the goal of the Emergency chart, in
12 general, it's a limited space, of course, is to paint an overall
13 picture of the patient. So that's a common phrase used to
14 describe someone who is sitting appropriately and answering
15 questions. They're not in any apparent distress.
16 **Q.** Okay. You went over, below that 0SI/HI, which is no
17 homicidal ideation or suicidal ideation?
18 **A.** Correct. And the, and, sorry, the "E",
19 objective/examination would be what the E stands for. Like the
20 whole O/E generally means what you're seeing.
21 **Q.** Okay. Below that appears to be the word speech and
22 something by it. What is that?

DR. JUSTIN CLARK, Direct Examination

1 **A.** So that's speech with an N and a circle around it, so
2 that means normal. So his speech was normal.
3 **Q.** And what is below that?
4 **A.** No evidence of psychosis.
5 **Q.** So I guess Dr. Rahman is definitely the person that
6 speaks to psychosis but your understanding of ... What is
7 psychosis, what you are looking for as an ER doctor?
8 **A.** So I guess it's when someone is disconnected from
9 reality in some way, so it's sort of a spectrum. There are a
10 number ... So when you're trying to look for any evidence of
11 psychosis. During the interview you observe the patient, listen
12 to their answers to questions, observe the behaviour, to try to
13 get an overall sense if there's features of psychosis. So
14 there's different components, I guess, what they look like: for
15 example, are they taking care of themselves; what's the
16 behaviour, are they disorganized or erratic, aggressive;
17 something called thought content. Is there any suggestion of
18 hallucinations or delusions? Something called thought process -
19 are they, you know ... do the details of what they're telling
20 you make sense? Is it all logical? Does the story make sense?
21 So you're looking at all these different components during the
22 interview in order to come up with a final assessment of whether

1 there's any evidence of psychosis.
2 **Q.** And was there any suggestion of any of those present
3 with Lionel Desmond?
4 **A.** No. So when I document no evidence of psychosis, all
5 those components in the entire interview sort of goes into that
6 conclusion.
7 **Q.** Okay. You talk about, in your global assessment, of
8 no suicidal ideation, no homicidal ideation. When you look at
9 previous records, would that be something you would be looking
10 for in those past records, if there were?
11 **A.** Yes.
12 **Q.** Yes. And I realize and appreciate you're limited to
13 the information that's provided to you. Had you been aware that
14 there was any suggestion of past comments or threats of suicide
15 or even concerns in obsessions or delusions regarding his wife
16 ...
17 **A.** Um-hmm.
18 **Q.** Is that information that would have assisted you in
19 your assessment of Lionel Desmond in the ER?
20 **A.** Yes.
21 **Q.** And in what way?
22 **A.** So, I mean, if you go through the risk factors for

1 suicide, a previous attempt or ... That's one of the risk
2 factors. So generally on my ... Typically, I would, at the end
3 of seeing a patient, if I were to manage the patient on my own
4 and discharge them from the Emergency Room, for example, I would
5 have a lot of things on this chart that aren't present. So that
6 portion is where I would typically list specific risk factors
7 and protective factors. So I may have been aware ... I don't
8 recall what I found from those charts, but that's something that
9 I would typically include in if I were the one coming up with a
10 management plan.
11 **Q.** Okay.
12 **A.** In this particular case I had consulted Dr. Rahman,
13 and there's a transfer of care there, and I wasn't present
14 during the final management plan.
15 **(15:37:03)**
16 **Q.** That's fine.
17 **A.** I guess those details would be something I would
18 typically include when I document the plan.
19 **Q.** And when you're asking the questions, assessing those
20 two concepts, you know, Do you have any thoughts of harming
21 yourself, Do you have any thoughts of harming others, is there a
22 question that, Did you recently threaten to harm yourself or Did

1 you recently in the past threaten to harm others, is that a
2 series of questions you ask?
3 **A.** Yes, it would be part of the interview, asking about,
4 I guess, at any time.
5 **Q.** And you would have asked those of Lionel Desmond, I'm
6 presuming?
7 **A.** Yes, yes.
8 **Q.** So back to sort of testing the validity of the
9 caution, I guess, with patients and what they're telling you, if
10 you were aware of a document that had said in the recent past he
11 had threatened to harm himself and the specifics of what he said
12 he would do ... And his answer in this case was no, I'm
13 presuming?
14 **A.** Yes.
15 **Q.** And so they, on its face, would appear to contradict
16 each other?
17 **A.** Yes.
18 **Q.** So he says no to you, that he hasn't threatened harm
19 to himself, but there's a chart out there that says he did and
20 you weren't aware, I presume, at the time, how would your
21 approach differ if you were aware of a chart that contradicted
22 your patient?

DR. JUSTIN CLARK, Direct Examination

1 **A.** That would make me more concerned and it would make
2 me more likely to consult a colleague in Psychiatry.
3 **Q.** And convey that information?
4 **A.** Yes.
5 **Q.** And that, certainly, if you came across that
6 information, is that, and when you did your consult to
7 Psychiatry is that information that you would have conveyed and
8 said, look, he told, I guess this scenario, He told me that he
9 didn't threaten harm to himself in the recent past, but there is
10 a chart out there that we know that he did?
11 **A.** I don't know for sure; possibly.
12 **Q.** Okay.
13 **A.** Yeah.
14 **Q.** And did you ever get a sense - I just want to be
15 clear. During your interview with Lionel Desmond or assessment
16 of Lionel Desmond on January 1st, at any point did you get any
17 sort of indication that he was being misleading or untruthful
18 with you?
19 **A.** No.
20 **Q.** And turning now to your consult, Doctor, if we look
21 below your note about psychosis, we see, above Diagnosis, what
22 is that? It's a little squiggly ...

DR. JUSTIN CLARK, Direct Examination

1 **A.** So A/P, so that's assessment and plan.
2 **Q.** Okay. That is your assessment and plan?
3 **A.** So that, if I were the one who came up with his final
4 management plan and disposition, that's where I would write it.
5 So I guess my plan from that point on was to consult the
6 psychiatrist.
7 **Q.** And ...
8 **A.** So that's ... So the next line with the Psy symbol is
9 sort of short form for Psychiatry. So that just means Psych to
10 see, so Psychiatry is going to come assess the patient.
11 **Q.** So I guess based on the totality of the information
12 you had received from Lionel Desmond and the totality of the
13 circumstances, you made the determination that you felt it
14 necessary to consult ...
15 **A.** Yes.
16 **Q.** Psychiatry. I'm wondering if you could indicate ...
17 Obviously, you were the one that made that judgment call.
18 **A.** Um-hmm.
19 **Q.** What led you to say, Okay, I've assessed him, I
20 gathered the information, I've looked at everything, Psychiatry
21 needs to be consulted? From your ER doctor perspective, what
22 were the reasons for that in Lionel Desmond's case?

1 **A.** So as an Emergency physician I see a lot of mental
2 health complaints. I'm obviously not an expert, so I have a low
3 threshold to involve my colleagues to begin with. In this case,
4 like I said previously, there was no collateral information, so
5 that was one of the factors going into not feeling comfortable
6 managing it on my own. Also, I don't have a lot of experience
7 treating young veterans with PTSD. Like I said before, it's not
8 a common complaint that we deal with. So for those reasons I
9 wanted to call Dr. Rahman.
10 **Q.** Okay. And looking to the right of that last thing
11 you identified, the Psy symbol, "To See" ... Consultation
12 appears to be checked off?
13 **A.** Correct.
14 **Q.** And again is that the same symbol?
15 **A.** Yes.
16 **Q.** Psychiatry. So what time was the consult requested?
17 **A.** So at 7:30, 19:30.
18 **Q.** So just sort of doing some math here, I guess, to get
19 a sense of the time you're ... It's ... 19:10 is when you enter
20 the room with Lionel Desmond?
21 **A.** Correct, 19:09.
22 **Q.** 19:09, sorry. And 19:30 is the consult requested?

1 **A.** Yes.
2 **Q.** So is 19:30 ... does that denote sort of your end of
3 contact with Lionel Desmond?
4 **A.** Yes.
5 **Q.** So you see Lionel Desmond for 21 minutes, I believe?
6 **A.** Correct.
7 **Q.** So Dr. Rahman, do you recall if he was readily
8 available for the consult?
9 **A.** He's always readily available by phone.
10 **Q.** Do you recall if he was by phone or in person, what's
11 your recollection?
12 **A.** I called him, initially. I believe, I can't remember
13 for sure, but I believe I called him.
14 **Q.** Do you remember speaking to him in person or ...
15 **A.** I did speak to him in person, as well.
16 **Q.** All right.
17 **A.** Yeah.
18 **Q.** And do you recall what sort of information you might
19 have provided to Dr. Rahman about Lionel Desmond and the reason
20 for your consult?
21 **A.** I don't recall the conversation we had over the phone
22 or prior to him seeing him.

1 **Q.** But you did ...
2 **A.** But I would have communicated ... I suspect I would
3 have communicated the details of my note here and told him I was
4 uncomfortable managing it on my own.
5 **Q.** And did he sort of agree to assist?
6 **A.** Oh, yeah.
7 **Q.** So once it's sort of turned over, I guess, to Dr.
8 Rahman, the consult at 19:30, we see a time on the left, just
9 below ...
10 **A.** 19:32.
11 **Q.** Yeah. So what's the significance of 19:32?
12 **A.** So 19:32 was probably the time I signed the bottom of
13 the chart and it was so the chart was complete. So it was
14 shortly after I called Dr. Rahman.
15 **Q.** And do you have any further contact with Lionel
16 Desmond past 19:32?
17 **A.** No.
18 **Q.** And at that point it's, I guess, turned over to Dr.
19 Rahman?
20 **A.** Yes.
21 **Q.** I'm going to show you, for the sake of completeness,
22 a piece of legislation - you may have it in front of you -

1 called the **Involuntary Psychiatric Treatment Act**, and on the top
2 left-hand corner you'll see the page numbers.
3 **A.** Yeah.
4 **Q.** So, in particular, I want to look at page 6, section
5 8 of the **Act**. It says "Medical Examination and Involuntary
6 Psychiatric Treatment", you see that?
7 **A.** Yes.
8 **Q.** And it says certificate for involuntary assessment.
9 **A.** Yes.
10 **Q.** Section 8.
11 **A.** Yeah.
12 **Q.** So, Doctor, you're somewhat familiar with that **Act**?
13 **A.** Yes.
14 **Q.** I guess ... I understand you might not know it front
15 to back, but the concepts that are conveyed in that particular
16 **Act**?
17 **A.** Yes, and this particular paragraph is on a form that
18 I have routinely completed at times.
19 **Q.** Okay. So that form, it's in relation to what? I
20 understand patients can be voluntary or involuntary and just
21 generally what are those concepts?
22 **A.** So if someone presents and they have certain symptoms

1 or they're telling me certain things and then they want to
2 leave, you have the ability to hold them in the hospital, I
3 guess, against their will, if they meet these certain criteria.
4 **Q.** And ER doctors, I guess, play a role in, could I say
5 initiating that process, where it's relevant?
6 **A.** Yes. It wouldn't be uncommon for someone to want to
7 leave and to need to fill out a form in order to have them stay.
8 **(15:47:02)**
9 **Q.** And in the particular case of Lionel Desmond, in your
10 ... This form, I guess, before we get to that, so this form you
11 complete, which is under section 8 of the **Act**, what generally is
12 that form and what's its purpose?
13 **A.** So the purpose is once the form is filled out the
14 patient's not allowed to leave until they're assessed by a
15 psychiatrist. So you have the ability to physically keep them
16 there. Now sometimes people leave because you can't physically
17 keep them and, if that's the case, we call the police and they
18 bring them back. So it forces the person to have an assessment.
19 **Q.** By a psychiatrist?
20 **A.** By a psychiatrist.
21 **Q.** Okay. So in this particular case, if we look at
22 section 8, it says, "Where a physician has completed a medical

1 examination of a person and is of the opinion that the person
2 apparently has a mental disorder ..." So was that the case in
3 Lionel Desmond's circumstances, that first little bit?
4 **A.** Yes, the patient had known mental health disorders.
5 **Q.** And then it says, " ...the person, as a result of the
6 mental disorder, (I) is threatening or attempting to cause
7 serious harm to himself or herself or has recently done so, has
8 recently caused serious harm to himself or herself, is seriously
9 harming or is threatening serious harm towards another person or
10 has recently done so ..." So in Lionel Desmond's case was there
11 a suggestion that that was present?
12 **A.** No, there was no suggestion.
13 **Q.** And below it it says, Or, so there's another
14 scenario, "As the result of the mental disorder, the person is
15 likely to suffer serious physical impairment or serious mental
16 deterioration, or both." Was there a suggestion that that may
17 be the case here?
18 **A.** There was no suggestion of that.
19 **Q.** And then it says, "(b) the person would benefit from
20 psychiatric inpatient treatment in a psychiatric facility and is
21 not suitable for inpatient admission as a voluntary patient."
22 So in the case with Lionel Desmond was he willing to see a

1 psychiatrist?
2 **A.** Yes.
3 **Q.** So was there any suggestion that you needed to hold
4 him there or force him there to undergo that assessment ...
5 **A.** No.
6 **Q.** ... with the psychiatrist?
7 **A.** No.
8 **Q.** And, again, so was there any suggestion that you ...
9 there was a need to fill out that form to hold him there, I
10 guess, involuntary?
11 **A.** No.
12 **Q.** And had certain circumstances existed as such, say,
13 if Lionel Desmond had not wanted ... he was, you know, in a
14 manic state, he was a threat to himself or others, not wanting
15 to undergo an assessment by a psychiatrist, in such a
16 circumstance, would you perhaps have considered, under this **Act**
17 and under that form, making, holding him for the purposes of a
18 psychiatric assessment?
19 **A.** Yes, in that circumstance, I would have.
20 **Q.** But there was no need here?
21 **A.** No.
22 **Q.** So were you present ... I know you indicated you

1 turned everything over to Dr. Rahman. At any point were you
2 present during Dr. Rahman's assessment or meetings with Lionel
3 Desmond?
4 **A.** In the room?
5 **Q.** Yes.
6 **A.** No.
7 **Q.** Do you recall, have any recollection as to where
8 Lionel Desmond stayed that particular night on January 1st?
9 **A.** I do recall a conversation with Dr. Rahman about
10 where he would spend the night.
11 **Q.** So if you could tell us a little bit about how that
12 conversation came about and what the conversation was about.
13 **A.** Okay. So like I said before, typically, a patient
14 with a mental health issue seen by a psychiatrist or waiting to
15 be seen by a psychiatrist would go to the Psychiatry ward. In
16 this case, Dr. Rahman told me that the patient didn't want to go
17 to the Psychiatry ward because his wife had friends who worked
18 there, so he felt uncomfortable. So Dr. Rahman asked if it was
19 appropriate or okay for him to stay in the observation area
20 overnight.
21 **Q.** And when you say his wife had friends that worked
22 there, was there any discussion about whether Shanna Desmond, in

1 fact, Lionel Desmond's wife, had, in fact, worked there, do you
2 remember?
3 **A.** I'm aware of that. I don't recall the conversation.
4 **Q.** Okay. So is that something you were willing to
5 accommodate, that request?
6 **A.** Certainly. I think it was more of a courtesy. To me
7 ... it wouldn't be up to me, I think, but it was a reasonable
8 thing.
9 **Q.** Okay.
10 **A.** Again, it wasn't in an Emergency Room bed, he wasn't
11 taking a bed that we would have been seeing patients in the
12 Emergency Room. There was an observation area and it was under
13 the care of him. So for me, there was no difference between the
14 observation area and the Psychiatry ward. So if it made the
15 patient more comfortable, then, then that was just fine.
16 **Q.** So he was separate and apart and away from sort of
17 the ER traffic?
18 **A.** Yes.
19 **Q.** Over in Observation?
20 **A.** Yes.
21 Q. And did you have any interactions with Lionel Desmond
22 or recall seeing him over in that observation area?

1 **A.** No.
2 **Q.** No. And in your experience, has that sort of
3 scenario ever happened before when you were working in the ER?
4 **A.** Not that I can recall. Do you mean just someone
5 being in the observation area waiting or the situation where
6 they don't want to go maybe to the ...
7 **Q.** A situation where normally they would go to another
8 area in the hospital but there's a request to keep them in an
9 ER?
10 **A.** No, no other request that I can recall. Sometimes
11 out of ... There's no bed available. That would be the only
12 other time.
13 **Q.** Do you recall when your shift, roughly, ended that
14 particular evening?
15 **A.** So my shift ended at 8 p.m. I don't recall when I
16 actually left. It wouldn't be uncommon to stay for half an hour
17 to an hour or more to finish up with patients.
18 **Q.** Were you involved to any degree in Lionel Desmond's
19 ultimate discharge from the hospital?
20 **A.** No.
21 **Q.** I'm just going to ask you briefly if you have an
22 understanding of the concepts of formal admission of a patient

1 and what's maybe loosely referred to as a social admission and
2 I'm wondering if you could discuss what they are and define
3 those concepts for us.
4 **A.** So a social admission refers to when someone is
5 either admitted or stays in the hospital but there's no
6 indication medically for them to be there.
7 **Q.** And in your experience had you, as an ER physician,
8 had someone there as not formally admitted but there as a social
9 admission?
10 **A.** It happens frequently. Probably the most common
11 example would be someone who's homeless who comes in at
12 nighttime and, for example, if they have chest pain, after
13 they're worked up for their chest pain and it's determined that
14 they're discharged, you know, it's night, it's winter, and they
15 have nowhere to go, no shelter, we'll often hold them overnight
16 to be discharged in the morning.
17 **Q.** And when they're held overnight is it your
18 understanding that they still receive sort of nurse observation,
19 medication ...
20 **A.** Yes.
21 **Q.** ... regular care?
22 **A.** Yes.

DR. JUSTIN CLARK, Direct Examination

1 **Q.** Is there any, in practical terms, is there any
2 distinction between the two other than one is sort of
3 accommodating someone that doesn't have a place to go?
4 **A.** It really just means there's no ... there's some
5 other reason other than a medical or psychiatric reason to keep
6 them in the hospital. They would otherwise be discharged but
7 there's usually a social factor that you accommodate.
8 **Q.** Okay.
9 **A.** That's the distinction I would have between those two
10 terms.
11 **Q.** Okay. And finally, Doctor, I'm going to ask you
12 some broad questions, I think it really is a prime opportunity,
13 and certainly feel free to share. I recognize to some degree,
14 as best I can, the stressors on ER doctors in Nova Scotia, the
15 valuable service you provide and how busy ER doctors are and how
16 vital they are to Nova Scotia. In situations such as this, and
17 what I'm driving at is in situations where patients appear in
18 the ER in some form of mental crisis and they're seeking
19 treatment, do you see any sort of, and in particular, this sort
20 of scenario, improvements or elements that can be made to assist
21 ER doctors, from your practical experience?
22 **(15:57:10)**

DR. JUSTIN CLARK, Direct Examination

1 **A.** I would say it would be beneficial to have access to
2 social workers or a crisis worker outside of daytime hours. I
3 think that would be of benefit.
4 In this particular case I think ... I believe the patient
5 presented at just before 7 p.m. and he saw a psychiatrist at 8
6 p.m. So that's very fast. I would say that's not typically
7 what would happen. Typically, patients will wait hours, and
8 usually they wouldn't be seen by a crisis worker or a
9 psychiatrist until the following day, if they presented in the
10 evening. But generally speaking, from the different emergency
11 rooms I've worked with, I think having more resources outside
12 daytime hours, with crisis teams and social workers, would be
13 beneficial.
14 **Q.** Okay. Anything else in terms of records and patient
15 history that may be helpful?
16 **A.** I mean any way that we can get more information
17 quickly is going to help.
18 **Q.** And anything in terms of ... It's a very difficult
19 task that you have when you're trying to evaluate risk of
20 suicide and homicide and it's a very pressured environment, it's
21 a very fast environment. Are there any sort of things you think
22 could help ER doctors to make their roles easier or more

1 complete?

2 **A.** I think resources or CME opportunities, those are
3 always a good thing for any area, especially if there's any
4 changes that are happening in the literature. So it's important
5 to stay up to date. So any opportunities that would allow us to
6 stay up to date would be good.

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

8 **A.** Continuing Medical Education. So, I mean, it's a
9 broad term ...

10 **Q.** Yes.

11 **A.** But sometimes there'll be, for example, someone, an
12 internist in a hospital may do a talk on heart failure and
13 update all the physicians and you can get CME credit for that.
14 So those happen for all sorts of different topics. So a CME
15 talk from a psychiatrist on some of these issues - and they
16 certainly are happening now - but I think would be beneficial,
17 they're always beneficial.

18 **Q.** Okay. And just back to one of the topics you
19 brought up about having access to sort of a social worker, did
20 you say sort of an outreach?

21 **A.** So there's something called a crisis worker in every
22 hospital that I work in, and they will often come assess the

1 patient prior to the psychiatrist. But this usually happens
2 during daytime hours. So it may be beneficial to have ... and
3 the crisis worker is ... I don't know their specific
4 credentials, but they're often a social worker. And so it's
5 helpful to have them present because they will do their own
6 assessment of the patient.
7 **Q.** Just so ... maybe deal with the aspects of
8 homelessness or where they're going to go, sort of ...
9 **A.** Certainly.
10 **Q.** ... day-to-day life stressors.
11 **A.** Certainly. And then they also do a full comprehensive
12 assessment. And they're very experienced with that sort of
13 thing, assessing risk and other things, as well.
14 **Q.** And, in your experience, are they available after
15 hours, let's say, after ...
16 **A.** No.
17 **Q.** No. Okay.
18 **A.** They're not available after dinnertime.
19 **Q.** No further questions for Dr. Clark. Thank you, Dr.
20 Clark.
21 **MS. WARD:** No questions, Your Honour.
22 **THE COURT:** Ms. Ward? Mr. Anderson?

1 **MR. ANDERSON:** No questions, Your Honour.
2 **THE COURT:** Thank you. Mr. Macdonald?
3 **MR. MACDONALD:** Thank you, Your Honour.
4
5 **CROSS-EXAMINATION BY MR. MACDONALD**
6 **(16:01:41)**
7 **MR. MACDONALD:** Good afternoon, Dr. Clark. I'm Tom
8 Macdonald and I'm the lawyer for the Borden family, so the late
9 Mrs. Desmond and also co-counsel with Tara Miller for Aaliyah
10 Desmond. So I just have a few questions. I'm going to hop
11 around just a little bit. And if I ask you a question and you
12 think I've phrased it that you do not understand or unfairly to
13 you, please tell me and we'll move on from there.
14 So just a question about the access to medical records you
15 would have had, taking you back to January 1st and 2nd of 2017.
16 So we know about the electronic system that was available to you
17 at St. Martha's. When you choose to look at that then, or even
18 today, how long would it take you to actually call up records?
19 Not asking how long it would take you to read them but to bring
20 the file ... the electronic file up. How do you do it and how
21 long would it take to do it?
22 **A.** It would take maybe ten seconds to sign in.

1 **Q.** Okay.
2 **A.** You sign in on a computer.
3 **Q.** Yes.
4 **A.** It would take ten seconds. You click on a tab where
5 all the documents are and then you can start to look through
6 them.
7 **Q.** Okay. You mentioned in a question with Mr. Russell,
8 sometimes patients who are presenting with mental issues don't
9 answer questions. Did Lionel Desmond refuse to answer any
10 questions?
11 **A.** No.
12 **Q.** Just a clarification. At St. Martha's, Psychiatry, is
13 that on the third floor and sort of known colloquially as "the
14 third floor"? Is that where the psychiatric unit is?
15 **A.** I believe so. I've only been there one time, so I
16 don't know for sure.
17 **Q.** And so was the one time when you saw Lionel Desmond or
18 ...
19 **A.** No.
20 **Q.** No, with ... another time. Okay. Understood.
21 So back to the triage questions and the intake. And you
22 explained, at least for my benefit, the scoring system one to

1 five. One is a heart attack, a true emergency; five is a
2 sprained ankle. Lionel Desmond was a two. In the St. Martha's
3 scheme of things in terms of triaging, that's pretty serious,
4 isn't it? It's just below a full-blown emergency. Is that
5 fair?
6 **A.** So the triage system is the same ... my understanding,
7 it's the same everywhere in Canada.
8 **Q.** Okay.
9 **A.** Not just St. Martha's. And triage level two suggests
10 that the patient should be seen soon. That may be for various
11 reasons.
12 **Q.** The notes on the chart with respect to situational
13 crisis ... and I ... in response to Mr. Russell, you mentioned
14 some factors. And I think ... at least as I was taking down
15 that ... I don't pretend the list is exhaustive; police
16 involvement, alcohol and drugs, a fight, for example. But one
17 of those factors would be domestic violence, wouldn't it?
18 **A.** Certainly.
19 **Q.** And of ...
20 **A.** Yeah. Any ...
21 **Q.** Yes.
22 **A.** ... altercation or ... yes.

1 **Q.** And on the chart we see the notation, "argue with
2 partner". Right?
3 **A.** Correct.
4 **Q.** Yeah. Would that, for you, raise the level two at all
5 or the immediacy of seeing someone?
6 **A.** So I do not ... as part of my job, I do not triage ...
7 **Q.** Right.
8 **A.** ... patients. So it's hard for me to comment on how
9 ... I know that they have objective criteria that they use and
10 there's also some component that's subjective criteria they can
11 use to change the score.
12 **Q.** Okay.
13 **A.** But I don't do that as part of my job, so it's hard
14 for me to comment on the specific score.
15 **Q.** Understood. So I just wanted to be clear. And I know
16 Mr. Russell was taking you through the electronic records. And,
17 I'm sorry, what was the name again? MEDITECH?
18 **A.** MEDITECH.
19 **Q.** MEDITECH. So can you say today with any clarification
20 that ... and I don't need you to look at the records unless you
21 need to. But the chart that came up, we know there was an
22 October 2016 visit by Mr. Desmond. Dr. Slayter saw him. We

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

1 know there was a December 2nd or 3rd. The report is there.
2 Prepared an analysis, I guess, prepared by Dr. Slayter. Can you
3 say with any certainty today whether those two documents I refer
4 to would have been on the MEDITECH system the night you went to
5 the computer at St. Martha's?
6 **A.** So I don't recall ...
7 **Q.** Right.
8 **A.** ... the visit that was documented on an emergency room
9 chart.
10 **(16:07:02)**
11 **Q.** Yes.
12 **A.** I believe it would be present in MEDITECH. And,
13 sorry, what was the second ...
14 **Q.** And the second would have been this December 2016
15 assessment, that Dr. Slayter saw Mr. Desmond the second time and
16 completed a lengthy psychiatric assessment.
17 **A.** That one would be from his private clinic.
18 **Q.** Yes, but I think it was at ... the letterhead, as I
19 understand it, has St. Martha's Hospital on it so maybe the
20 clinic was at the hospital.
21 **A.** Right. I don't recall seeing that document.
22 **Q.** Okay.

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

1 **A.** And in my experience, I've never seen a psychiatric
2 clinic note present in MEDITECH.
3 **Q.** Okay. If it turns out ... and I don't know the answer
4 to give you today, but if it ... so I'm not trying to trick you.
5 But if it turns out that it was on the MEDITECH system, you'd
6 agree with me it would have been available for you to read if
7 you chose to do so ...
8 **A.** Oh, certainly.
9 **Q.** ... and if you'd seen it.
10 **A.** Yes.
11 **Q.** Thank you.
12 **A.** And that would have been a document I would certainly
13 read.
14 **Q.** Understood.
15 **A.** Yeah.
16 **Q.** And you called Dr. Rahman and spoke with him on the
17 telephone. Dr. Rahman is present here today, listening to your
18 evidence, isn't he?
19 **A.** Yes.
20 **Q.** He's seated in the gallery over here?
21 **A.** Yes.
22 **Q.** Yes. Okay. You mentioned about ... and I think Mr.

1 Russell put it, I guess, the way I would, weapons, firearms, and
2 then the word "guns" came into it or if not, I'll use it. Do
3 you have ... and you said, I believe, that that was normally
4 something you would ask about.
5 **A.** Yes. It would be a typical question.
6 **Q.** Exactly. Do you have a specific recollection that you
7 asked Mr. Desmond anything about guns on January 1st?
8 **A.** I don't have a specific recollection. No.
9 **Q.** And I know you said that it might have been a typical
10 question you would ask about access to guns.
11 **A.** Correct.
12 **Q.** Would you also ask if someone had possession of a gun?
13 **A.** Yes.
14 **Q.** And so you ...
15 **A.** The ...
16 **Q.** ... understand where I'm coming from, "access" means
17 ...
18 **A.** Correct.
19 **Q.** ... I can get my father's gun. "Possession" means
20 I've got my own gun or ...
21 **A.** I would start with asking if they have their own guns
22 in their home.

1 **Q.** Okay.
2 **A.** And then I would progress to ask do they have access
3 in any way ...
4 **Q.** Understand.
5 **A.** ... from a friend, from ...
6 **Q.** Okay.
7 **A.** ... another family member.
8 **Q.** Is there any reason ... if that's something you think
9 you would have done with Mr. Desmond, why wouldn't it be
10 somewhere noted on the chart?
11 **A.** Like I mentioned before, I would typically include
12 that ... a detailed risk assessment, risk factors, protective
13 factors. I would include those things with my management plan
14 ...
15 **Q.** Yes.
16 **A.** ... kind of at the bottom of my chart. So because I
17 wasn't ... I consulted the patient to see a psychiatrist, so I
18 wasn't present and didn't come up with any management plan. So
19 that's why that documentation isn't there. So that risk
20 assessment, plus a lot of other things like medication changes,
21 follow-up plan and return precautions, all of these things would
22 be included sort of in my management plan area.

1 **Q.** Okay.

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

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

10 **A.** I may have.

11 **Q.** Okay.

12 **A.** Yeah.

13 **Q.** Yeah.

14 **A.** Hard to say for sure.

15 **Q.** Those are my questions, Dr. Clark. Thank you very
16 much.

17 **THE COURT:** Mr. Rogers?

18

19 **CROSS-EXAMINATION BY MR. ROGERS**

20 **(16:11:37)**

21 **MR. ROGERS:** Dr. Clark, my name is Rory Rogers and I'm
22 one of the counsel for the Nova Scotia Health Authority. You

1 talk in your testimony about availability of psychiatrists in
2 various institutions. Can I focus your attention on St.
3 Martha's? St. Martha's does have psychiatry services available?
4 **A**. Correct.
5 **Q**. So when you're providing ER shifts at St. Martha's, if
6 you feel the need or benefit for a psychiatric consult, that's
7 something that's available to you.
8 **A**. Yes.
9 **Q**. And so that can be done by referring or consulting
10 with the psychiatrist who happened to be present in the hospital
11 when they are present. Correct?
12 **A**. Correct.
13 **Q**. And at other times there's a phone system, an on-call
14 system, so that 24/7 you have access to psychiatric services?
15 **A**. Correct.
16 **Q**. And in this case, the psychiatric services were
17 provided and were made available to you by and through Dr.
18 Rahman. Correct?
19 **A**. Correct.
20 **Q**. And what can you say about the timeliness of Dr.
21 Rahman's response and availability with respect to the consult
22 you sought for Mr. Desmond?

1 **A.** I could say it was very good. It wouldn't be typical.
2 Dr. Rahman is usually very willing to come assess patients
3 himself. Certainly not typical for a psychiatrist to assess a
4 patient at nighttime in any of the hospitals I work in.
5 **Q.** Okay. So when you say "not typical", this was gold
6 standard delivery of psychiatric services by ...
7 **A.** Uh-huh.
8 **Q.** ... Dr. Rahman in terms of timeliness and his
9 willingness to spend time with Dr. ... or with Mr. Desmond?
10 **A.** Yes.
11 **Q.** Thank you. You made reference to the triage record
12 that's part of the chart that's available to you when you have
13 time to assess a new patient who comes in to Emerg. Correct?
14 **A.** Correct.
15 **Q.** And I think that's found at page 33 of Exhibit 67?
16 **A.** (No audible response.)
17 **Q.** So this is the triage record that you typically have
18 as part of the chart together with the list of meds when you
19 determine you're able to see somebody who has been triaged.
20 Correct?
21 **A.** Correct.
22 **Q.** And you see here that the reference was to triage

1 level two. Correct?

2 **A.** Yes.

3 **Q.** Is it fair to characterize this triage assessment as

4 largely a means and a mechanism for the hospital to prioritize

5 those individuals who come into the hospital and who are in the

6 waiting area seeking treatment?

7 **A.** Correct.

8 **Q.** So that you know if you have somebody who comes in who

9 needs urgent treatment, they're going to be given a triage level

10 score higher so it gets them through the door to see you or one

11 of your colleagues faster. Correct?

12 **A.** Correct.

13 **Q.** Because the goal is to say who needs to see a

14 physician earliest among our group who's in the waiting room or

15 who has arrived. Fair?

16 **A.** Exactly.

17 **Q.** And the assessment note, that's the note that we see

18 under the heading that says "Triage Assessment"?

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

20 **Q.** And that's typically entered by the triage nurse who

21 does that quick three-, four-, five-minute triage assessment.

22 Fair?

1 **A.** Correct.

2 **Q.** In your evidence earlier, Dr. Clark, you said that the
3 triage scale affects the timing of your assessment.

4 **A.** Correct.

5 **Q.** So is it ultimately your assessment as an emergency
6 room physician that really is the determining factor as to what
7 the diagnosis will be or what the treatment will be? You're not
8 relying upon the triage assessment to supplant what you're doing
9 as the physician in treating ... an emergency room physician.
10 Is that fair?

11 **A.** Sorry. Could you phrase that again?

12 **Q.** Sure. So when someone comes in to see you, you're
13 doing your own assessment as a physician. Correct?

14 **A.** Correct.

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

17 **A.** Umm ...

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

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

21 **Q.** Okay. You described briefly the number of beds in the
22 Emergency Department at St. Martha's and then the observation

1 area. I just want to go through that a little bit. You talked
2 about the fact that there are 10 to 12 beds in the Emergency
3 Department at St. Martha's. Correct?
4 **A.** Correct.
5 **Q.** But over and above that there are rooms available that
6 I think you described, in part, as the family room and I believe
7 now may have changed its term to an interview room ...
8 **A.** There's two such rooms at St. Martha's.
9 **Q.** Okay. So let's take it to the January 2017 period.
10 There was a family room that was less clinical in nature and had
11 solid walls and a couch and nice chairs. Correct?
12 **A.** Correct.
13 **Q.** And your understanding is that mental health patients
14 were often taken to that room because it's more private?
15 **A.** It's more private and more comfortable. Yeah.
16 **Q.** And more comfortable in what way?
17 **A.** Well, sitting on a couch rather than on an examination
18 bed.
19 **Q.** Okay. Fair enough. And so that's where you saw Mr.
20 Desmond on the night of January 2nd. Correct?
21 **A.** Correct.
22 **(16:16:57)**

1 **Q.** Okay. Then over and above ... and just to talk about
2 changes that have been put in place, I understand that that room
3 has now moved but there are two interview rooms or more-quiet,
4 more-personal, less-clinical rooms available in St. Martha's
5 Emergency?
6 **A.** So the room I saw Mr. Desmond in was an interview room
7 at that time and it is still, currently. That room hasn't
8 changed. I think you might be referring to they added a second
9 one.
10 **Q.** Okay.
11 **A.** I'm not sure when that took place.
12 **Q.** Fair enough. So there's now two of those rooms
13 available to deal with or interview folks presenting with any
14 mental health issues. Fair?
15 **A.** Correct.
16 **Q.** Okay. And over and above that, you talked about the
17 observation area. And is that area slightly separate and
18 distinct from the 10 to 12 emergency room beds ...
19 **A.** Yes.
20 **Q.** ... that you referred to?
21 **A.** Yes.
22 **Q.** And that area of the observation that I think you

1 described as five or six beds, is it fair to say it's an area
2 that's shared between what's referred to in St. Martha's as the
3 observation area as well as Clinical Decision Unit beds or CDU
4 beds?
5 **A.** Correct.
6 **Q.** So those two areas are really short-term beds for
7 people who have left the emergency room beds but are waiting for
8 determination as to whether they will be discharged or admitted
9 to the hospital on a floor.
10 **A.** Correct.
11 **Q.** Okay. And in the observation beds, that's your
12 understanding that Mr. Desmond was moved to one of those
13 observation beds.
14 **A.** That's my understanding. Yes.
15 **Q.** And I think that the Inquiry may have heard evidence
16 earlier that suggested that there was second- or third-hand
17 information that Mr. Desmond was left on a stretcher somewhere
18 in the hospital. And we've all heard some press reports of that
19 example. But the beds in the observation area of the Clinical
20 Decision Unit area, those aren't stretchers. Those are normal
21 full hospital beds. Correct?
22 **A.** I'm not sure.

1 **Q.** Okay. You talked a bit, Dr. Clark, about the records
2 access and what you had available to you electronically to
3 review as part of your assessment of Mr. Desmond. You're aware
4 that the Nova Scotia Health Authority is looking at and aiming
5 at something called "one patient/one record"?
6 **A.** Yes.
7 **Q.** And what's your understanding as to what that would
8 then make available to physicians such as yourself in an
9 emergency department when a patient presents?
10 **A.** So my understanding is that it would be an electronic
11 medical record that would capture every interaction ... every
12 healthcare interaction in the province in one EMR.
13 **Q.** Okay. So that would cover ...
14 **A.** That's my understanding.
15 **Q.** ... all the hospitals of the Nova Scotia Health
16 Authority as well as private family physicians, as well.
17 **A.** I would assume. I don't know for sure. I've just
18 read some about it and that's the only ...
19 **Q.** Okay.
20 **A.** ... place I got information.
21 **Q.** You indicated in addition to looking typically at what
22 information you'd have available in terms of a medical history

1 before you see a patient that there are examples and situations
2 where you have thought it beneficial to seek information of a
3 medical nature from another province. Correct?
4 **A.** Correct.
5 **Q.** And I assume ... and then you said that in those cases
6 you would have someone from the clerical side of the hospital
7 make the inquiry in an attempt to have those records faxed to
8 you. Correct?
9 **A.** Correct.
10 **Q.** And I think you said that, typically, there can be
11 restrictions on that through the evening hours but that that's
12 something that can be available through the day. Correct?
13 **A.** Correct.
14 **Q.** So would it be fair to say you make a judgement call
15 each time that you learn that there may be records in another
16 jurisdiction, in another province or another country? You make
17 a judgement call as to whether those records would be helpful
18 and necessary for you as part of your treatment?
19 **A.** Yes. I would determine if they were relevant for
20 treating the patient's acute issue. The example I gave of
21 someone having a history of cardiac disease, if you had no
22 information whatsoever, then some records would be important.

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

1 **Q.** Okay. But that's a judgement call you make all the
2 time. And you don't request those records from every other
3 provincial jurisdiction every time you see a patient, do you?
4 **A.** No, certainly not. It would be fairly uncommon.
5 Typically, it would be when I have no information at all.
6 **Q.** Okay. You talked a little bit earlier in response to
7 some questions Mr. Russell put to you as to what recommendations
8 or suggestions you might have for change. And you made
9 reference to potential benefit of increasing the hour
10 availability of what you called the "crisis team". At St.
11 Martha's, that's the Mental Health Crisis Team. That's a
12 service available to emergency room physicians. Correct?
13 **A.** Correct.
14 **Q.** So if you see a need for a mental health assessment to
15 be undertaken as part of the work you're going to be doing, you
16 have the ability to refer those patients to Mental Health Crisis
17 at St. Martha's. Correct?
18 **A.** Correct.
19 **Q.** And, to be fair, I think you indicated you weren't
20 sure exactly the background of the first line of the workers who
21 would assess. You believe there would be some social workers.
22 Are there, to your knowledge, also some nurses with some special

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

1 training in mental health issues that perform that service?

2 **A.** I mean that makes sense but I don't know of any,

3 personally, that I know that are nurses. I'm not aware of any.

4 **Q.** And then ... but to your knowledge when you again are

5 seeking to have a patient access that service at St. Martha's,

6 then there is also the availability of a psychiatrist through

7 that service as part of that referral. Correct?

8 **A.** Yes. So 24 hours a day there is a psychiatrist on

9 call. And then during the daytime hours, you can consult the

10 Crisis Team or Crisis person. In my experience, during the day

11 it is usually an initial assessment by the Crisis Team and then

12 there's a determination from them whether or not to get the

13 psychiatrist involved.

14 **Q.** Okay.

15 **A.** That's my understanding of how it works, but ...

16 **Q.** Okay. And turning next and speaking of psychiatrists,

17 you were taken to the emergency record you prepared. And that's

18 page 33 of the materials in front of you?

19 **A.** Yes.

20 **Q.** And take you to your handwritten note. And I see you

21 make reference to the fact that Mr. Desmond was followed by Dr.

22 Slayter. And Dr. Slayter is a psychiatrist at St. Martha's.

1 Correct?
2 **A.** Correct.
3 **Q.** So your note says, "He was followed by Dr. Slayter.
4 Veterans Affairs." Correct?
5 **A.** Correct.
6 **Q.** And I think in the question that Mr. Russell put to
7 you, he asked whether you could recall if that reference to Dr.
8 Slayter was information that was provided to you by Mr. Desmond
9 or it came from your review of the electronic records or
10 whatever records were available. And if I'm recalling
11 correctly, you thought it might have come from your review of
12 MEDITECH. But, certainly, the information about Veterans
13 Affairs, would it be fair to say that would have come directly
14 from the patient, from Mr. Desmond?
15 **A.** I don't recall. If Veterans Affairs was mentioned on
16 any of the notes in MEDITECH, that may have triggered me to
17 write that.
18 **Q.** Yeah.
19 **A.** I don't recall where I got that information.
20 **Q.** Okay. That's fair. Just a few additional questions,
21 Dr. Clark.
22 You referred to the concept of a social admission as

1 opposed to a formal admission. Based on the information you saw
2 and the information we were able to obtain from Mr. Desmond,
3 would you characterize his period of time in Observation as a
4 social admission as opposed to something further?
5 **A.** Yes. I'm not a psychiatrist, so ... and ... so that
6 would largely be based off the assessment of the psychiatrist.
7 But from my point of view, yes, I would call that more of a
8 social admission. But ...
9 **Q.** Okay. And, lastly, the Inquiry has heard evidence
10 that may be, again, second- or third-hand that suggested that
11 Mr. Desmond told some others, potentially some family members,
12 in the day or two after he left St. Martha's that he wasn't kept
13 there because the hospital or the third floor, the Mental Health
14 Unit, was full. Do you have knowledge as to whether there were,
15 in fact, beds available on the third floor or the psychiatric
16 floor at St. Martha's that day?
17 **A.** The only knowledge I have is based off of my
18 conversation with Dr. Rahman, who told me that the patient
19 preferred not to go to the ward. So, presumably, there were ...
20 that was a possibility at the time.
21 **Q.** And there was certainly a bed available in the
22 observation area where Mr. Desmond remained that night.

1 **(16:27:00)**

2 **A.** Yes.

3 **Q.** Thank you.

4 **THE COURT:** Ms. Miller?

5

6 **CROSS-EXAMINATION BY MS. MILLER**

7 **(16:28:48)**

8 **MS. MILLER:** Thank you, Dr. Clark. My name is Tara
9 Miller and I represent Brenda Desmond and also share
10 representation with Mr. Macdonald of Aaliyah Desmond. I'm going
11 to pick up on a few threads and topics that were previously
12 canvassed by all other counsel.

13 **A.** Sure.

14 **Q.** I'm going to start with this concept of social
15 admission. I think I have a pretty good handle of your
16 explanation about why oftentimes people will be kept in hospital
17 for not really a medical reason but more of a social reason.
18 You gave the example of the individual who would be homeless and
19 not to be releasing him at night into the cold. And then my
20 friend had asked you about Lionel staying in the observation
21 area of the emergency room and whether or not that was a social
22 admission. And I think your response, I don't want to misstate

1 it, was that all you really know about that was what Dr. Rahman
2 told you and that Lionel had some discomfort with being on the
3 third floor.
4 **A.** Correct.
5 **Q.** Okay. And we'll certainly talk to Dr. Rahman
6 tomorrow. But is it your understanding that had Lionel not
7 expressed discomfort with being on the third floor, that he
8 would have been admitted to the third floor?
9 **A.** Yes.
10 **Q.** And would that then have been a formal admission or
11 would it have been a social admission?
12 **A.** No. The location is irrelevant.
13 **Q.** Okay.
14 **A.** Yes. He was under the care of Dr. Rahman and happened
15 to physically be in the observation area. A formal admission
16 would have been determined by Dr. Rahman and not by myself.
17 **Q.** Okay.
18 **A.** So ...
19 **Q.** Yeah.
20 **A.** But the physical location does not.
21 **Q.** So he could have been formally admitted to the third
22 floor with two things: if he was comfortable going there; and

1 then if Dr. Rahman felt that that was necessary from a treatment
2 perspective.
3 **A.** Correct.
4 **Q.** Okay. I want to talk about risk factors again, and
5 you've spoken about them and we've heard about them and they're
6 important, as I understand it, in the context of identifying
7 suicidal and/or homicidal ideation. Correct? Those are the
8 risk factors that you're talking about in terms of reviewing
9 with the patient to assess whether or not they're at risk of
10 harming themselves or others?
11 **A.** So you would assess suicidal and homicidal ideation by
12 directly asking the patient.
13 **Q.** Correct.
14 **A.** And then whether they say "yes" or "no", you
15 independently look at risk factors.
16 **Q.** Right. You don't rely solely on the patient saying, I
17 don't have any suicidal ideation, or, I don't have any homicidal
18 ideation.
19 **A.** Right.
20 **Q.** The analysis is far broader than that. You don't ...
21 **A.** Correct.
22 **Q.** ... take the patient ... for example, if they say, No,

1 I don't have any, that's not the end of the analysis. Correct?

2 **A.** Correct.

3 **Q.** And, in fact, it's very important to go through those

4 risk factors .

5 **A.** Correct.

6 **Q.** ... to elucidate and determine whether or not there is

7 actually something there that should be of concern to you or any

8 other of the assessing doctors. Is that fair to say? Without

9 relying on the patient saying, No, I don't have this.

10 **A.** That's correct. Now generally the risk factors are

11 more relevant when someone is suicidal.

12 **Q.** Fair enough, but you're still making that assessment.

13 **A.** Yes.

14 **Q.** Even if they say they're not suicidal.

15 **A.** Correct.

16 **Q.** Okay. That's part of your sort of broader mandate

17 when they come in, particularly with a mental health complaint.

18 Is that fair to say?

19 **A.** Correct.

20 **Q.** Okay. And you had talked about when you do that risk

21 assessment independent of what the patient has told you you

22 would typically have a very detailed review of your notes in the

1 ER information if you were planning on managing that patient.

2 **A.** Correct. I would typically include risk factors and

3 protective factors as part of my disposition plan.

4 **Q.** Right, and you have ...

5 **A.** Patient's being discharged ...

6 **Q.** ... notes about that.

7 **A.** ... this is their follow-up, this is their risk.

8 **Q.** Yes.

9 **A.** Yes.

10 **Q.** That would be part of your detailed note-keeping if

11 you were planning on following up with managing them yourself.

12 **A.** Correct.

13 **Q.** But in this case, you didn't do that because you were

14 transferring care to Dr. Rahman.

15 **A.** Correct.

16 **Q.** Okay. What are protective factors? You mentioned

17 that before.

18 **A.** So there's a number of them. So things that would

19 suggest safety. So they have family, they have pets. We use

20 the term "future oriented". Someone who says they're suicidal

21 but they're taking about things that might happen a year or two

22 from now.

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

1 **Q.** Okay.
2 **A.** There's a list of ...
3 **Q.** Okay.
4 **A.** ... things such as that
5 **Q.** And again, you talk about a list, and I think you said
6 that, you know, every medical student has them sort of drilled
7 into their ...
8 **A.** Yeah. And we're tested on them and ... yeah.
9 **Q.** And you're tested on it. And Mr. Russell had asked
10 you questions about being aware of a criteria sheet. And you
11 said you weren't specifically aware of that. But ...
12 **A.** Correct.
13 **Q.** ... you know, doctors will use an app and you have
14 them ingrained in you when you go through them.
15 **A.** Yes.
16 **Q.** Okay. I just wanted to ask you to take a look at that
17 same exhibit, page 7, Dr. Clark. Yes, on the screen. So this
18 is a document which is contained in the St. Martha's Hospital
19 materials and it is from a visit that we know. Lionel Desmond
20 had an emergency room visit in October, October 24th, 2016. And
21 this document is called Mental Health and Addictions Crisis
22 Response Service Mental Health/Risk Assessment.

1 Have you seen this? I'll ask this two ways. Have you
2 seen, generally, this type of an assessment form before?
3 **A.** Yes.
4 **Q.** Okay, and then it appears this had been filled out
5 specifically with respect to an assessment of Lionel that was
6 done in his October 24th, 2016 visit? Is that fair to say?
7 **A.** Yes.
8 **Q.** Okay. And would you have had access to this when you
9 were reviewing his documents on MEDITECH?
10 **A.** I believe so.
11 **Q.** Okay. Now ...
12 **A.** If this was completed in the Emergency Department, and
13 part of the emergency chart, I believe, I would have access to
14 this.
15 **Q.** Okay, and we'll hear from other witnesses on that, but
16 I assume, if you turn to page 4, you see the emergency room
17 record from October 24th, 2016.
18 **A.** So it's included in ...
19 **Q.** It looks like it would logically, from your
20 perspective, be included? Does that ...
21 **A.** Yes.
22 **Q.** ... make sense? Okay, so this is a very detailed

1 assessment and it goes from page 7 to page 10. It's four pages
2 of detailed information, which I assume is to assess mental
3 health/risk assessment, and that's what the document is
4 entitled?
5 **A.** Yes.
6 **Q.** Okay. Would you ever have occasion to fill this sheet
7 out in the course of your role as emergency room doctor?
8 **A.** No.
9 **Q.** Okay. Is this a type of document I think that you
10 said that during daytime hours there would be a crisis team who
11 would typically fill out this assessment and then hand it off to
12 a psychiatrist?
13 **A.** And I guess discuss with the psychiatrist.
14 **Q.** Okay.
15 **A.** And oftentimes they will also discuss with the
16 emergency physician as well ...
17 **Q.** Right.
18 **A.** ... the disposition plan.
19 **Q.** Okay. So an emergency room physician or a
20 psychiatrist would not fill this document out.
21 **A.** No.
22 **Q.** It would be somebody on the crisis response team?

1 **A.** Correct.
2 **Q.** And those folks go home at 5 o'clock-ish.
3 **A.** Yes.
4 **Q.** Okay, so after hours if you show up with a mental
5 health challenge, a situational issue, no one's going to fill
6 out or take the detail ...
7 **A.** Of this particular form, no.
8 **Q.** ... of this document. No? Okay, and when I look
9 through it. I want to take you to page 9, Dr. Clark. The
10 bottom section of this page talks about suicide risk assessment
11 and we see interview risk profile, individual risk profile and
12 ... I can't really read that. Protective factors. So would
13 these be the risk factors and protective factors that you had
14 talked about earlier that would exist?
15 **(16:37:06)**
16 **A.** Yes.
17 **Q.** That every doctor knows sort of by rote but these
18 would be those risk factors?
19 **A.** Yes.
20 **Q.** Okay, so when I look through this list I don't see
21 anything in here that assesses whether or not somebody has a gun
22 or access to a gun. You see that? But based on your evidence

1 ...
2 **A.** So ...
3 **Q.** ... I understand that that is something that you would
4 have raised and typically do raise.
5 **A.** So on these lists it's usually described as access to
6 lethal means.
7 **Q.** Okay.
8 **A.** You're correct. I don't see it written on here but
9 ...
10 **Q.** Yeah.
11 **A.** ... typically you would see it on a list such as this.
12 **Q.** Okay. That is what you would envision it should have,
13 access to a lethal ...
14 **A.** Yes.
15 **Q.** ... weapon. Because it certainly could be a knife or
16 a sabre or something like that.
17 **A.** Correct.
18 **Q.** But you'll agree with me that on this risk assessment
19 there is nothing that would trigger someone to ask ...
20 **A.** Yes.
21 **Q.** ... about a gun or anything of that nature? Okay. Is
22 there anything that you can see here about recent separation or

1 marital breakdown?
2 **A.** On the list of risk factors?
3 **Q.** Anywhere in this section, interview risk profile,
4 individual risk profile, and protective factors. Anything in
5 there that I'm maybe not interpreting?
6 **A.** The bottom of the first column, recent crisis conflict
7 loss.
8 **Q.** Okay, and that, from your perspective, would include
9 marriage breakdown or separation?
10 **A.** Yes.
11 **Q.** Okay. If you determine that somebody does have access
12 to firearms - either they own them or they can get access to
13 the- - is there anything, any system that you can access,-to put
14 the police on notice that this person may be a potential risk to
15 themselves or others, Dr. Clark?
16 **A.** Yes, you can notify the police and the police will
17 confiscate the weapon.
18 **Q.** Okay, so that would happen, that you would pick up the
19 phone or ...
20 **A.** I've never initiated that myself ...
21 **Q.** Okay.
22 **A.** ... that I can recall but I know it happens quite

1 commonly.

2 **Q.** Okay, and to your knowledge, how does that happen?

3 **A.** In the cases that I can recall, a patient's friend or

4 family member call the police. The police take the weapon. One

5 way or another, the patient ends up in the emergency room. So

6 it's usually it happened before I would do my assessment.

7 **Q.** Okay. Is there ever a case where a person would be in

8 the emergency room and you would identify that they have some

9 risk factors but not enough to warrant invoking **IPTA** ...

10 **A.** Right.

11 **Q.** ... an involuntary admission? But they have some risk

12 factors that would include having access to a gun but not enough

13 to trigger involuntary admission. Is there ever any situation

14 where you'd still take that information about some concerns but

15 not enough to meet this very high threshold and let the police

16 know?

17 **A.** No. They would go together.

18 **Q.** Okay, so if it's not going to meet the **IPTA** threshold

19 that information could conceivably just get lost in the system.

20 **A.** Correct.

21 **Q.** Okay, and ...

22 **A.** I guess it depends what you mean by "lost in the

1 system".

2 **Q.** Well, it would be captured somewhere in the medical

3 records but it would never be actioned on to any other agency

4 ...

5 **A.** Right.

6 **Q.** ... for review or oversight.

7 **A.** There may not be indication to act on it, yeah.

8 **Q.** Okay. Similar on that line of questioning, if you ask

9 a patient if they have access to a firearm and they say no ...

10 and you said earlier you don't always take things that a patient

11 ... certainly, this wasn't the case that you had any suspicions

12 here, but you don't always take what patients tell you at face

13 value. Is there any way for you to check in any government

14 system, police, firearms? Is there any way for you to check if

15 you have a niggling worry about access to firearms? Is there

16 any way you can check that as a physician?

17 **A.** Not that I'm aware of.

18 **Q.** Okay.

19 **A.** Other than checking with family members or friends.

20 **Q.** Would you agree that there's value in you being able

21 to access an independent system to verify the presence or

22 absence of a firearm or access to a firearm when you're making

1 these risk assessments?

2 **A.** Yes.

3 **Q.** Okay. And would you agree it would be helpful to have

4 some specific authority which would allow you to disclose to the

5 police the presence or access to firearms in a situation that

6 doesn't invoke **IPTA** but still causes you some concerns? Would

7 it be helpful for you to have that specific statutory other

8 authority to let the police know just in case?

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

10 **Q.** Okay. Training. Training, you talked about

11 continuing medical education, which certainly we, as lawyers,

12 are familiar with in our profession. We do legal education

13 training. My sense is that it can be very largely self-

14 directed?

15 **A.** Correct.

16 **Q.** Yeah, and you talked about, you know, you can fill

17 some of those components by listening to podcasts?

18 **A.** Correct.

19 **Q.** Can you fulfill all of those components on your own

20 self-directed?

21 **A.** No.

22 **Q.** No. Okay. So is there some that's actually

1 structured and mandated by the College of Physicians?
2 **A.** Yes, there's different categories of the credits.
3 **Q.** Yes?
4 **A.** And some of them, it would need to be something like a
5 conference or a talk.
6 **Q.** Okay.
7 **A.** Accredited talk. But some can be self-directed.
8 **Q.** Okay. But within the categories that the College of
9 Physicians would mandate you still have the ability to pick and
10 choose what you want to attend.
11 **A.** Which topics you attend.
12 **Q.** Which topics.
13 **A.** Yes.
14 **Q.** Yes. Is there anything that's mandated and
15 specifically required for you as an emergency room physician by
16 either the College or the Nova Scotia Health Authority?
17 **A.** Not that I'm aware of.
18 **Q.** Okay. So if there was specific training on
19 identifying risk factors, for example, that have been gathered
20 from data from death review committees that suggest there may be
21 some risk links to deaths in marriage relationships, there's a
22 possibility that you would never take that training without it

1 being mandated. Is that fair to say?
2 **A.** Correct.
3 **Q.** Okay. And since this incident happened in January of
4 2017 are you able to share with us, from your perspective,
5 anything that has changed in terms of process, policy, the way
6 your duties are carried out, Dr. Clark, that you believe is in
7 response to this situation that we're here today about?
8 **A.** In my personal practice?
9 **Q.** Yes.
10 **A.** I don't think anything has changed. I continue to
11 have allow threshold to involve my psychiatry colleagues.
12 **Q.** Mm-hmm.
13 **A.** Yeah, I don't. I can't think of anything specific
14 that has changed.
15 **Q.** Okay. That's your personal practice and then broader
16 than that have there been any changes that have been mandated by
17 St. Martha's, by the Health Authority that you understand or
18 believe would be as a response to the death of Lionel Desmond
19 and his family members?
20 **A.** Not that I'm aware of.
21 **Q.** Okay. I have one last question and it involves
22 charting. When you're charting in hospital records is the

1 general rule of thumb, Dr. Clark, that you stay within the lines
2 on the page and, you know, if there's a blank you put a line
3 across to indicate that there is nothing else that's filled into
4 that space?
5 **A.** I mean you can tell from the nurses' notes that that's
6 routinely done with nurses. Every ...
7 **Q.** Right.
8 **A.** ... single line.
9 **Q.** Yes.
10 **A.** I would say that would rarely, if ever, be done by
11 physicians.
12 **Q.** Okay.
13 **A.** If there's a very large portion of the chart that's
14 not filled in a big line through it would be common, but
15 individual lines ...
16 **Q.** Okay.
17 **A.** ... I've never seen that.
18 **Q.** And would you also say that with physicians you would
19 see charting material outside of those lines, maybe scrawled in
20 the bottom of the page or in the margins?
21 **A.** Yes, and often we will print what we call a progress
22 note if you want to continue an emergency room record and you

1 need more space to write.

2 **Q.** Okay. Those are my questions. Thank you for your

3 time, Dr. Clark.

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

5 **MR. ROGERS:** Thank you, Your Honour.

6

7 **CROSS-EXAMINATION BY MR. RODGERS**

8 **(16:46:38)**

9 **MR. RODGERS:** Dr. Clark, I'm Adam Rodgers. I'm

10 representing the personal representative of Lionel Desmond,

11 Corporal Desmond. I'm here to jump around a little bit because

12 most of my colleagues have covered off the topics, Doctor, but I

13 guess thinking of risk factors you identified, and you talked

14 about someone who is future oriented, an individual who is

15 future oriented.

16 Would examples of those kinds of topics include, say,

17 searching for real estate, getting a gym membership, returning

18 shoes to get new shoes, those kinds of things? Would that be

19 what you would consider future oriented?

20 **(16:47:04)**

21 **A.** I guess I would consider those things future oriented.

22 It would need to be something that was specific to the day that

1 the crisis is taking place. So I guess if you assess a patient
2 who is suicidal in the Emergency Department and they bought a
3 gym membership the next day …
4 **Q.** Yes.
5 **A.** ... then that may indicate that they're future
6 oriented. But it doesn't say much if they thought it the
7 previous day because something may have happened from that time.
8 **Q.** Sure.
9 **A.** Now I guess I would be more referring to having a
10 conversation and someone casually talking about the future as if
11 it will happen. So they may talk about something, a wedding
12 they plan to go to in the summer ...
13 **Q.** Okay.
14 **A.** ... for example.
15 **Q.** All right, so ...
16 **A.** It would be unusual to have a very concrete plan that
17 they're going to go home and kill themselves yet they're
18 casually talking about going to a wedding the next summer.
19 **Q.** Sure. Okay. I understand that. Now I want to ask a
20 question. You said maybe 10 to 15 percent of the individuals
21 coming through the emergency door have a standalone mental
22 health situation. Can you tell us ... you know, maybe not in

1 percentage terms. It might be difficult. But how often would
2 someone come in in Corporal Desmond's situation, where he's
3 apparently fairly calm and trouble at home, preexisting mental
4 health, and yet has the awareness to calmly go in and seek help.
5 Is that an unusual presentation?
6 **A.** No.
7 **Q.** One might think that if a person was in a mental
8 health crisis that the ability to present calmly might be a
9 difficult thing for them to do but ...
10 **A.** Well, commonly people present. People have calmed
11 down by the time I see them in the Emergency Department.
12 **Q.** Yeah.
13 **A.** A crisis may have happened and brought them there, but
14 there may be a period of time in which they have become calmed
15 down.
16 **Q.** Okay, and marital difficulties. Presuming that that's
17 not an uncommon complaint or element of what's presented to you.
18 **A.** Correct.
19 **Q.** All right. Question for you, Doctor. You indicated
20 you had limited experience with younger military veterans or
21 maybe military veterans of any age, but what about training as
22 whether it's in medical school or as a resident? Is there any

1 specific training that you receive for how to manage individuals
2 that are military veterans?
3 **A.** Well, I guess the focus would be more on their mental
4 health or medical issues, specifically the PTSD or co-occurring
5 conditions that often happen with PTSD.
6 **Q.** Yeah.
7 **A.** So we'd learn about those extensively and ...
8 **Q.** One of the questions I have is, for those with PTSD is
9 there any part of your training that would say, Well, these
10 individuals have a harder time with bureaucracy, with taking
11 instructions, with following through on things? Is that
12 something, in your experience, that ... or in your training
13 that's identified?
14 **A.** Yes, those things could be part of features of
15 symptoms they would have.
16 **Q.** You mentioned that you were a member of the Society of
17 Rural Physicians of Canada, and this is a broader question than
18 is specific here. But are there questions of social isolation
19 or are those topics that are raised in the context of that
20 organization? I'm thinking of, in this particular case,
21 socialized isolation of a veteran. Maybe not having a community
22 of like-minded people or peers to whom they could relate. Is

1 that something that comes up in the context of that
2 organization?
3 **A.** Not that I'm aware of.
4 **Q.** You've talked somewhat extensively about the suicidal
5 and homicidal ideation questions and the framework, the mental
6 framework, that you go through when you're asking these
7 questions. This may be more of a question for the
8 psychiatrists, but is there any concern that asking the question
9 might suggest the option?
10 **A.** No. No, there's no concern for that. My
11 understanding ... you're right, it's probably a better question
12 for a psychiatrist.
13 **Q.** Yeah, I guess it's a question ... is that described to
14 you in a way that, Hey, make sure you ask the questions in a
15 certain way so that you don't suggest ...
16 **A.** No, my understanding is there's overwhelming evidence
17 that it’s better to ask directly.
18 **Q.** Okay, and finally, just a question. You talked about
19 your drives and listening to medical podcasts. Is there a good
20 variety of medical podcasts out there?
21 **A.** Yes, there is, yeah.
22 **Q.** Okay, and what are some of the ones you listen to?

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

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

3 physicians.

4 **Q.** Okay.

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

6 **Q.** Sure.

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

8 But there's a few.

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

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

11 extent of the options out there.

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

13 Doctor. Thank you.

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

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

16 Clark.

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

18 **(16:54:06)**

19 **MR. HAYNE:** You were asked a number of times regarding

20 your ability to access other medical records that were not in

21 MEDITECH or SHARE, for example, and some examples were presented

22 to you. Dr. Slayter's consultation note from December 2nd, 2016

1 and an ER visit from New Brunswick that was referenced by Mr.
2 Russell. In particular, with respect to the ER visit in New
3 Brunswick, you were asked questions about whether you had
4 information regarding a previous attempt at suicide, and I think
5 your evidence was that that would be something you'd consider
6 perhaps as a risk factor. Is that right?
7 **A.** Correct.
8 **Q.** Okay. And you also gave evidence, and correct me if I
9 mischaracterize it. But that if your plan was to manage a
10 patient, a mental health patient, yourself where suicide risk
11 may have been an issue you may have listed in your chart note
12 more details regarding risk factors and protective factors. Is
13 that right?
14 **A.** That's the typical place I would document that.
15 **Q.** And when you were presented with this information sort
16 of in the hypothetical form I believe it was your evidence that
17 ... it was that if you had this information it may have made you
18 more likely to consult Psychiatry in sort of in an abstract
19 sense. Is that right?
20 **A.** Correct. It would make me more concerned.
21 **Q.** Right. And in this case, however, you did, in fact,
22 consult Psychiatry. Correct?

1 **A.** Correct.
2 **Q.** And so the lack of having those records had no change
3 to your process in the sense that the end result was the same
4 and you did consult Psychiatry. Correct?
5 **A.** Correct. I was also concerned because I had a lack of
6 collateral information. So that was one of my concerns as well.
7 **Q.** Again, just a few questions. I'm jumping around. I
8 believe it's Exhibit 67 that we've been looking at, and the
9 emergency chart record. The vital signs, and it's not up in
10 front of us right now. But that's fine. I'll read them. The
11 vital signs that were recorded, they would have been recorded by
12 the triage nurse? Is that right?
13 **A.** Correct.
14 **Q.** Okay. And in this case the heart rate is 75. That's
15 beats per minute?
16 **A.** Correct.
17 **Q.** Respiration rate is 18.
18 **A.** Correct.
19 **Q.** And the blood pressure is 115 over 79.
20 **A.** Correct.
21 **Q.** And from your perspective, those are all within the
22 normal range. Correct?

1 **A.** Correct.
2 **Q.** And those vital signs are consistent with your
3 assessment of no acute distress. Would you agree with that?
4 **A.** Correct.
5 **Q.** And also consistent with a reference by the triage
6 nurse that Mr. Desmond presented as calm and speaking quietly.
7 **A.** Correct.
8 **Q.** You were also asked some questions about triage score,
9 and I think your evidence was, and correct me if I'm wrong, that
10 you look at the vital signs and then you look at the text
11 description of the assessment by the triage nurse. That's your
12 primary focus ...
13 **A.** Yes.
14 **Q.** ... over and above the actual score itself.
15 **A.** Yes. I'm well aware of the score, but more relevant
16 to me is the vital signs and the description.
17 **(16:57:05)**
18 **Q.** Right. And then you take that information and then
19 you assess the patient directly. Correct?
20 **A.** Correct.
21 **Q.** And is it fair to say that the most important
22 information is that information that you obtain when you're

1 assessing the patient in front of you. Is that right?

2 **A.** Correct.

3 **Q.** And just one quick little clarification. In your

4 handwritten chart note you say - I just want t- make sure I get

5 it correct here. "No harm to family per patient." And your

6 evidence was that "per patient" was that you were indicating

7 that that's the information you receive from Mr. Desmond.

8 Correct?

9 **A.** Yeah. Another way to phrase that would be "according

10 to the patient" there was no harm done to the family.

11 **Q.** Right, but again, that's the information from the

12 patient.

13 **A.** Correct.

14 **Q.** But you also had no information to indicate otherwise.

15 Is that right?

16 **A.** Correct.

17 **Q.** Thank you. Those are my questions, Your Honour.

18 **THE COURT:** Okay.

19 **MR. MACDONALD:** Your Honour, excuse me, I had one question

20 arising from a question by counsel. I'm wondering if I could

21 ask it, it's by way of re-direct (sic).

22 **THE COURT:** Go ahead.

1 **MR. MACDONALD:** Thank you very much.

2

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

4 **(16:58:39)**

5 **MR. MACDONALD:** Dr. Clark, my friend Mr. Rogers asked you a
6 question about ... and I'm paraphrasing and you correct me if I
7 have it wrong and I'm sure my friend, Mr. Rogers, will very
8 quickly. Dr. Rahman providing gold standard of care in terms of
9 Mr. Desmond. As I understood your response, it related to the
10 fast response to you by Dr. Rahman when you called him. Is that
11 your recollection?

12 **A.** I guess ...

13 **Q.** You called him and he called back quickly.

14 **A.** ... what I mean was that he came to see the patient
15 quickly ...

16 **Q.** Yes.

17 **A.** ... and that he came to see the patient in the
18 evening, which would not be typical.

19 **Q.** Understood.

20 **A.** Typically a patient would wait until the next day to
21 see a psychiatrist.

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

1 Rahman of Mr. Desmond, you weren’t there.

2 **A.** Correct.

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

4 position to characterize it as gold standard or not gold

5 standard, are you?

6 **A.** Correct.

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

8 **A.** Correct.

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

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

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

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

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

14

15 **EXAMINATION BY THE COURT**

16 **(17:00:10)**

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

18 crisis", what does crisis mean? Like how does something become

19 a crisis? You know, you look at Mr. Desmond's vital signs at

20 the time that somebody's doing triage ...

21 **A.** Mm-hmm.

22 **Q.** ... and you'd expect if there was some kind of a

1 crisis, I would think in terms of there being some, you know,
2 physical manifestation in one of the functions that you're
3 measuring would be indicative of that. So what does crisis
4 mean?
5 **A.** So the term "situational crisis" is used a lot. I'm
6 assuming it's a drop-down menu where you put the complaint on
7 the triage sheet. It's basically something that's used when
8 there's nothing else specific to use.
9 **Q.** So something that's happened that's very upset and
10 can't be managed on their own and so they come to see you in the
11 mental health context?
12 **A.** It could. It could apply to that but it also could
13 apply to anything that doesn't have a specific physical symptom
14 or anything very specific or psychiatric symptom. So if a child
15 was agitated and acting up at school and somehow they ended up
16 in the emergency room. They might say that.
17 **Q.** Okay.
18 **A.** It has nothing to do with how the patient is in the
19 triage room. Basically the person's deciding, How do I describe
20 this overall situation? You know, it's easy if it's ankle pain.
21 You just put "ankle pain". But if something's going on with
22 them and there's a bunch of details and you're only, you know,

1 writing in on a document you kind of just pick this one. So it
2 could literally be referring to a lot of ...
3 **Q.** All right.
4 **A.** ... different situations.
5 **Q.** Okay. I understand. Is there a suicide prevention
6 policy that you're aware of that would relate to any of your
7 conduct behaviours in the ER Department of the St. Martha's
8 Hospital?
9 **A.** There's no policy that I'm aware of, no.
10 **Q.** Are you aware of a suicide prevention policy as it
11 relates to youth in the Province of Nova Scotia?
12 **A.** No.
13 **Q.** No? Okay. When the nurses are doing the triage I
14 take it they have access to the MEDITECH as well or is that just
15 the physicians have access to it?
16 **A.** They have sign-ins for MEDITECH.
17 **Q.** They can sign in and access whatever is there? In
18 other words ...
19 **A.** I'm not ...
20 **Q.** ... can they see exactly what you see? Or do you ...
21 **A.** I don't know.
22 **Q.** You don't know? Okay. When you were interviewing Mr.

1 Desmond I know you decided that in terms of managing his
2 circumstances you weren't comfortable doing it without a
3 psychiatric consult, in which case you would hand him over to
4 the psychiatrist.
5 **A.** Correct.
6 **Q.** Okay. Short of that, if you had been comfortable ...
7 maybe it's a bit hypothetical. But would you have admitted him?
8 **A.** I don't have the ability to admit someone to the
9 Psychiatric unit.
10 **Q.** All right. If he had ...
11 **A.** Yes.
12 **Q.** ... said to you ... if you had made the determination,
13 All right, so do you have another place to stay tonight, and he
14 said, No, I don't have anywhere to go tonight, I just can't go
15 home till tomorrow, I'm going to respect what the request was,
16 can I stay here, would you have the authority to say, All right,
17 you can stay here for the night? And then if he stayed there
18 for the night you would continue to observe him for the rest of
19 the night as you would anybody else that stays in the hospital?
20 **A.** So I have the ability to have someone in observation
21 ...
22 **Q.** Mm-hmm.

DR. JUSTIN CLARK, Examination by the Court

1 **A.** ... under my care.
2 **Q.** Under your care.
3 **A.** I would do that quite frequently.
4 **Q.** Okay, so if it came ...
5 **A.** So, for example, someone who has fluid in their lungs.
6 I can put them in observation overnight and reassess them in the
7 morning and if their symptoms have improved I can discharge them
8 myself. But in this case the patient was in observation under
9 the care of Dr. Rahman, not under my care.
10 **Q.** Dr. Rahman.
11 **A.** Yeah.
12 **Q.** But if you hadn't made the psychiatric referral and
13 you were prepared to let Mr. Desmond go on his way ...
14 **A.** Okay.
15 **Q.** And whatever other advice you would have given in
16 terms of your management of whatever the plan was to manage his
17 situation, if he'd asked you to stay there he would have been
18 permitted to stay there in observation overnight.
19 **A.** It's hard to say what I would have done.
20 **Q.** All right. I won't press you on it. I appreciate
21 it's a bit ...
22 **A.** I would need a lot more ...

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

2 **A**. ... information to ... if I were the one coming up
3 with a management plan ...

4 **Q**. Yeah.

5 **A**. ... I would need a lot more information than I had at
6 the time that ...

7 **Q**. Yeah.

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

9 **Q**. And that may or may not have affected your decision
10 ...

11 **A**. Exactly.

12 **Q**. Is what you're saying. Yeah, I understand that.
13 Thank you.

14 You talked about an app that you have. If you're looking
15 at risk factors or you're looking at something on your app, you
16 log the time and you can use it as part of your continuing
17 education credits. So is there one particular app that you use?

18 **A**. Yes.

19 **Q**. Or do you have a number?

20 **A**. There's an app called UpToDate, which is basically a
21 reference for anything in all of medicine. There's articles
22 written by every specialist on basically every topic.

1 **Q.** Mm-hmm. So you can go to the app if you want to just
2 refresh your memory about risk factors, suicide prevention? You
3 would go on there and ...
4 **A.** Correct.
5 **Q.** ... take a few minutes and read what's there as a
6 refresher?
7 **A.** Correct.
8 **Q.** And that's all the questions I have. All right.
9 Thank you, Dr. Clark, for your time. You're free to go, and
10 we'll stand adjourned till tomorrow morning at 10 o'clock.
11 All right. Thank you, then.
12
13 **COURT ADJOURNED (17:06 HRS.)**
14
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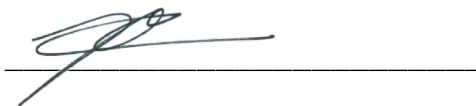
22

CERTIFICATE OF COURT TRANSCRIBER

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



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DARTMOUTH, NOVA SCOTIA
February 5, 2020