Report of the Fatality Inquiry into the Death of Howard Hyde

In the Matter of a Fatality Inquiry Regarding the Death of Howard Hyde Halifax, Nova Scotia

REPORT, pursuant to the
Fatality Investigations Act

November 30, 2010

Anne S. Derrick
Provincial Court Judge
Halifax, Nova Scotia

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PART I

Introduction

This Report was born of tragedy: the death on November 22, 2007 of Howard Hyde, a man with many interests, passions and friends, who lived for 27 years with severe, chronic schizophrenia. This Inquiry learned far more about the last thirty hours of Mr. Hyde's life than we did about the 45 years before his final experiences with the criminal justice and health care systems. We were fortunate to get a snapshot, in the words of Mr. Hyde's common-law partner, Karen Ellet, who described him to the Inquiry, when he was healthy, as:

> …a very fantastic person…He was very caring of people. He loved people. He loved sports. He was a musician. He loved singing. He was just an incredible man.[1]
>
> …
>
> …very lively. He enjoyed life. His love was sports and music. He was very, very sociable. Many people liked him. He was just a joy to be around. He was so interested in nature…[I had] incredible moments with him…He was a very, very likeable man…[2]

I have endeavoured in this Report to do justice to Mr. Hyde's experiences in those last, tragic hours of his life, and make his legacy one of hope for those who live with a severe, persistent mental illness. And for the people who work in the criminal justice and health care systems with persons with mental illness, I have tried to fashion out of the evidence recommendations that rest on the belief that, for all that is done well, as a society, we can do better.

This Fatality Inquiry was called at the order of the Minister of Justice on September 17, 2008. The order stipulates that the judge appointed to conduct the inquiry shall make a report containing any findings as to:

- the date, time and place of death;
- the circumstances under which the death occurred;
- the cause of death;
- the manner of death; and
- any recommendations of the judge about any matters arising from the inquiry.

My report has been organized to reflect my legislated mandate: Part I (Introduction and Preface); Part II (the Factual Narrative of the events on November 21 and 22, 2007 leading up to Mr. Hyde's death); Part III (Cause and Manner of Death); Part IV (Matters Arising from the Inquiry); Part V (Major Findings); Part VI (Changes Since November 2007); Part VII (Recommendations) and Part VIII

(Conclusion). Parts II, III and IV contain a total of fifty-seven chapters addressing factual and systemic matters.

Reading the Report

To write this Report I have mined a rich vein of evidence and other material. What has emerged is lengthy and detailed. I have tried to write it in a manner that is readable and with this in mind, have deliberately chosen to use a less formal style. It is however a dense thicket of information, heavily referenced by notes. The notes are not only citations for the testimony relied on; in many instances they contain substantive comment or point to additional relevant evidence or sources. The conscientious reader will study them closely.

Another author might have chosen to summarize the evidence more economically. I decided that Mr. Hyde's experiences and the testimony of the witnesses deserved a very thorough treatment. Those who want to know what happened during Mr. Hyde's journey through the criminal justice and health care systems will be fully informed by the narrative of the facts. The Inquiry also heard extensive evidence that will be relevant to readers wanting to understand how these systems operate and policy-makers who will be considering how to craft improvements. There is no executive summary: the reader who needs an overview will have to refer to Parts V (Major Findings) and VII (Recommendations). The Findings, noted so that readers can trace their origins, are excerpted from the comprehensive narrative of the evidence and represent what seemed to me to be most germane to the Recommendations.

Although the production of the Report was done professionally, all the writing is my own and, as may be obvious, I have not had the services of an editor. The responsibility for any errors, deficiencies or oversights is exclusively mine.[3]

Notes

1 Testimony of Karen Ellet, page 133

2 Testimony of Karen Ellet, page 201

3 In my closing remarks at the conclusion of the Inquiry's public proceedings on June 10, 2010, I indicated that Inquiry Counsel, Mr. MacRury, and Acting Inquiry Counsel, Mr. Broderick, would not be part of, or consulted in, the writing of the Report. I stated that the writing of the Report would be my sole responsibility which it has been.

PART I

Preface

A Thumbnail Sketch of the Events of November 21 and 22, 2007

After assaulting his common-law partner, Howard Hyde was arrested by Halifax Regional Police officers on November 21, 2007 at approximately 01:00. He had been experiencing a recurrence of his chronic schizophrenia for several weeks which was characterized by paranoia, anxiety, agitation and psychosis.

Mr. Hyde was transported to Halifax Regional Police Service (HRPS) Booking to be placed in cells in anticipation of a court appearance in the morning for arraignment on a charge of assault. While being processed in Booking, Mr. Hyde became terrified and a struggle ensued with police officers when he tried to get away from them. A Conducted Energy Weapon (CEW) was deployed and Mr. Hyde was shocked in two separate incidents. Following a further struggle in the Booking hallway, Mr. Hyde collapsed and stopped breathing. He was revived with CPR and taken to hospital.

Mr. Hyde remained at the QEII Emergency Department from approximately 02:30 until 09:15 on November 21. His condition stabilized and he was discharged back into police custody for court. The ER physicians believed that Mr. Hyde urgently needed a psychiatric assessment and treatment for his illness. They thought he would be sent by the court for a psychiatric assessment and were under the erroneous impression this would serve to get him the care he needed for his mental illness.

From the QEII Mr. Hyde was returned to HRPS Booking and transported to court in Dartmouth around 14:00. He appeared in court a couple of hours later and was remanded to the Central Nova Scotia Correctional Facility (CNSCF) overnight as it was too late in the day for him to arrange his bail and get released.

From approximately 18:00 on November 21 until 07:30 on November 22, Mr. Hyde was housed in a Health Segregation cell at the CNSCF. He paced relentlessly all night and did not sleep.

In the morning of November 22, while being escorted from his cell to Admissions in preparation for being transported to court, Mr. Hyde became extremely fearful and refused to proceed. He attempted to get away from the correctional officers who were trying to take him down a hallway. A struggle occurred as correctional officers sought to restrain him. Once subdued, Mr. Hyde was taken to a cell, the plan still being that he would attend court. Mr. Hyde resisted entering the cell and a further struggle erupted. While Mr. Hyde was restrained in the cell by correctional officers he stopped breathing. No pulse could be detected. He was transported by EHS to hospital and pronounced dead at 08:43 on November 22, 2007.

History of the Inquiry's Proceedings

The Inquiry convened on February 18, 2009, and at this first of three organizational pre-hearings, standing[1] was granted to nine parties: the Attorney General of Nova Scotia (AGNS); the Nova Scotia Government and General Employees Union (NSGEU); Joanna and Dr. Hunter Blair[2], the Halifax Regional Police Service (HRPS); the Capital District Health Authority (CDHA); Dr. Janet MacIntyre, Dr. Stephen Curry, the Schizophrenia Society of Nova Scotia (SSNS); and the Canadian Mental Health Association (CMHA). All parties but the CMHA were represented by counsel throughout the Inquiry's proceedings. The CMHA appeared through its then Executive Director, Ms. Carol Tooton, with several *pro bono* law students assisting.

Two further organizational pre-hearings were conducted on April 22 and June 12, 2009. At these hearings issues such as finalizing the Rules of Procedure and the webcasting of the proceedings were discussed.

On June 30, 2009, I attended a viewing of the Halifax Regional Police Service Booking area and the Central Nova Scotia Correctional Facility accompanied by Inquiry counsel and counsel for the parties.[3]

The Inquiry commenced hearing testimony from witnesses on July 7, 2009. (July 6 was the first day of the Inquiry's public proceedings and was used to mark exhibits.) The Inquiry sat until July 24 and then resumed from August 4 to 14. Testimony from witnesses continued on October 19 until October 28 and again from December 1 to 11, 2009.

Further evidence was heard, primarily from expert witnesses, from February 1 through 26, 2010. Counsel for the parties filed their written submissions on May 19, 2010. Inquiry counsel filed written submissions on June 2. Final oral submissions were made by all counsel during June 8, 9 and 10. The evidence of all the witnesses and counsel's final oral submissions were live streamed to the internet.

In the course of the proceedings I rendered six written decisions (included in this Report as an Appendix) addressing webcasting and expert evidence issues.

The Inquiry heard from 84 witnesses, 10 of whom were qualified as experts, over 53 days. This generated over 11,000 pages of transcript. 291 exhibits were introduced into evidence. They included 8 witness statements, experts' reports for all but one of the expert witnesses, and many hours of video surveillance from the Halifax Regional Police Service (Booking area) and the Central Nova Scotia Correctional Facility. Inquiry counsel and the parties provided me with written submissions totaling more than 400 pages, augmented by 500 transcripted pages of oral submissions, and offered close to 200 recommendations for my consideration.

Mandate and Scope of Mandate of the Inquiry

This Inquiry was ordered pursuant to section 27(2) of the *Fatality Investigations Act.*[4] Its mandate is broad. Notably, the Minister's Order of September 17, 2008 empowers me to make "any recommendations…about any matters arising from the inquiry."[5]

In their final submissions, a number of counsel emphasized the importance of rooting my findings and recommendations in the evidence received by the Inquiry. The Attorney General of Nova Scotia put the issue very well:

> Mr. Hyde's story is the guiding star for this Inquiry and recommendations need to be tied to the evidence presented in relation to his experience in the health and criminal justice systems…[6]

Other counsel added a further emphasis: that my recommendations had to be grounded in "matters that were explored and explored fully by the parties before this Inquiry."[7]

I agree with the view that what comes out of this Inquiry must be grounded in what went into it. The relationship between the evidence, my findings and my recommendations is a linear one, as the following submission recognized:

> The purpose of the findings in your report are to provide the necessary evidentiary foundation for the recommendations…for how we move forward and avoid a similar tragedy in the future…your findings need to be grounded in the evidence. That's a very important proposition because the recommendations that you will make will flow from those findings. So indirectly, at least, the recommendations need to flow from the evidence...[8]

That being said, the Inquiry received a great deal of evidence, some of it offering a window into Mr. Hyde's experiences with the mental health and criminal justice systems before November 2007. Counsel's questioning of witnesses and final submissions covered a broad scope. This Inquiry was asked to look at much more than just the specific events of November 21 and 22, 2007. When I began to write this Report I started at the beginning, with Chapter 1 in Part II. I kept writing until I reached Chapter 57 in Part IV. I had to set out all the evidence made available to me before I could begin to consider what it told me and what recommendations should be developed from it. "Writing imposes a valuable discipline on analysis and reasoning." [9]

It will be clear from the Report's heavily "sourced" text that my findings and recommendations are anchored in the evidence. My prolific use of notes is an acknowledgement of the reader's entitlement to know that the contents of this Report originated from the testimony and exhibits received by the Inquiry and other materials in the public domain that I consulted.[10]

No Findings of Legal Responsibility

Section 39(2) of the *Fatality Investigations Act* provides that my findings "shall not contain any findings of legal responsibility."[11]

In final submissions, I was advised that it would not be appropriate to point out individual failures and that only system or systems failures should be identified.[12] I have several comments about this submission.

First of all, the principle of fairness that must characterize any inquiry requires that hindsight be applied appropriately, to recommendations, which must be forward-looking, and not to the actions (or inactions) and decisions that were made. As observed by Professor Ratushny[13]:

> Justice Campbell [Review of the Paul Bernardo investigation] drew a distinction between formulating recommendations, where hindsight is essential, and assessing past conduct, where hindsight is unfair: "The only fair way to review past conduct is to avoid hindsight. The only fair way is to put yourself in the shoes of the person who had to make the decision. What did they know when they decided to quit a particular line of investigation? What did they know and what did they think when they failed to report a particular incident?"[14]

However, this does not preclude identifying from the facts where a decision or action/inaction constitutes a failure to satisfy the appropriate standard of performance. A reference to the "failure" to do something that should have been done is not a finding of civil liability. "…there are many different types of normative standards, including moral, scientific, and professional-ethical. To state that a person "failed" to do something that should have been done does not necessarily mean that the person breached a criminal or civil standard of conduct. The same is true of the word "responsible."[15]

Inquiries are not trials and do not offer the evidentiary or procedural safeguards available in a trial. They are inquisitorial, not adversarial. The "primary role, indeed the raison d'etre, of an inquiry investigating a matter is to make findings of fact."[16] A judge conducting an inquiry "has the power to make all relevant findings of fact necessary to explain or support the recommendations even if these findings reflect adversely upon individuals…"[17]

It will be evident from my Report that I have not made significant findings of individual failure and have taken pains to fairly explore what the evidence reveals about why certain assumptions were made and particular decisions taken, or not, as the case may be. It is not enough to simply conclude that both the criminal justice and health care systems failed Mr. Hyde in November 2007; it is also necessary to understand the roles of the individuals involved in his narrative.

Notes

1 The *Fatalities Investigation Act, S.N.S. 2001, c. 31* provides in section 36(2) that the participants at a fatality inquiry include "any person who applies to the judge before or during the inquiry and is declared by the judge to be an interested person."

2 Pursuant to section 36(2) of the *Fatality Investigations Act, S.N.S. 2001, c. 31*, the personal representative of the deceased is statutorily included as a participant at a fatality inquiry.

3 The "view" was videotaped and the video recording was entered as Exhibit 140.

4 *Fatality Investigations Act, S.N.S. 2001, c. 31*

5 Order of the Honourable Cecil P. Clarke, then Minister of Justice, dated September 17, 2008. Section 39(1) of the *Fatality Investigations Act, S.N.S. 2001, c. 31* provides that: "At the conclusion of the fatality inquiry, the judge shall make and file with the Provincial Court a written report containing any findings made by the judge as to… the issues identified by the Minister in the order requiring an inquiry to be held…"

6 Final oral submissions by Dana MacKenzie, counsel for the Attorney General of Nova Scotia, pages 11195–11196; see also, Final oral submissions by David Roberts, counsel for the Nova Scotia Government and General Employees Union, page 11217; Final oral submissions by Sandra MacPherson-Duncan, counsel for the Halifax Regional Police Service, page 11326

7 Final oral submissions by Rory Rogers, counsel for the Capital District Health Authority, page 11362

8 Final oral submissions by Michael Wood, Q.C., counsel for Dr. Stephen Curry, pages 11490–11491

9 Ratushny, Ed "The Conduct of Public Inquiries – Law, Policy and Practice" Irwin Law Inc., 2009, at page 359

10 This Report is very extensively noted. All readers will be able to see where the content of the Report originates from and those readers with access to the transcripts and exhibits can examine the evidentiary source directly. Some explanation about the notes: not every transcript reference for a particular fact or proposition is reflected in the notes. In other words, there may be other transcript references than the ones I have

cited. I have tried to cite the most important or concise or clearest references found in the evidence. Also, some exhibits were entered more than once, as part of a larger exhibit. For example, the HIT Form is Exhibit 68 (a single page exhibit) and is also found in Exhibit 159, Tab 4. It appears elsewhere as well. I have referred to it throughout as either Exhibit 68 or Exhibit 159, Tab 4.

11 *S.N.S. 2001, c. 31*

12 Final oral submissions by Michael Wood, Q.C., counsel for Dr. Stephen Curry, pages 11487–11490

13 Ratushny, Ed "The Conduct of Public Inquiries – Law, Policy and Practice" Irwin Law Inc., 2009, at page 362

14 Justice Archie Campbell "The Bernardo Investigation Review" in Commissions of Inquiry: Praise or Reappraise? ed. Allan Manson and David Mullen, 2003, Irwin Law, page 396

15 *Canada (Attorney General) v. Canada (Commission of Inquiry on the Blood System in Canada – Krever Commission), [1997] 3 S.C.R. 440 at paragraph 62, per Cory, J.*

16 *Canada (Attorney General) v. Canada (Commission of Inquiry on the Blood System in Canada – Krever Commission), [1997] 3 S.C.R. 440 at paragraph 52, per Cory, J.*

17 *Canada (Attorney General) v. Canada (Commission of Inquiry on the Blood System in Canada – Krever Commission), [1997] 3 S.C.R. 440 at paragraph 57 (b), per Cory, J.*; see also, *T.M. v. Alberta (Public Inquiry into the death of J.C.), [1999] A.J. No. 1371 (Alta. Q.B.) at paragraph 60*: "It is clear that a fatality inquiry is not a court of law and that its primary function is to determine facts. It is equally clear that in fulfilling its role as fact finder a public inquiry may, of necessity, make findings of fact which have the potential to damage reputations."

Part II

Factual Narrative

Profile of Howard Hyde

Howard Hyde was born in New York City on October 6, 1962. He was 45 years old when he died on November 22, 2007. He grew up in New York City, one of two children of Elizabeth and Francois Hyde.

After their parents' divorce in 1964, Mr. Hyde and his sister, Joanna (now, Joanna Blair) lived with their mother in New York City. In 1977, Mr. Hyde and his sister became Canadian landed immigrants with connections to the Shelburne area.[1] The connection was to a summer property in Jordan Bay owned by Howard and Joanna's grandparents.[2]

Following graduation in 1980 from Nyack High School, Mr. Hyde enrolled in State University of New York at Oswego (SUNY Oswego) in upstate New York where he studied music and English for a year or so. It appears that Mr. Hyde then briefly attended SUNY Purchase, majoring in music and theatre.[3] In the wake of his dropping out of university, Mr. Hyde's mother suggested he visit his father who was living in Saudi Arabia. Mr. Hyde set off on this trip in late 1983.[4]

While staying with his father, Mr. Hyde began experiencing symptoms of what was eventually diagnosed, back in New York City, as paranoid schizophrenia. Mr. Hyde reported that in fact schizophrenia had led to his dropping out of university. In Saudi Arabia, he became paranoid, suspecting his stepmother of poisoning his food. Mr. Hyde also developed delusions about his stepbrother, who was not even in the country, believing that he had shot Mr. Hyde in the abdomen with a laser gun causing something to rot away in his stomach.

Following his diagnosis in New York City, Mr. Hyde was referred to Mount Sinai Hospital in Toronto, and hospitalized for several months. His mother identified a now-discredited treatment modality called Orthomolecular Psychiatry which involved a special diet, a megavitamins regime and anti-psychotic medication.[5] She located a psychiatrist in New York City who practiced Orthomolecular Psychiatry and Mr. Hyde returned home to his care. Joanna Blair observed in her statement to the RCMP on November 25, 2007 that her brother "when left on his own…never followed his dietary regiment…nor took the vitamins he was supposed to be taking, nor his medication…"[6] However, with the support and care of his mother and sister, Mr. Hyde began to show some improvement in his symptoms.

By the mid-eighties, Elizabeth Hyde had moved to Nova Scotia and was living on McNutt's Island, Shelburne County. Mr. Hyde was living on his own in Nyack, New York, working for the Rockland Journal News, a small newspaper. His psychotic symptoms began to re-surface and, with the help of a paternal uncle, Joanna brought Mr. Hyde to Nova Scotia to live with their mother.[7]

Although Mr. Hyde reported in a 1992 Pre-Sentence Report[8] that he had held various jobs in the Shelburne area as a forestry worker and a sheep farmer, Ms. Blair's ex-husband indicated in an interview with the RCMP on November 25,

2007 that Mr. Hyde experienced considerable difficulty looking after himself and managing the requirements of daily living. He worked for a short time on a mussel farm, and did odd jobs and provided support to Elizabeth Hyde until she died in March 1993.[9] Within a year or two after his mother's death, Mr. Hyde enrolled in theatre studies at Dalhousie University in Halifax for about a year.[10]

Elizabeth Hyde had arranged to transfer her interest in the Jordan Bay property to Mr. Hyde and he lived in the property, with some difficulty, when he was not in hospital. He supported himself through social security payments from the United States and money released to him by Ms. Blair, the executrix of Elizabeth Hyde's estate.

Notwithstanding the recurrence of his illness during the time Mr. Hyde lived in the Shelburne area and the challenges he encountered because of it, Mr. Hyde found some creative outlets for his talents. For a time he gave public speeches about his illness, under the direction of a man named Peter Miller in Yarmouth. Mr. Miller "thought very highly of Howard, because he was an excellent public speaker, he was never nervous, he was articulate, he was handsome, people liked listening to what he had to say."[11] Mr. Hyde also played saxophone and clarinet and enjoyed singing karaoke. Mr. Hyde reported in the 1992 Pre-Sentence Report that he was a member of the Lockport Sports Programme, playing basketball, was involved with organized hockey in the area, and played badminton. He became involved with the Special Olympics.[12] He also described playing tenor saxophone with the Shelburne Stage Jazz Band and assisting the Jordan Bay Community Hall with their Friday Bingo nights. He followed up his interest in theatre, appearing in a local production of "Our Town."[13]

Sadly, Mr. Hyde's illness intruded again. He started saying he was not really ill which led to a discontinuance of his public talks as his outlook was thought to be unhelpful to other people living with mental illnesses.[14] He also stopped playing his instruments and there were recurring incidents involving family, the police and hospitalization.

In 2002, as a result of an admission to the psychiatric service of the Yarmouth Regional Hospital, and criminal charges arising from an incident involving the police, Mr. Hyde was sent to the East Coast Forensic Hospital for a fitness and responsibility assessment under the *Criminal Code*. A finding that he was not criminally responsible led to his being placed at the ECFH from May 21, 2002 to February 3, 2004, under the jurisdiction of the Criminal Code Review Board. With the assistance of his forensic team, in October 2003, Mr. Hyde was able to secure an apartment in Dartmouth and began spending nights there until he was released from the ECFH in February 2004. During his time in hospital, Mr. Hyde continued to visit Jordan Bay on passes.

While Mr. Hyde lived in the Shelburne area, his sister endeavoured to help and support him as did her former husband, Peter Haeghaert, and her current husband, Dr. Hunter Blair. Both Mr. Haeghaert and Dr. Blair described Mr. Hyde as someone, who while appearing to be dangerous at times, never really presented a genuine threat. Mr. Haeghaert told RCMP that he "never ever felt threatened by him" a statement Dr. Blair agreed with, saying: "…I never found him threatening, he would be agitated, he would be angry, he would be pissed off at somebody or something but never a person that I felt I was gonna have to defend myself against."[15] Mr. Haeghaert recounted recent comments by people about Mr. Hyde. "A lot of the people that I've been talking to in the last two days that have known Howard always

thought of him as being very social and outgoing and friendly. They all enjoyed Howard when he was healthy, when he was doing well, and he would participate and play hockey, playing for his fans and that sort of thing."[16]

Karen Ellet, who met Mr. Hyde in 2005 and was his common-law partner when he died, has similar memories of Mr. Hyde's sociability and enthusiasm for life. As she told the Inquiry, she enjoyed many good times with Mr. Hyde whom she experienced as "very sociable, very lively, loved people and nature, loved sports, music and movies, enjoyed walking on the beach and on country roads…a joy to be around, very, very likeable…just an incredible man."[17] She stayed with him even when his illness made him violent and aggressive because she loved him.[18]

Notes

1 Exhibit 61, Tab 59, RCMP Interview, November 25, 2007, page 1 (Joanna Blair)

2 Exhibit 289, Information provided by Joanna Blair

3 Exhibit 61, Tab 59, RCMP Interview, November 25, 2007, page 1 (Joanna Blair): see also: Exhibit 289, Information provided by Joanna Blair

4 Exhibit 289, Information provided by Joanna Blair

5 Exhibit 265, Report of Dr. Stephen Hucker dated May 28, 2009

6 Exhibit 61, Tab 59, RCMP Interview, November 25, 2007, page 3 (Joanna Blair)

7 Exhibit 289, Information provided by Joanna Blair: see also Exhibit 61, Tab 59, RCMP Interview, November 25, 2007 (Joanna Blair)

8 Exhibit 123, pages 5–10

9 Exhibit 289, Information provided by Joanna Blair

10 Exhibit 289, Information provided by Joanna Blair

11 Exhibit 61, Tab 59, RCMP Interview, November 25, 2007, page 12 (Joanna Blair)

12 Exhibit 289, Information provided by Joanna Blair

13 Exhibit 289, Information provided by Joanna Blair

14 Exhibit 61, Tab 59, RCMP interview, November 25, 2007, page 12 (Joanna Blair)

15 Exhibit 61, Tab 59, RCMP Interview, November 25, 2007, pages 17 & 18

16 Exhibit 61, Tab 59, RCMP Interview, November 25, 2007, pages 17 & 18

17 Testimony of Karen Ellet, page 133: see also, page 201 "Howard was very lively. He enjoyed life. His love was sports and music. He was very, very sociable. Many people liked him. He was just a joy to be around. He was so interested in nature, and he helped me become aware of nature, and it was incredible moments with him."

18 Testimony of Karen Ellet, page 205

Howard Hyde's Mental Health History – Before 2007

The records filed with the Inquiry do not clearly indicate when Mr. Hyde experienced the onset of schizophrenia although it appears to have been when he was in his late teens or early twenties. Joanna Blair recalls Mr. Hyde becoming ill while staying with their father in Saudi Arabia although Mr. Hyde reported that he had experienced mental health problems earlier, leading to his dropping out of university. Mr. Hyde indicated that his illness first manifested itself as a psychosis characterized by pacing, verbal aggression and paranoia.[1]

After hospitalization in Toronto and treatment in New York, Mr. Hyde moved in the mid-1980's to the Shelburne area of Nova Scotia where his mother and sister were living. He continued to struggle with the symptoms of schizophrenia which led to a number of hospitalizations in both the Yarmouth and Shelburne area:

Yarmouth Regional Hospital	June 15 – 19, 1987
Roseway Hospital	April 26 – 27, 1990
Yarmouth Regional Hospital	April 27 – 30, 1990
Roseway Hospital	May 5 – 14, 1990
Roseway Hospital	November 8 – 15, 1991
Yarmouth Regional Hospital	November 25 – December 17, 1991
Yarmouth Regional Hospital	April 12 – May 18, 1992
Yarmouth Regional Hospital	September 5 – November 26, 1993
Roseway Hospital	March 30 – April 2, 1994
Yarmouth Regional Hospital	July 26 – August 7, 1996
Yarmouth Regional Hospital	March 18 – April 2, 2001
Yarmouth Regional Hospital	February 19 – April 23, 2002

Additional to these hospitalizations, Mr. Hyde's MSI Patient History (Exhibit 173) charts numerous visits to general practitioners and psychiatrists on the South Shore from May 1987 through 2002. In some years, Mr. Hyde had little contact with medical practitioners: as infrequently as 1–3 visits only in each of the years between 1998 and 2002. (1989 and 1993 also only show billings for two to three visits.) Other years indicate much higher levels of contact: in 1987 – 25 visits; 1988 – 18 visits; 1995 – 21 visits; and 10 and 8 visits respectively in 1996 and 1997.[2]

Documents relating to Mr. Hyde's hospitalizations indicate a long history of poor compliance with his medications. The discharge summary from Mr. Hyde's June 1987 admission to the Yarmouth Regional Hospital noted: "His compliance with medication is questionable and he acknowledges at times not taking the medication as directed."[3] In 2002 Mr. Hyde's court-ordered assessment reported that Mr.

Hyde tended to "discontinue his medication frequently, leading to relapses of his illness."[4]

Excerpts from various hospital discharge summaries provide a snapshot of the difficulties Mr. Hyde was experiencing with his illness. Dr. O'Flynn noted in the discharge summary following Mr. Hyde's hospitalization from April 12 – May 18, 1992 that: "He was again brought to the Outpatient Department [of the Yarmouth Regional Hospital] by the police in a state of acute agitation, issuing violent threats, expressing delusional thinking, flight of ideas, pressure of speech, alienation of thought and thought disorder. At the time of admission he was extremely angry, thirsty and disheveled and had obviously been neglecting himself for awhile. It was impossible to get a clear impression as to his compliance with medication while he was at home. Judging by past history, this was probably poor." In Dr. O'Flynn's opinion good compliance with medication was necessary to keep Mr. Hyde "out of long-term institutional care."[5]

Dr. Ian Clarke, writing in Mr. Hyde's discharge summary following an admission to the Yarmouth Regional Hospital from September 5 – November 26, 1993 observed that Mr. Hyde had been deluded, agitated, paranoid and in denial about his illness. Dr. Clarke noted the role of family stresses, such as the death of Mr. Hyde's mother earlier in the year, and the effects of social isolation in Mr. Hyde's deterioration. He commented: "Obviously, Howard's prognosis is very dependent on whether or not he can maintain contact as an outpatient and clearly his mental state is likely to deteriorate fairly rapidly if he does not receive his medication or if he remains consistently isolated."[6]

By 2000, Mr. Hyde had been prescribed Fluanxol Depot, a long-acting, antipsychotic medication used to treat the symptoms of schizophrenia. Although records filed with the Inquiry indicate that Mr. Hyde discontinued these injections in October 2000,[7] it appears that he received them in November and December 2000.[8]

In the spring of 2001, Mr. Hyde was again receiving Fluanxol. He continued with the monthly injections through July, August, September and October.[9] In November 2001, Mr. Hyde discontinued the medication complaining that he was tired of the side-effects.[10] Although he did not at that time specify what these side-effects were, presumably Mr. Hyde was experiencing what had been described as his complaints in a discharge summary from the Yarmouth Regional Hospital following an admission from March 18 – April 2, 2001 – lack of libido and erectile dysfunction.[11]

On March 18, 2001, Mr. Hyde was brought by the RCMP to the Roseway Hospital in an acutely psychotic, paranoid state. His admission record describes him as "agitated, pacing, threatening at times" with "paranoid delusions."[12] He was certified under the *Hospitals Act* and taken to the Yarmouth Regional Hospital in police custody.

In addition to problems related to side-effects from the medication, Mr. Hyde was acutely aware of the stigma associated with having a diagnosis of a serious mental illness. He denied having schizophrenia and expressed the belief that it could be "cured." He told Dr. Appavoo, a psychiatrist at the Yarmouth Regional Hospital that schizophrenia should be described as a condition, not as a "disease, illness or disorder."[13] By denying his illness, Mr. Hyde could counter its negative implication: "I am a very intelligent person. I don't have anything wrong."[14]

Mr. Hyde's brother-in-law, Dr. Hunter Blair, noted the relationship between stigma and Mr. Hyde's resistance to taking his medications: "He was his own worst enemy because he didn't like to take pills…this is not unusual, this is a very com-

mon phenomena in the mentally ill; they don't want to be mentally ill and taking medication is a symbol of being mentally ill, so they don't want to do it."[15]

Having discontinued his Fluanxol, Mr. Hyde began to unravel again in February 2002. His family doctor, Dr. Riley, spoke to him on February 15. His chart notes indicate that Mr. Hyde was "really stressed" from looking after his girlfriend who had broken her leg. (The effects of the demands associated with this responsibility are noted elsewhere in the medical records for Mr. Hyde in evidence before this Inquiry.) Dr. Riley noted that it did not appear that Mr. Hyde had been getting his Fluanxol injections.[16]

On February 18, 2002, Mr. Hyde's girlfriend called the police to report that he had assaulted her. Fearful of being hospitalized and forced to take medication, Mr. Hyde took off before the police arrived and was pursued, at a low speed, refusing to pull over. At the Port Clyde bridge, police officers were able to box Mr. Hyde's vehicle in. Despite being told he was under arrest. Mr. Hyde remained in the car and the officers broke a window to extricate him.[17] The police took Mr. Hyde to the Yarmouth Regional Hospital where he was admitted to the Psychiatry In-Patient Unit. He was charged on February 20, 2002 with resisting arrest contrary to section 129(a) of the *Criminal Code* and evading a police officer by refusing to stop his car contrary to section 249.1(1).

Mr. Hyde's attending psychiatrist recommended that Mr. Hyde be assessed for criminal responsibility and on April 23, 2002, Mr. Hyde was remanded by court order to the East Coast Forensic Hospital for this purpose. A report to the court from the East Coast Forensic Hospital expressed the opinion that Mr. Hyde was not criminally responsible for his actions on February 18, 2002 due to being "actively psychotic at the time of the alleged offences." He was described as experiencing, as a result of his paranoid schizophrenia, paranoid delusions that he was in danger from the RCMP. The report noted that Mr. Hyde had been "unstable for some time due to lack of compliance with treatment." He was described as having resisted an increase in his antipsychotic medication. "He does not believe he has an illness and will, in our opinion, stop his treatment if left to his own devices."[18]

Mr. Hyde was found not criminally responsible on May 21, 2002 on the resisting arrest charge. The section 249.1(1) charge was withdrawn. Mr. Hyde was placed under the jurisdiction of the Criminal Code Review Board and sent to the East Coast Forensic Hospital rehabilitation unit. He received an absolute discharge from the CCRB on July 8, 2004.[19]

The "not criminally responsible" disposition occasioned Mr. Hyde's first experience in the forensic system. Although, by 2002 he had a criminal record, for being unlawfully in a dwelling and careless use of a firearm in 1992 and uttering threats in 1996, on both occasions he had received a sentence of probation.

In Mr. Hyde's discharge summary dated February 3, 2004 from the East Coast Forensic Hospital, it was noted that he "experiences residual negative symptoms best characterized by his difficulties processing new stimuli, heightened anxiety and, at times, confusion." Reintegration into the community was seen as requiring "the presence of supportive mental health teams to monitor Mr. Hyde's compliance with medications as well as helping resolve his concerns regarding his anxieties."[20]

Mr. Hyde had been granted a conditional discharge on July 8, 2003 and found a suitable apartment in Dartmouth in September. From mid-October 2003 Mr. Hyde began spending overnights in his apartment. However follow-up in the community through the Supportive Community Outreach Team (SCOT Team) was not avail-

able to him due to workload/staffing issues with the team. It was not until January 2004 when the Team began accepting new clients to their caseload again that the Team became involved with Mr. Hyde.[21] Until the SCOT Team was able to accept Mr. Hyde into their programme, he could not be discharged into the community from the East Coast Forensic Hospital.[22]

A "Readiness Assessment Profile and Summary" from the East Coast Forensic Hospital in March 2003 described Mr. Hyde as someone who was social, outgoing and enjoyed connecting with people. Some of his interests were reported to be chess and keeping up with current events and he was said to be feeling a little emotionally and intellectually isolated in the hospital.[23]

The May 11, 2004 Report to the Criminal Code Review Board[24] concerning Mr. Hyde indicated that he was living alone in a one-bedroom apartment in Dartmouth. He was spending one weekend a month in the Jordan Bay house, reporting that he felt safe and secure there and while he enjoyed the solitude, he had no plans to return to the Shelburne area permanently, recognizing the benefit of community supports he had available to him in Metro. He was working part-time at the Atlantic Superstore stocking shelves and attending to grocery carts and participating in social activities at Connections Clubhouse and the YMCA on a regular basis.

An amateur video made of Mr. Hyde at the YMCA shows him shooting hoops and talking energetically about his interests and issues of concern to him. His sociability, sense of humour and enthusiasm for physical activity are all plainly evident.[25]

Mr. Hyde's experience in the forensic system amplified his awareness of the stigma associated with a severe, chronic mental illness. He consistently identified this stigma as an issue. In a telephone call to the East Coast Forensic Hospital when he was AWOL past his evening curfew, Mr. Hyde said he didn't belong in the hospital and that it had "ruined his life." In his words: "…having the tag, forensic, it really sucks."[26] He expressed concern to Dr. Bhattacharyya, the psychiatrist for the SCOT Team, about the stigma of being in a forensic hospital[27] and described his perception that some people at Connections Clubhouse were shunning him because they knew he was a forensic patient.[28] In March 2004, Mr. Hyde reported that loneliness was a problem.[29] This was a theme Mr. Hyde had mentioned before, describing himself as having "no close friends."[30]

Mr. Hyde's social/sexual needs may have contributed to his difficulties with medication compliance. During a subsequent hospitalization in 2005, Mr. Hyde expressed the view that his medications interfered with his ability to "have a relationship."[31]

Although Mr. Hyde seems to have developed a rapport with the SCOT Team and enjoyed his part-time employment and socializing through Connections Clubhouse, he began to unravel again. Dr. Sarban Singh, the general practitioner Mr. Hyde started seeing in 2003 noted that in late November 2004, Mr. Hyde had become very suspicious and paranoid and believed he was "getting radiation from some sort of gadget."[32] By December 23, 2004, he had been suspended from Connections Clubhouse because of an infatuation with a volunteer and was let go by Superstore as they had noted a decline in his performance.[33]

Mr. Hyde's mental health declined significantly in early January 2005. He was refusing to interact with the SCOT Team and was unresponsive to the Team's efforts to get him to see Dr. Bhattacharya. On January 10, 2005, SCOT Team members could hear Mr. Hyde inside his apartment screaming: "Get the fuck away from here – your meds have ruined my life."[34]

Police were called to Mr. Hyde's apartment on January 12, 2005 following a complaint that he was behaving erratically and yelling out of his window saying he had a gun (which he did not) and was going to start shooting people. Mr. Hyde was unresponsive to the police knocking on his door and identifying themselves. He had barricaded himself inside. According to an initial police report, police officers forced their way into the apartment and found a completely naked and agitated Mr. Hyde. Both before and after he succeeded in locking himself in the bathroom, he was warned that the police officers were armed with a Conducted Energy Weapon (CEW). It was used in a touch stun mode during the attempt by police to gain control of Mr. Hyde. Mr. Hyde continued to struggle with police once the touch stun was discontinued, but control of him was achieved through the use of a Level II neck restraint.[35]

Mr. Hyde was apprehended under the *Hospitals Act*[36]. He was taken first to the Dartmouth General Hospital for a mental health assessment, blood work and toxicology tests. Once released from the Dartmouth General, police officers transported him to the Nova Scotia Hospital. No criminal charges were laid. Information obtained by the police from the SCOT Team indicated that Mr. Hyde had stopped taking his medication.[37]

Following the apartment incident Mr. Hyde was a patient at the Nova Hospital from January 13 to May 9, 2005. He was discharged against medical advice, rejecting a recommendation that he enter the Mount Hope Recovery and Integration Rehabilitation Services Unit at the Nova Scotia Hospital site. He told Dr. Blair Hicken, the attending psychiatrist at the Nova Scotia Hospital, that he wanted to return to Shelburne to live in the Jordan Bay property. Dr. Hicken had "very considerable reservations" about Mr. Hyde's plan "because of his poor planning abilities and what I thought were considerable deficits in his general abilities to look after himself and to cope socially."[38] Dr. Hicken wanted Mr. Hyde to receive psycho-social rehabilitation before he left hospital. He felt that Mr. Hyde's prognosis for "continued symptom control" was poor. He predicted eventual deterioration and further hospitalization.[39] Mr. Hyde reported that he was looking forward to returning to Jordan Bay and was concerned about getting good follow-up care.[40]

The records of Mr. Hyde's hospitalization from January to May 2005 reveal that Mr. Hyde was preoccupied by his encounter with police at his apartment. He had expressed apprehension about the police previously: this is noted in records from his 2002 to 2004 hospitalization.[41] A 1992 incident in Jordan Bay that resulted in Mr. Hyde being apprehended by police and hospitalized may have germinated Mr. Hyde's fears.[42]

Mr. Hyde's pre-existing fear of the police was amplified by his tasering in January 2005. In discussions with clinical staff at the Nova Scotia Hospital, Mr. Hyde was explicit about how traumatized he was by the experience. Clinical records disclose that Mr. Hyde was paranoid about the police and became very agitated when discussing the tasering. He was also preoccupied with thoughts that he had suffered damage to his heart and lungs. In March 2005 he attributed flu-like symptoms to being tasered. Although by early April 2005, clinical staff noted that Mr. Hyde was "much less angry and fixated" on the actions of the police, he remained "still somewhat preoccupied with the residual effect of the taser" on his physical health.[43]

Mr. Hyde never overcame his fear of the police and the trauma of being tasered. He expressed these anxieties over many months before his death.[44] And in an eerie foreshadowing of the tragic circumstances leading up to his death, he was under-

stood to be "most prone to act impulsively and/or aggressively when acutely psychotic and feels his liberty is about to be curtailed."[45]

Notes

1 Exhibit 79-B, Page 286 Clinical Progress Note January 27, 2004

2 In preparing these numbers, I discounted any MSI billings for Mr. Hyde during periods when he was hospitalized and did not include any visits that were not coded as relating to his mental health issues.

3 Exhibit 79-F, Tab K, page 19

4 Exhibit 124, page 61, Report dated May 6, 2002 of Dr. C.C.Ojiegbe, Staff Psychiatrist with the East Coast Forensic Hospital to the Honourable Judge Robert Prince of the Provincial Court of Nova Scotia

5 Exhibit 79-F, Tab K, page 26

6 Exhibit 79-F, Tab K, pages 27–28

7 Exhibit 79-F, Tab K, page 32, Discharge Summary for March 18 – April 2, 2001 Admission to Yarmouth Regional Hospital

8 Exhibit 288, Roseway Hospital Outpatient Record, pages 21–25 of Dr. Riley's Chart

9 Exhibit 288, Yarmouth and Roseway Hospital Outpatient Records, pages 8–16 of Dr. Riley's Chart

10 Exhibit 124, page 73, letter dated April 16, 2002 from Dr. Wayne Edwards, staff psychiatrist at the Yarmouth Mental Health Centre to Paul Scovil, Senior Crown Attorney, Public Prosecution Service of Nova Scotia. Criminal charges in 1992 had led to Mr. Hyde agreeing to again take his medication by injection. Mr. Hyde's psychiatrist, Dr. O'Flynn indicated in a Pre-Sentence Report dated November 20, 1992 that Mr. Hyde could function fairly well on his medication but did not always accept that he needed it.

11 Exhibit 79-F, Tab K, page 31

12 Exhibit 288, Roseway Hospital Emergency/Outpatient Record, page 17, Dr. Riley's Chart

13 Exhibit 79-F, Tab K, Yarmouth Regional Hospital Mental Health Centre Assessment June 14, 2000, page 30

14 Exhibit 79-A, Tab B, page 21, Nova Scotia Hospital Comprehensive Assessment, April 23, 2002

15 Exhibit 61, Tab 59, RCMP interview, November 25, 2007 at page 18 (Dr. Hunter Blair)

16 Exhibit 288, Chart Notes of Dr. Riley, February 15, 2002

17 Exhibit 79-D, Tab G, pages 13–14, Discharge Summary Report, East Coast Forensic Hospital, February 3, 2004

18 Exhibit 124, pages 64–65

19 Exhibit 124, pages 32–35, Reasons for Disposition of the Criminal Code Review Board, July 8, 2004

20 Exhibit 79-D, Tab G, page 16, Discharge Summary authored by Dr. Ursula Wawer, Staff Psychiatrist, ECFH

21 Exhibit 124, page 80, Annual Report to the Criminal Code Review Board, dated May 11, 2004, by Susan Hagell, Forensic Community Coordinator and Louise Bradley, Health Services Director, ECFH

22 Exhibit 124, page 92, Dr. Ursula Wawer, Staff Psychiatrist, ECFH to Peter Lederman, Chair of the CCRB, November 19, 2003

23 Exhibit 79-D, Tab H, page 163, 171

24 Exhibit 124, pages 79–84

25 Exhibit 284

26 Exhibit 79-B, Tab D, page 245, Clinical Record, September 14, 2003

27 Exhibit 124, page 78, letter from Dr. Bhattacharyya to Peter Lederman, Chair of the CCRB, June 1, 2004, referring to an interview with Mr. Hyde on April 26, 2004

28 Exhibit 79-D, Tab H, page 213 Baseline Assessment January 13, 2004

29 Exhibit 79-D, Tab H, page 134 Client Service Plan Review, March 18, 2004

30 Exhibit 79-D, Tab H, page 213 Baseline Assessment, January 13, 2004

31 Exhibit 79-E, page 43, Nova Scotia Hospital Weekly Team Progress Report, January 18, 2005

32 Exhibit 269, Chart notes of Dr. Sarban Singh, November 22, 2004

33 Exhibit 79-D, Tab H, pages 50–51, Clinical Record SCOT Team

34 Exhibit 79-D, Tab H, pages 53–57, Clinical Record SCOT Team

35 Exhibit 60, Tab 10:2, page 5 of 21, Initial Officers Report (Cst. Tony Croft) January 12, 2005

36 R.S.,1989, c. 208 as amended

37 Exhibit 60, Tab 10:2, Report entered by Cst. Joanne McNeil, January 12, 2005

38 Exhibit 79-E, page 8, Discharge Summary Report prepared by Dr. Blair Hicken

39 Exhibit 79-E, page 217, In-Patient Clinical Record, May 6, 2005 (notation by Dr. Blair Hicken)

40 Exhibit 79-E, page 213, In-Patient Clinical Record, May 3, 2005

41 Exhibit 79-A, Tab B, page 20, Nova Scotia Hospital Comprehensive Assessment, April 23, 2002: "A little bit of fear from (sic) from police." Exhibit 124, page 108, Report to the Criminal Code Review Board prepared by Dr. Ursula Wawer and Louise Bradley, June 17, 2003: "Initially he felt slightly paranoid when out walking on the street. He felt particularly afraid of police." Exhibit 79-B, page 245, Clinical Record, September 14, 2003: "He began to speak about being mistreated by police in the past…"

42 Exhibit 61, Tab 59, RCMP interview, November 25, 2007, pages 5–8 (Joanna Blair and Peter Haeghaert)

43 Exhibit 79-E, pages 45, 81 (January 24, 2005); pages 128, 133, 134, 136 (February 9, 12, 13 and 15, 2005); pages 171, 172, 174, 175, 183, 184 (March 17, 20, 22, 28, 30, 2005); pages 186, 190, 191 (April 2, 5, 2005) In-Patient Clinical Records; page 32 (March 8, 2005) Weekly Team Progress Report

44 Testimony of Dr. Sarban Singh, pages 10385–10386; Exhibit 79-E, In-Patient Clinical Records, pages 45, 81 (January 24, 2005); page 128 (February 9, 2005); pages 133, 134, 136 (February 12, 13, 15, 2005); pages 171, 172 (March 17, 2005); page 174 (March 20, 2005); page 175 (March 22, 2005); page 183 (March 28, 2005); page 184 (March 30, 2005); page 186 (April 2, 2005); page 190 (April 5, 2005); and Weekly Team Progress Report, page 32 (March 8, 2005); Exhibit 269, Chart notes of Dr. Singh, September 6, 2007

45 Exhibit 124, page 113, Report to the Criminal Code Review Board prepared by Dr. Ursula Wawer and Louise Bradley, June 17, 2003

Howard Hyde's Mental Health – 2007

By January 2007, Mr. Hyde was living in Dartmouth at 175 Albro Lake Road and in a relationship with Karen Ellet whom he had met in 2005 during his hospitalization at the Nova Scotia Hospital.[1] He was continuing to experience difficulties as a consequence of his severe, chronic mental illness. On January 22, 2007, he contacted Community Mental Health Services stating that he needed to see someone as soon as possible. He expressed paranoid thoughts, saying that he felt he was being watched "all the time by cameras etc." He also talked about hearing voices, particularly those of his dead mother. Although Mr. Hyde was scheduled for an intake assessment on February 6, 2007, he did not show up.[2]

By March 2007, Mr. Hyde was once again not taking his medication. He was observed to be exhibiting bizarre behavior, including talking to himself.[3] As the end of April approached, Mr. Hyde was "increasingly unwell…talking loudly, yelling, being confused about current events, and generally behaving in a disorganized fashion." He was paranoid, denying anything was wrong and expressing considerable anger when any suggestion was made to him about medication, doctors or hospital.[4] Ms. Ellet tried to manage Mr. Hyde's behaviours as she thought a visit by mental health professionals to the apartment would make him angry.[5]

Ms. Ellet was very familiar with the patterns that emerged when Mr. Hyde was not taking his medications. His anxiety would escalate and he would pace the floor, becoming delusional and psychotic. Ms. Ellet tried to handle Mr. Hyde herself, attempting to calm him down and urging him to take his medications, sleep and eat. It was her experience that when Mr. Hyde did not get enough sleep he became more psychotic. She found it very difficult to get through to Mr. Hyde when he became ill and he became angry if help was summoned that he did not think he needed.[6]

The Mobile Mental Health Crisis Team decided to make a visit to Mr. Hyde on May 1, 2007 for the purpose of trying to assess Mr. Hyde. When no one answered the door, a card was left with contact information. Subsequently the police received information that Mr. Hyde had contacted his sister to indicate that he would rather kill himself than go back to the Nova Scotia Hospital. Mr. Hyde had also been seen by his superintendent hanging from his fourth floor balcony. He had made a threat to stab the superintendent. When the police arrived at the Albro Lake Road apartment, Mr. Hyde was no longer there. He was located at MicMac Mall by police and agreed to accompany them without incident. The police took Mr. Hyde to the Dartmouth General Hospital where he was observed to be confused and grandiose. He acknowledged that he was not taking his medication. After blood work was done and Mr. Hyde's vital signs were taken, he was transported by police to the Nova Scotia Hospital.[7]

On admission to the Nova Scotia Hospital Mr. Hyde was agitated, irritable, and delusional.[8] Even after a few days in hospital, he was still agitated and was pacing on the unit and in and out of his room.[9] Even so, he expressed appreciation for having medications and dosages explained to him.[10] He remained in hospital until May 14, 2007 when he was discharged against medical advice, rejecting a recommendation that he transfer to an acute care floor of the hospital.[11] Ms. Ellet was not aware that Mr. Hyde had left the hospital contrary to medical advice, just as she had not known of his doing so in May of 2005. She also did not know Mr. Hyde had sought help in January 2007 but had not followed up the appointment with Mental Health Services.

When he left the NSH in May 2007, Mr. Hyde was assessed as having an elevated risk of being re-hospitalized in the short term.[12] At the time of discharge, clinical staff considered it distinctly possible that Mr. Hyde would, "in the near future", return to hospital as either a voluntary or an involuntary patient. It was hoped that Mr. Hyde could be followed up in the community by a psychiatrist through Connections Clubhouse.[13] Before leaving the hospital, Mr. Hyde made an appointment to see his family doctor, Dr. Singh, on May 16.[14]

On leaving the hospital, Mr. Hyde was given the Mobile Mental Health Crisis Team phone number, a bus ticket, a prescription and his discharge medications. He said that he would continue to take his medications and thanked staff for the help they had given him during his hospital stay.[15]

During this two week hospitalization some familiar themes re-surfaced. Mr. Hyde's anxiety over being tasered in 2005 had not disappeared. He referred to his right shoulder being "not quite right" as a result of the tasering and talked about taser-related deaths in Canada.[16] He was upset about medication side-effects, specifically weight gain from taking olanzapine.[17] Ms. Ellet visited Mr. Hyde, leaving a note for staff expressing concerns that when discharged he would stop taking his medication and relapse again. She commented on Mr. Hyde's difficulties with compliance: "My hope [is] that he has counseling about his medications and his frustrations. He is unable to realize different situations he is involved in at the time. He doesn't understand why he had to take medications and [is] very oppose [d] to taking them."[18]

Mr. Hyde kept his appointment with Dr. Singh on May 16, 2007 but only saw him twice more after this. These visits were on June 26 and September 6, 2007. Dr. Singh found Mr. Hyde to be in good physical health in June and prescribed him olanzapine. In September Mr. Hyde started talking once again about being tasered by police in January 2007. In Dr. Singh's view, he was very paranoid about the taser.[19] Dr. Singh did not give Mr. Hyde a prescription for olanzapine because he believed that he had seen his doctor in Shelburne, Dr. Riley. In fact, Mr. Hyde had not seen Dr. Riley since 2006, if the MSI records and Dr. Riley's records are accurate.[20]

Dr. Singh's prescription for Mr. Hyde on June 26, 2007 was the last olanzapine prescription indicated in the records of Mr. Hyde's pharmacy, Lawtons on Primrose Street in Dartmouth. It was for thirty days.[21] It is not known if Mr. Hyde was compliant with taking this final prescription but in any event, it was the last prescription he received.

It seems most likely that by July 2007 Mr. Hyde had stopped taking olanzapine. It is somewhat confusing that Ms. Ellet recalls Mr. Hyde being off his medication for only three weeks before the events of November 21 and 22 because there is no evidence of a source for any olanzapine at least after the last prescription Dr. Singh

provided Mr. Hyde in June. However, on September 6, 2007, at Mr. Hyde's last appointment, Dr. Singh had prescribed sixty days of lorazepam which was intended to treat Mr. Hyde's anxiety.[22] I believe it was this medication to which Ms. Ellet was referring when she described Mr. Hyde having been off his medication for three weeks prior to the November events. That September 6, 2007 prescription would have run out in early November.[23]

Ms. Ellet's evidence indicates that Mr. Hyde had been deteriorating significantly.[24] She noted that Mr. Hyde was resistant to taking his medication, telling Ms. Ellet that he didn't need it and that it made him physically sick and that it would "hurt him".[25] She testified that when she counted his pills there were more left than there should have been.[26] I presume this must have been the lorazepam as I can see nothing to indicate a source for olanzapine after the June prescription. Furthermore, from consulting and comparing the primary documentary records I have to go by - Dr. Singh's chart and the MSI records[27] – I think it is unlikely that Mr. Hyde was getting his prescriptions on a consistent basis in any event.

The tragic events of November 21 and 22, 2007 were closing in on Mr. Hyde. Earlier that month, he and Ms. Ellet were walking home from Micmac Mall together. Mr. Hyde wanted to hitchhike but Ms. Ellet did not. Mr. Hyde became agitated and punched Ms. Ellet twice in the head, hard, with his closed fist. She experienced severe headaches as a result but did not report the incident to the police. [28]

There is evidence that Ms. Ellet hoped Dr. Singh could intervene and help Mr. Hyde. Her concern about Mr. Hyde being off his medications led to her going to Dr. Singh's office to make an appointment, telling Dr. Singh's secretary that Mr. Hyde needed medical help.[29] That appointment was for November 20, 2007. Dr. Singh's records show an appointment scheduled for Mr. Hyde on that date which he did not attend.[30] Ms. Ellet described her attempts to get Mr. Hyde to the appointment as futile. He was not comprehending what she was trying to get him to do and was becoming incoherent.[31] He would not leave the apartment.[32] The situation was becoming increasingly desperate for Ms. Ellet and Mr. Hyde.

Notes

1 Exhibit 61, Tab 59, RCMP Interview, page 14 (Joanna Blair and Dr. Hunter Blair): Also testimony of Karen Ellet

2 Exhibit 79-F, Tab J, pages 2–4

3 Exhibit 79-F, Tab J, page 75, record from Mobile Mental Health Crisis Team dated May 1, 2007 (telephone calls from Karen Ellet – March 21, 2007, and Joanna Blair – April 1, 2007)

4 Exhibit 79-F, Tab J, page 9, records from the Mobile Mental Health Crisis Team (telephone conversation with Karen Ellet – April 25, 2007)

5 Testimony of Karen Ellet, page 182

6 Testimony of Karen Ellet, page 183

7 Exhibit 60, Tab 10:2, page 3 of 7, Initial Officers Report, May 1, 2007 (Cst. Mark Stevens)

8 Exhibit 79-F, Tab J, page 22, NSH Mental Health Program Brief Assessment

9 Exhibit 79-F, Tab J, page 34, Multidisciplinary Progress Notes, May 4, 2007

10 Exhibit 79-F, Tab J, page 33, Multidisciplinary Progress Notes, May 4, 2007

11 Exhibit 79-F, Tab J, page 16, Mental Health Program Clinical Care Summary

12 Exhibit 79-F, Tab J, page 16, Mental Health Program Clinical Care Summary

13 Exhibit 79-F, Tab J, page 55, Multidisciplinary Progress Notes

14 Exhibit 79-F, Tab J, page 55, Multidisciplinary Progress Notes

15 Exhibit 79-F, Tab J, page 55–56, Multidisciplinary Progress Notes

16 Exhibit 79-F, Tab J, page 35, Multidisciplinary Progress Notes, May 5, 2007

17 Exhibit 79-F, Tab J, page 37, Multidisciplinary Progress Notes, May 6, 2007

18 Exhibit 79-F, Tab J, page 58, Karen Ellet's note of May 10, 2007

19 Testimony of Dr. Sarban Singh, page 10400

20 Exhibit 173, page 5 of 7; Exhibit 288, Chart notes of Dr. Riley, page 1

21 Testimony of Sandra MacLeod, R.N., page 5597

22 Exhibit 269, Chart notes of Dr. Singh, page 10

23 The testimony of Sandra McLeod, R.N. about calling Lawton's on November 21, 2007 when Mr. Hyde was being admitted to the CNSCF indicates she was informed that Mr. Hyde had not had any olanzapine prescription filled since June 2007. Olanzapine was the only medication Mr. Hyde told Ms. McLeod about during the admission process and appears to be the only medication she inquired about when she called the pharmacy. I can only assume that the September 2007 lorazepam prescription was not identified during Ms. McLeod's call.

24 Testimony of Karen Ellet, page 130

25 Testimony of Karen Ellet, pages 132, 142

26 Testimony of Karen Ellet, page 132

27 Exhibit 173

28 Testimony of Karen Ellet, page 126

29 Testimony of Karen Ellet, page 131

30 Exhibit 269, Chart notes of Dr. Singh, page 10

31 Testimony of Karen Ellet, page 176

32 Testimony of Karen Ellet, page 141

Dr. Sarban Singh's Involvement with Mr. Hyde

Dr. Singh first saw Mr. Hyde in November 2003 at his Dartmouth clinic. He learned at that time that Mr. Hyde had a diagnosis of paranoid schizophrenia and was on anti-psychotic medication. Mr. Hyde informed Dr. Singh that he was seeing a psychiatrist, Dr. Battacharyya. He identified Dr. Mark Riley in Shelburne as his family doctor.

Mr. Hyde saw Dr. Singh a total of sixteen times from November 2003 to September 2007.[1] During this period, according to MSI records,[2] Mr. Hyde also made two visits to Dr. Riley, a physician in Shelburne whom he had seen over the years when he lived on the South Shore. If the MSI records are accurate, then Mr. Hyde only saw Dr. Riley twice in the four years he was seeing Dr. Singh. There is nothing in Dr. Riley's chart for Mr. Hyde to indicate that he saw him more often than that.[3] Notwithstanding that the available documentary record and logic[4] indicate that Mr. Hyde saw Dr. Singh more frequently than he saw Dr. Riley, Dr. Singh thought Dr. Riley was Mr. Hyde's primary physician and described himself as Mr. Hyde's "secondary doctor."[5] The two doctors never spoke. Dr. Singh requested that Mr. Hyde arrange for his medical records to be transferred to him from Dr. Riley but this never happened.

Mr. Hyde's contact with Dr. Singh in 2004 was quite minimal: he saw him only twice and Dr. Singh understood Mr. Hyde was getting his prescriptions from Dr. Battacharyya. When Dr. Singh saw Mr. Hyde next on July 27, 2005 he noted in his chart that Mr. Hyde had a Zantac[6] prescription to counter anxiety and five refills of his olanzapine[7] prescription from Dr. Riley.[8] (MSI records indicate Dr. Riley saw Mr. Hyde on May 20, 2005.)[9]

At the July 27 appointment Dr. Singh knew from the discharge summary forwarded to him that Mr. Hyde had been hospitalized at the Nova Scotia Hospital from January 12 to May 9, 2005.

He saw Mr. Hyde another couple of times in 2005: on November 18 and 28. When Mr. Hyde saw Dr. Singh on November 18 he informed him that Dr. Riley had provided medication refills to last him until May 2006.[10]

At the November 18 office consultation, Dr. Singh noted that Mr. Hyde was "very obsessed" with the tasering he had received from the police in January 2005. Mr. Hyde told Dr. Singh the police "had taken something out of his chest"[11] although there was no clinical evidence to support this belief.[12] Mr. Hyde associated pain he experienced in his chest and back with the tasering incident. He was very afraid of the police and of being tasered again. "I never want to be tasered again", he told Dr. Singh.[13]

Discussing the incident brought on shortness of breath and Dr. Singh con-

cluded that Mr. Hyde was suffering anxiety attacks, a post traumatic reaction to being tasered by police earlier that year.[14] Mr. Hyde also admitted to Dr. Singh that he was talking to his dead mother. Dr. Singh did not conclude this was delusional although it raised suspicions in his mind.[15]

Mr. Hyde saw Dr. Singh five times in 2006: March 10, April 19, June 12, October 18 and November 22. Dr. Singh prescribed Ativan[16] for Mr. Hyde's anxiety, only a month's supply at a time[17] and was not sure where Mr. Hyde was getting his other medications from.[18] The Ativan calmed Mr. Hyde down and helped him sleep.

As I noted earlier, Mr. Hyde apparently had prescription refills from Dr. Riley up until May 2006. With these refills Mr. Hyde was able to get his prescribed medications simply by going to his local pharmacy.[19] Dr. Singh prescribed olanzapine to Mr. Hyde in April and June 2006.

When Dr. Singh met with Mr. Hyde on June 12, 2006 he noted that Mr. Hyde had missed some doses of all his medications and urged him to be more diligent about compliance. It was Dr. Singh's understanding that Mr. Hyde was getting his prescriptions through Dr. Riley, a month's supply at a time and refills. However, according to the MSI records, the only appointment Mr. Hyde had with Dr. Riley in 2006 was September 6, 2006.[20] That also appears to be the last appointment Mr. Hyde had with Dr. Riley. It occurs to me that it is possible Mr. Hyde obtained prescription refills from Dr. Riley without Dr. Riley making any MSI claims for this service but I do not know this. It is of interest that an Emergency/Outpatient Record from the Roseway Hospital dated September 6, 2006 documenting a walk-in visit by Mr. Hyde that day contains the following notation: "Lives mostly in Dartmouth. Sees MD there regularly. Schizophrenia – no meds at present."[21]

During the November office consultation Mr. Hyde informed Dr. Singh that he was looking for a temporary job which Dr. Singh saw as a very good sign of his recovery and his interest in being part of the community and an indication that Mr. Hyde was motivated and coping well.[22]

When Mr. Hyde went to see Dr. Singh in early 2007, he was struggling more with his illness than Dr. Singh had seen previously. He was paranoid and grandiose, claiming that people were "hounding" him because he was famous.[23] Although delusional he remained calm which was consistent with Dr. Singh's experience of him. Dr Singh always found Mr. Hyde to be very calm and soft-spoken, even describing his delusions "in a very casual sort of way."[24]

Dr. Singh observed that Mr. Hyde was disheveled with long hair and had not bathed for several days although this was not extraordinary in his experience of Mr. Hyde. He saw manifestations of Mr. Hyde's paranoid schizophrenia but did not think he needed to be hospitalized. At the January 3, 2007 consultation he prescribed Mr. Hyde 10 mgs of olanzapine once per day for a month, and Ativan. There was no explanation from Mr. Hyde as to why he had not obtained his medications from Dr. Riley.[25] Dr. Singh assumed because Mr. Hyde was living in Dartmouth and Shelburne was quite a distance away he relied on Dr. Singh to provide him with his prescriptions when he needed them urgently.[26] Dr. Singh never gave Mr. Hyde any medication in blister pack samples; when Mr. Hyde used up his refills at the pharmacy he would drop in to see Dr. Singh who would give him a thirty-day supply of medication.[27]

During the period of February through September 2007 when Dr. Singh saw Mr. Hyde on four occasions[28] he continued to monitor Mr. Hyde's mental health. He noted that Mr. Hyde had put on weight and prescribed him olanzapine and

Ativan. There was no discussion about Dr. Riley although at the September office consultation Dr. Singh did not prescribe olanzapine believing that Mr. Hyde had recently seen Dr. Riley.[29]

On May 16, 2007, Dr. Singh saw Mr. Hyde for the appointment that was arranged by Mr. Hyde just before he left the Nova Scotia Hospital. Mr. Hyde's discharge summary was faxed to Dr. Singh's fax number and it is probable that he saw it before meeting with Mr. Hyde although he now does not recall. Dr. Singh recorded the medications for Mr. Hyde at the May 16 office consultation exactly as they appear on the Clinical Care Summary from the NSH.[30]

Mr. Hyde's last consultation with Dr. Singh was September 6, 2007. Mr. Hyde once again began talking about being tasered by the police in January 2007. In Dr. Singh's opinion, Mr. Hyde was "very paranoid" about the tasering incident.[31] The experience still traumatized him more than two and a half years later. An appointment noted in Dr. Singh's chart for Mr. Hyde of November 20 was never kept.

During the time Mr. Hyde was his patient, Dr. Singh believed he was compliant with his medications. It was Mr. Hyde's consistently calm, quiet presentation that led him to conclude this. Dr. Singh remembers Mr. Hyde affectionately: "I found him to be a sort of very mild sort of a character, always [a] very soft spoken man… He never raised his voice on any occasion, nor was there any reason to. He came, said his piece…I gave him plenty of time to talk. Took his medications [with him] and he would just very quietly go away. Actually, I was very much impressed with him...I deal with a lot of patients with schizophrenia….I liked the guy…He acted very normally. You would never know, if he was seated…in a shop drinking his coffee…that he [had a major mental illness.]…I think he was a real gentleman, yes, indeed."[32]

Notes

1 Exhibit 269, Chart Notes of Dr. Singh

2 Exhibit 173, pages 4 and 5 of 7

3 Exhibit 288, Chart Notes of Dr. Riley

4 In the period of November 2003 to September 2007, Mr. Hyde was resident in Dartmouth.

5 Testimony of Dr. Singh, page 10384

6 An anxiolytic medication

7 An anti-psychotic medication

8 Chart Notes of Dr. Singh, July 27, 2005. Presumably this would have provided Mr. Hyde with his medications until December 2005.

9 Exhibit 173, page 4 of 7

10 Chart Notes of Dr. Singh, November 18, 2005. There is nothing in Exhibit 288, Chart Notes of Dr. Riley, to indicate when he would have seen Mr. Hyde to provide this prescription and no MSI record for any appointment with Dr. Riley in the relevant time period.

11 Testimony of Dr. Singh, page 10415

12 Testimony of Dr. Singh, page 10416

13 Testimony of Dr. Singh, pages 10429–10430

14 Testimony of Dr. Singh, page 10386

15 References in Exhibit 79-F, Tab J indicate that Mr. Hyde's conversations with his dead mother were a feature of his delusional behaviour related to his illness

16 An anxiolytic medication, lorazepam

17 Dr. Singh's strategy was to build in an incentive for Mr. Hyde to come back to see him so he could continue to monitor Mr. Hyde's mental health status. (Testimony of Dr. Singh, page 10463)

18 Testimony of Dr. Singh, page 10389

19 Testimony of Dr. Singh, pages 10468–10470

20 Exhibit 173, page 5 of 7

21 Exhibit 288, Chart Notes of Dr. Riley

22 Testimony of Dr. Singh, page 10392

23 Chart Notes of Dr. Singh, January 3, 2007

24 Testimony of Dr. Singh, page 10394

25 Testimony of Dr. Singh, page 10396

26 Testimony of Dr. Singh, page 10396

27 Testimony of Dr. Singh, pages 10468–10469

28 February 19, May 16, June 26, September 6

29 Testimony of Dr. Singh, pages 10400–10401

30 Exhibit 79-F, Tab J, page 15; Testimony of Dr. Singh, page 10457

31 Chart Notes of Dr. Singh, September 6, 2007: Testimony of Dr. Singh, page 10400

32 Testimony of Dr. Singh, pages 10403–10404

Albro Lake Road – November 21, 2007

The Calls to the Mobile Mental Health Crisis Team and 911

On November 21, 2007 Mr. Hyde was very agitated and anxious. Despite Karen Ellet's efforts to stabilize him by encouraging him to eat and sleep and take his medication, he had been becoming more and more aggressive in the preceding weeks. He had not been taking his medication, which included lorazepam for high anxiety and olanzapine for psychosis[1], and was not eating properly or sleeping.[2] It was late at night when Karen Ellet decided she needed help to deal with him. The situation in the apartment was increasingly tense and she could see Mr. Hyde was unraveling. He was paranoid, and more agitated than she had ever seen him.[3] She could not calm him down.[4] She knew she could not handle him and that he needed professional help.[5]

Ms. Ellet decided to call the Mobile Mental Health Crisis Team (MMHCT or Mobile Mental Health) so that someone from the Team would come and assist.[6] She knew that Mobile Mental Health could make in-person visits[7] and thought that a nurse would assess Mr. Hyde at the apartment which is what she wanted.[8]

Mr. Hyde did not take kindly to Ms. Ellet's decision to call Mobile Mental Health.[9] He was irate. He did not want her talking to anyone and did not believe he needed any help.[10] While Ms. Ellet was on the telephone, he grabbed it and hung up or disconnected the line. Mobile Mental Health could hear him yelling into the telephone and speaking to Ms. Ellet very aggressively.[11] Mr. Hyde also hit Ms. Ellet with the phone on the right side of her face.[12] She was scared. Mr. Hyde was unpredictable and incoherent.

Mobile Mental Health contacted 911 about Ms. Ellet's call. Mobile Mental Health told 911 that Ms. Ellet's boyfriend, Howard Hyde, had a diagnosis of schizophrenia and a "history of violence." While Mobile Mental Health was on the telephone with 911, Ms. Ellet called in to 911 herself. [13]

Ms. Ellet told 911 she was calling about "a psychotic person" whom she identified as Howard Hyde, her boyfriend. She said he needed to be removed from the apartment and taken to hospital.[14] She was fearful because he had been violent toward her, grabbing and pushing her and grabbing the telephone while she was on it. She was making the call quietly while Mr. Hyde was in another room, and told 911 that if he heard her, he would grab her again.[15] She was afraid that if he knew she was on the telephone he would become more aggressive.[16]

Ms. Ellet talked to 911 about how she had been unable to get Mr. Hyde to leave the apartment and her fears that if she had left, he would have barricaded himself

in. She felt he would respond violently to any intervention and referred to his "track record" of twenty years of similar behaviour. She had never seen him this bad and described how his deterioration had led her to going to see his doctor and arranging an appointment for him for November 20 which Mr. Hyde did not attend. She told 911 Mr. Hyde had not been compliant with his medications "in over a year" although she had thought he was still taking them.[17]

The Attendance of the Police – Csts. Gyles Gillis and Bradley Jardine

Domestic violence calls are treated as priority calls because of the high risk for someone getting hurt.[18] Officers try to respond as quickly as possible.[19] Ms. Ellet later told the Inquiry in a letter that the officers had "walked into a highly unpredictable situation" and were "professional…fine gentlemen" in dealing with her.[20]

Ms. Ellet remained on the telephone with 911 until the police arrived. Csts. Gyles Gillis and Bradley Jardine had been dispatched at 00:15[21] to a "domestic assault in progress." They went immediately to the scene[22], climbed the stairs to the fourth floor apartment and listened outside the door. Everything was quiet. When the officers announced it was the police, Mr. Hyde started yelling and cursing. Cst. Jardine concluded that there was "an aggressive guy behind that door and he was very angry."[23]

When Ms. Ellet appeared at the door the officers took her into the hallway to speak to her.[24] To Cst. Jardine who had considerable experience as a patrol officer responding to domestic violence calls, she looked like "a victim of a domestic assault."[25] Obviously frightened, shaky and concerned,[26] Ms Ellet told Cst. Jardine that Mr. Hyde was schizophrenic, had hit her and that he "went over the balcony" before he was arrested "the last time."[27]

Cst. Gillis told Ms. Ellet they would go in and arrest Mr. Hyde and that she should wait in the hallway outside the apartment while they did this.

The officers were unable to find Mr. Hyde in a search of the apartment. The disappearance of Mr. Hyde could only be explained by him having scaled down the balconies to the ground.[28] At the hospital later, Mr. Hyde admitted to Cst. Gillis that he had climbed down to the ground to get away from them.[29] According to Cst. Gillis' notes he already knew that as he had recorded that Ms. Ellet stated "last time HYDE jumped over patio – fourth floor."[30]

Csts. Jardine and Gillis got a description of Mr. Hyde from Ms. Ellet and disseminated it to police units in the area.[31] While they were inside the building continuing to look for Mr. Hyde,[32] Cst. Jonathan Edwards called on the radio about a male matching the description whom he had located on the street at the back of Ms. Ellet's apartment building. He asked Cst. Jardine if he was "arrestable." Based on the information from Ms. Ellet, Cst. Jardine responded that the man was "arrestable for assaulting his wife and he's very mentally unstable, so heads up."[33]

Cst. Gillis does not now recall this radio exchange, although concedes he "possibly" heard it.[34] It would not have factored into what he thought was the right course of action – to arrest an aggressive male in a "highly volatile" situation of a domestic assault, according to the Intimate Partner Violence Policy of the Halifax Regional Police.[35] Cst. Edwards, who made the arrest, took the same view.[36]

Csts. Gillis and Jardine ran down to the parking lot to meet Cst. Edwards. He had Mr. Hyde in handcuffs by the car.[37] The arrest had been uneventful: Mr. Hyde had complied with Cst. Edwards direction.[38] He was very apologetic, although Cst.

Edwards was not sure why,[39] but denied the assault.[40] He indicated to Cst. Edwards that he wanted to speak with a lawyer once he got to Booking.[41]

What Cst. Jardine encountered when he and Cst. Gillis raced out of the building to assist Cst. Edwards was very different from what he expected after Ms. Ellet's description of being assaulted and hearing the noise coming from the apartment when they first arrived. He was braced for an aggressive man, and a fight.[42] Mr. Hyde was calm and showed no aggression. He understood he was being arrested for hitting Ms. Ellet and that he was going to Booking. [43] Cst. Jardine had expected to encounter "a much different person downstairs" than he had heard at the door.[44]

Even though it was November, Mr. Hyde was wearing only shorts as he minded the heat in the apartment.[45] He was also not wearing any shoes.[46] It was cold out: when Cst. Gillis started his shift at 18:00 hours, it had been zero degrees. The police officers did not find it wholly unusual to encounter someone dressed inappropriately for the weather like Mr. Hyde.[47] Both Csts. Gillis and Jardine[48] believed Mr. Hyde had just not had time to change out of his shorts before slipping out of the apartment to evade police and did not make the link that he was suffering from an illness. "I didn't have any reasonable grounds to believe he had a mental illness at the time of the arrest."[49]

Cst. Gillis recalls Mr. Hyde rambling, and not making any sense,[50] but nevertheless being under control and cooperative. The situation seemed under control.[51] Cst. Gillis did not regard Mr. Hyde's rambling or his presentation as out of the ordinary. He did not pay close attention to what Mr. Hyde was saying and thought it was possible he was under the influence of drugs. He does not recall being trained on how to distinguish a person experiencing the effects of drug intoxication from a person experiencing a mental illness, and sees the distinction as difficult to make.

Cst. Gillis did not conclude that Mr. Hyde was exhibiting signs of a mental disorder. "I wouldn't say it would be fair to say that [Mr. Hyde was having some mental health issues] Sometimes we get people who are pretty high on drugs that also act this way."[52] It wasn't until he heard that Mr. Hyde had been tasered after an altercation at the police station and was on his way to the hospital that Cst. Gillis formed the view that he had severe emotional problems.[53]

Cst. Gillis recalls no discussion down by the car with Cst. Edwards that Mr. Hyde was mentally unstable.[54] Cst. Edwards had "no reason to believe…that [Mr. Hyde] was suffering from any mental health issue at the time." He observed Mr. Hyde to be "very calm, cool, collected" and oriented as to what was happening.[55] Cst. Edwards does not recall hearing the radio transmission from Cst. Jardine that Mr. Hyde was "mentally unstable."[56] He did hear that Mr. Hyde was arrestable.[57]

With Cst. Edwards having agreed to transport Mr. Hyde to Halifax Regional Police Booking in Halifax, Csts. Gillis and Jardine returned to Ms. Ellet's apartment to get a statement.[58]

Ms. Ellet told the officers that Mr. Hyde was "a schizophrenic" and had been "on and off" his medication for a year.[59] She mentioned being assaulted by Mr. Hyde three weeks previously.[60] She did not tell the police he was subject to panic attacks.[61]

When Cst. Jardine was interviewed by the RCMP on November 25, 2007, he indicated that Ms. Ellet had told him Mr. Hyde had been tasered in the past.[62] This is consistent with what Ms. Ellet herself recalls about telling "one of the police officers" that Mr. Hyde had been tasered.[63] Ms. Ellet didn't know much about the incident as Mr. Hyde did not talk about it when he was well. He mentioned it to Ms.

Ellet when he became "really sick."[64] She told Cst. Jardine that she had been on the telephone trying to get help for HH and that he was "paranoid of police."[65]

Ms. Ellet told the officers she did not want Mr. Hyde back in the apartment because he was very violent and unpredictable. She was frightened he would return.[66] She agreed to him being ordered to stay away from her and she did not want him back in the apartment.[67] She feared he would become more violent.[68]

The police officers reassured Ms. Ellet that she would be safe[69] as Mr. Hyde would not be released that night and would be "held for court"[70]. Cst. Gillis told her that a judge would decide whether to order an assessment.[71] He expected that an assessment would be ordered for Mr. Hyde.

Although Ms. Ellet believed Mr. Hyde needed medical help, she did not ask the police officers to take Mr. Hyde to hospital. She thought the police would take him to the Abby Lane or Nova Scotia Hospitals. She did not understand that Mr. Hyde would spend the night in cells.[72] If she had known that, she says she would have asked that he receive psychiatric treatment.[73] Cst. Gillis had no concerns at the time because "when we were dealing with him he wasn't displaying any visible mental health issues to us."[74]

Cst. Gillis had concluded relatively quickly that the only real options were to either release Mr. Hyde or hold him in custody for court.[75] He did not see anything in Mr. Hyde's behaviour that provided grounds for an arrest under the *Involuntary Psychiatric Treatment Act* (IPTA).[76] Although the IPTA option had not occurred to him at the time, when he thought about this option later he felt the grounds had not been present. In any event, Cst. Gillis believed that the approach being taken with Mr. Hyde was the best one – having him held in custody for court in the morning and have a judge decide if he needed to be sent for an assessment.[77]

Cst. Jardine did not consider taking Mr. Hyde to the hospital for a psychiatric assessment because they were dealing with him according to the Intimate Partner Violence Policy and did not observe "any irrational behaviour…There was no… speaking in tongues or any irrational thought process that I could pick up."[78] Even once they learned that Mr. Hyde had a diagnosis of schizophrenia and was off his medication, Cst. Jardine relied on Mr. Hyde's presentation as indicating that there was no mental health "episode" happening: "…he's coherent. He's cognizant. He wasn't offensive. He was respectful. You know, I didn't see those things [that would have been suggestive of a mental health crisis.]"[79]

In Cst. Gillis' view, information from Ms. Ellet was not a sufficient basis for an IPTA arrest.[80] When he saw Mr. Hyde in Cst. Edward's custody, Mr. Hyde was cooperative and showing no signs of a mental disorder or engaging in self-harm. At this point, Cst. Gillis had not yet learned that Mr. Hyde had a diagnosis of schizophrenia.[81] However even as the officers gained more information about Mr. Hyde, Cst. Gillis remained convinced that they had taken the right approach.[82]

In making their decision that Mr. Hyde should not be released, Csts. Gillis and Jardine focused on the fact that they were dealing with a domestic assault where Mr. Hyde had provided no information concerning where he could go for the night and Ms. Ellet's fears that if released, he would return to the apartment.[83] The officers were concerned about the risk to Ms. Ellet's safety if Mr. Hyde went back to Albro Lake Road.[84]

The police officers' decision-making about how to deal with Mr. Hyde followed the Intimate Partner Violence Policy for the HRPS.[85] The source of the Policy is the Ministerial Directive on Spousal/Intimate Partner Violence. This zero tolerance

policy provides that in any domestic violence occurrence where there is a dominant aggressor, charges have to be laid.[86] Csts. Gillis and Jardine dealt with Mr. Hyde according to the Policy which provides in part that:

> Intimate partner violence is a serious societal problem, which requires focused, special attention and sensitivity of police officers and other justice system personnel and service providers. Therefore, the investigation of intimate partner violence and related incidents shall stress that domestic violence is criminal conduct, and any request for assistance involving intimate partner violence is the same as any other request for assistance where violence or potential violence occurs.[87]

In accordance with the Policy, Mr. Hyde was arrested immediately and not released on an Appearance Notice.[88] The officers had no discretion under the Policy to release Mr. Hyde without conditions.[89] HRPS Policy did permit the concurrent operation of the Intimate Partner Violence Policy and the *Involuntary Psychiatric Treatment Act* so that an accused facing charges could be taken to the hospital for a psychiatric assessment.[90]

Cst. Gillis acknowledged that if there was clearer policy guidance as to what would trigger the option of taking a person to hospital under IPTA for a mental health assessment, the IPTA option might have been used with Mr. Hyde.[91]

The officers' view of their options with respect to Mr. Hyde is reflected in Cst. Edwards's comments when he was asked if he would have taken Mr. Hyde to the hospital for an assessment had he known that he was very mentally unstable:

> No, I would not have…It was a domestic situation, where it was pro-charge, dominant aggressor. Someone can say someone is mentally unstable but I have to investigate that myself. I have to actually observe Mr. Hyde for myself along with what someone has said. When I dealt with him he showed no signs of a mental illness or a mental health issue.[92]

Completion of Paperwork and Database Searches For Information

With Mr. Hyde removed to Booking by Cst. Edwards and Ms. Ellet's statement taken, Csts. Gillis and Jardine went back to their Dartmouth office to start doing background checks.[93] Cst. Gillis ultimately prepared the HRP Intimate Partner Checklist, the HRP Domestic Violence Risk Assessment Form and the HRP Emotionally Disturbed Person Form.[94] He faxed the Emotionally Disturbed Person Form off to the MMHCT as required by HRPS Policy.[95]

Despite looking, Cst. Gillis did not find any information about Mr. Hyde's mental health history[96] as evidenced by what the forms he completed do not indicate.[97] A subsequent search during the RCMP investigation into Mr. Hyde's death located information that Mr. Hyde had been found Not Criminally Responsible (NCR) in 2002 as well as references to him having a mental health history:

> Howard HYDE was residing at 175 Albro Lake Road, Dartmouth, Nova Scotia. Prior to this, he had resided at Shelburne County area; that being, 168 Shore Road, Jordan Bay, Shelburne County, Nova Scotia. System checks included CPIC, PIRS, JEINS, PROS, as well as the Halifax Regional Police Versadex system. Hyde has criminal convictions dating back to 1992

including unlawfully in a dwelling house under Section 349(1), careless use of a firearm under Section 82(2), as well as uttering threats under Section 264.1(1)(a).

The JEIN system shows eleven (11) charges under the Criminal Code of Canada, as well three (3) charges under the Motor Vehicle Act. Apart from the above noted convictions, other charges included resist arrest x four, dangerous operation of a motor vehicle, assault, assault with a weapon, as well as a breach of release conditions. As HYDE was only convicted of three offences, the remaining eight charges were noted as withdrawn, dismissed, or accused found not criminally responsible.

Checks of the PIRS system revealed four incidents involving mental health issues and an assault. The PROS system was similar, three reported incidents with concerns in regards to HYDE's psychological state and resulting behaviour. The Halifax Regional Police Versadex system has six entries mostly dealing with mental health issues. This is one reported assault; that being, the initial domestic call on the 21st of November 2007. There is a second report whereby two members escorted HYDE to Provincial Court where he was placed in care of the Sheriffs Department. The final entry of the call to Burnside Provincial Correctional Facility. All reports are included in this profile.[98]

The officers had not tried to search for information earlier on the computer in their patrol car because they were on foot patrol[99] and it was a "routine call" – domestic assault calls being so common.[100] Notwithstanding that they had no access to the PROS and JEIN databases[101], Cst. Gillis could have checked for background on Mr. Hyde through the Canadian Police Information database (CPIC) which would have disclosed that Mr. Hyde had been found Not Criminally Responsible (NCR) in 2002.

Cst. Gillis also did not call MMHCT. He was present during Ms. Ellet's statement to Cst. Jardine where she said she had called "Mobile Crisis" that night when Mr. Hyde assaulted her.[102] Cst. Gillis has used MMHCT before. He did not consider contacting them on November 21 although he doesn't know why he did not consider it.[103]

Awareness of Mr. Hyde's Mental Health Issues

By the time he wrote up the Crown Brief Report[104] stating that Mr. Hyde was "mental health – unsafe to release", Cst. Jardine was of the opinion that Mr. Hyde should be seen by a mental health professional.[105] He felt that Mr. Hyde had mental health issues that needed to be addressed.[106] He formed this view after learning about the incident in Booking and spending some time with Mr. Hyde at the hospital where, toward the end of his shift there, Mr. Hyde began to show signs of delusional thinking.[107] He made an entry in his police notes: "Mr. Hyde has severe emotional mental health problems."[108] He thought Mr. Hyde could benefit from seeing a psychiatrist.[109]

The notation "unsafe to release – mental health" was Cst. Jardine's indication of the police position on Mr. Hyde's bail. He expected this to be reviewed by the Crown and communicated to the court.[110] Although Crowns routinely call police about bail notations on the Crown Brief Report, Cst. Jardine received no such call in relation to Mr. Hyde's case.[111]

Once Ms. Ellet's statement had been obtained, around 02:00 on November 21, Csts. Gillis and Jardine knew Mr. Hyde was schizophrenic and had not been taking his medication. They also knew he had previously been tasered. They learned this information after Mr. Hyde had been arrested and was in Cst. Edwards' custody on his way to Booking.[112] They did not communicate that information to the officers in Booking where they knew Mr. Hyde was being held for the night.[113] This was before the tasering incident. It would have been relevant for the Booking officers to have known about Mr. Hyde's mental health issues in the context of handling their prisoner.[114]

Notes

1 Testimony of Karen Ellet, pages 172–173

2 Testimony of Karen Ellet, page 142

3 Testimony of Karen Ellet, page 136

4 Testimony of Karen Ellet, page 136

5 Testimony of Karen Ellet, page 134

6 Testimony of Karen Ellet, page 152

7 Testimony of Karen Ellet, page 169

8 Testimony of Karen Ellet, pages 153; 182

9 Exhibit 79A, Tab 4, page 1, MMHCT notes of call with Karen Ellet, November 21, 2007: "Karen called upset whispering saying her boyfriend has schizophrenia and then writer heard male yelling 'who the fuck are you on the phone with' and sounds of scuffling and heard Karen say 'uhh, uhh, it's my daughter okay leave me alone' and then male yelled 'your daughter is fucked your fucked you liar get off the phone now…"

10 Testimony of Karen Ellet, page 183

11 Exhibit 120, Audio Recording of MMHCT call to 911, Tracks 1–4

12 Testimony of Karen Ellet, page 126

13 Exhibit 120, Track 4

14 Exhibit 120, Track 4

15 Exhibit 120, Tracks 5–9

16 Testimony of Karen Ellet, page 123

17 Exhibit 120, Tracks 5–9

18 Testimony of Cst. Bradley Jardine, page 515

19 Testimony of Cst. Bradley Jardine, page 516

20 Exhibit 165, Letter from Karen Ellet dated July 17, 2009

21 Testimony of Cst. Gyles Gillis, page 210

22 Testimony of Cst. Gyles Gillis, page 401

23 Testimony of Cst. Bradley Jardine, page 671

24 Testimony of Cst. Gyles Gillis, page 208

25 Testimony of Cst. Bradley Jardine, pages 519–520

26 Testimony of Cst. Gyles Gillis, page 401

27 Testimony of Cst. Bradley Jardine, page 523

28 Testimony of Karen Ellet, page 124

29 Testimony of Cst. Gyles Gillis, pages 331–332

30 Exhibit 125, page 40, Notes of Cst. Gyles Gillis

31 Testimony of Cst. Gyles Gillis, page 210

32 Testimony of Cst. Gyles Gillis, pages 211–212

33 Exhibit 145, Halifax Regional Police Service radio transmissions, Track 19; Testimony of Cst. Bradley Jardine, pages 522–523

34 Testimony of Cst. Gyles Gillis, page 482

35 Testimony of Cst. Gyles Gillis, pages 473–474

36 Testimony of Cst. Jonathan Edwards, page 876

37 Testimony of Cst. Gyles Gillis, page 254–255

38 Testimony of Cst. Jonathan Edwards, pages 877–878

39 Testimony of Cst. Jonathan Edwards, page 878

40 Testimony of Cst. Gyles Gillis, page 262

41 Testimony of Cst. Jonathan Edwards, page 879

42 Testimony of Cst. Bradley Jardine, page 525

43 Testimony of Cst. Bradley Jardine, page 525

44 Testimony of Cst. Bradley Jardine, page 675

45 Testimony of Karen Ellet, page 124

46 Testimony of Karen Ellet, page 125

47 Testimony of Cst. Gyles Gillis, page 330

48 Testimony of Cst. Bradley Jardine, page 785

49 Testimony of Cst. Gyles Gillis, page 379

50 Testimony of Cst. Gyles Gillis, page 263

51 Testimony of Cst. Gyles Gillis, page 403

52 Testimony of Cst. Gyles Gillis, pages 263–264

53 Testimony of Cst. Gyles Gillis, page 274

54 Testimony of Cst. Gyles Gillis, page 487

55 Testimony of Cst. Jonathan Edwards, page 886

56 Testimony of Cst. Jonathan Edwards, pages 875; 1039

57 Testimony of Cst. Jonathan Edwards, pages 875; 1038

58 Testimony of Cst. Gyles Gillis, pages 213, 264: This statement, the "Jardine" statement, is found in Exhibit 61, Tab 26 (00:55 hrs – 01:14 hrs) A second statement, the "Gillis" statement, found in Exhibit 125, page 64, was taken late in the night on November 21 (21:55 hrs – 22:12 hrs.) In the second statement, Ms. Ellet described in more detail being assaulted by Mr. Hyde in early October 2007 when they were returning home from Micmac Mall. In her first statement, Ms. Ellet had indicated this previous assault had happened "3 weeks ago."

59 Testimony of Cst. Gyles Gillis, pages 214, 270, referring to Ms. Ellet's statement (Exhibit 61, Tab 26); Testimony of Cst. Bradley Jardine, page 534. (Cst. Jardine's General Occurrence Hardcopy in Exhibit 125, page 72a referred to Ms. Ellet indicating in her statement that Mr. Hyde had been off his medication for a week although her statement actually said: "He has been taking medication on and off for a year.")

60 Testimony of Karen Ellet, page 140; Exhibit 61, Tab 26, Ms. Ellet's first statement to Csts. Jardine and Gillis, November 21, 2007

61 Testimony of Karen Ellet, page 194

62 Exhibit 60, Tab 1, A, Cst. Jardine's can-say statement

63 Testimony of Karen Ellet, pages 131; 153

64 Testimony of Karen Ellet, page 138

65 Testimony of Cst. Gyles Gillis, page 359, referring to Ms. Ellet's first statement (Exhibit 61, Tab 26)

66 Testimony of Cst. Gyles Gillis, page 404

67 Testimony of Cst. Gyles Gillis, pages 215, 404

68 Testimony of Karen Ellet, pages 166–167

69 Testimony of Cst. Bradley Jardine, page 587

70 Testimony of Cst. Gyles Gillis, page 215

71 Testimony of Cst. Gyles Gillis, page 215: Karen Ellet does not recall being told this (Testimony of Karen Ellet, page 197) but Cst. Gillis testified he has a "specific" recall of doing so (Testimony of Cst. Gyles Gillis, pages 301–302)

72 Testimony of Karen Ellet, page 150

73 Testimony of Karen Ellet, page 150

74 Testimony of Cst. Gyles Gillis, page 294

75 Testimony of Cst. Gyles Gillis, pages 214–215

76 Testimony of Cst. Gyles Gillis, page 216

77 Testimony of Cst. Gyles Gillis, pages 221, 233, 235, 243

78 Testimony of Cst. Bradley Jardine, page 532

79 Testimony of Cst. Bradley Jardine, page 543

80 Testimony of Cst. Gyles Gillis, pages 216–217

81 Testimony of Cst. Gyles Gillis, page 232

82 Testimony of Cst. Gyles Gillis, page 439

83 Testimony of Cst. Gyles Gillis, pages 297–298

84 Testimony of Cst. Gyles Gillis, page 396

85 Exhibit 142

86 Testimony of Cst. Gyles Gillis, page 415

87 Exhibit 142

88 Testimony of Cst. Gyles Gillis, page 421, referring to Exhibit 142

89 Testimony of Cst. Gyles Gillis, page 425

90 Testimony of Cst. Gyles Gillis, pages 440–441; Testimony of Cst. Bradley Jardine, page 544

91 Testimony of Cst. Gyles Gillis, page 338

92 Testimony of Cst. Jonathan Edwards, page 1061

93 Testimony of Cst. Gyles Gillis, pages 219–220

94 Testimony of Cst. Gyles Gillis, page 245 referring to Exhibit 125 at page 74. See, also: Exhibit 137

95 Testimony of Cst. Gyles Gillis, pages 246–247 referring to Exhibit 82, Tab F

96 Testimony of Cst. Gyles Gillis, page 272

97 See, for example, Exhibit 137, the Emotionally Disturbed Person Form on which Cst. Gillis checked 'no' for 'previous section 38', an indication he did not locate the record of Mr. Hyde's May 1, 2007 arrest under section 38 of the *Hospital's Act*; also see, Testimony of Cst. Gyles Gillis, pages 230 and 232

98 Exhibit 60, Tab 1 (page just before Tab 1) Report of Cst. Patrick K. Murphy, NorthEast Nova Major Crime Unit, Port Hawkesbury Detachment, Port Hawkesbury, N.S.

99 Testimony of Cst. Gyles Gillis, pages 367, 400; Testimony of Cst. Bradley Jardine, page 527

100 Testimony of Cst. Gyles Gillis, page 367

101 Testimony of Cst. Gyles Gillis, pages 256, 302

102 Testimony of Cst. Gyles Gillis, pages 358–359

103 Testimony of Cst. Gyles Gillis, pages 388–389

104 Exhibit 125, page 84

105 Testimony of Cst. Bradley Jardine, page 557

106 Testimony of Cst. Bradley Jardine, page 651

107 Testimony of Cst. Bradley Jardine, pages 561; 708-709

108 Testimony of Cst. Bradley Jardine, referring to Exhibit 149

109 Testimony of Cst. Bradley Jardine, page 843

110 Testimony of Cst. Bradley Jardine, pages 574–575

111 Testimony of Cst. Bradley Jardine, page 851

112 Testimony of Cst. Gyles Gillis, pages 358–359

113 Testimony of Cst. Jonathan Edwards, page 886; Testimony of S/Cst. Gregory MacCormick, page 1765

114 Testimony of Cst. Gyles Gillis, pages 227–228

Transport to Halifax Regional Police Service Booking

The eleven minute[1] drive to Booking was uneventful. Cst. Edwards had no conversation with Mr. Hyde in the patrol car.[2] Mr. Hyde said nothing during the trip.[3]

Cst. Edwards found Mr. Hyde to be "very calm, cool and collected."[4] He understood he was being taken to police cells and showed no signs of having a mental health issue.[5] Cst. Edwards testified that even if he had known information (held by the Halifax Regional Police Service)[6], that Mr. Hyde had a mental health history that included contacts with police, it would not have influenced his approach. Cst. Edwards would have accorded Mr. Hyde the same respect and dignity, irrespective of any such knowledge.[7] Cst. Edwards knew nothing about information supplied by Ms. Ellet to Csts. Jardine and Gillis that Mr. Hyde was paranoid of the police and panicking because of being tasered in 2005.[8]

Mr. Hyde started talking once Cst. Edwards got to Booking and took him out of the car.[9] As can be heard on the video footage, Mr. Hyde became quite voluble with Cst. Edwards at this point.[10]

Notes

1 Exhibit 146, Audio log sheet from November 21, 2007, 00:47:51 – 00:58:24

2 Testimony of Cst. Edwards, page 888

3 Testimony of Cst. Edwards, page 1044

4 Testimony of Cst. Edwards, page 886

5 Testimony of Cst. Edwards, pages 886, 1306

6 Testimony of Cst. Edwards, page 885

7 Testimony of Cst. Edwards, page 885

8 Testimony of Cst. Edwards, pages 1307–1308

9 Testimony of Cst. Edwards, page 1045

10 Exhibit 121A, view 1, Halifax Regional Police Service (HRPS) Booking Video from November 21, 2007

Halifax Regional Police Service Booking – Arrival and the LiveScan Room

Mr. Hyde was cooperative and compliant when he arrived at Halifax Regional Police Booking in Cst. Edwards' custody. He can be heard on video surveillance footage referring to the medication prescribed for his psychosis, olanzapine. "Olanzapine makes you fat."[1] Cst. Edwards doesn't recall hearing this.[2] Mr. Hyde makes another medication-related comment that does not register with Cst. Edwards, saying something about "30 – 40 milligrams."[3] Cst. Edwards has seated him on a bench facing the Booking counter. Mr. Hyde is wearing shorts and has no shirt or shoes. His hands are cuffed behind his back. His demeanor and monologue suggest he is negotiating a safe space for himself[4], indicating to Cst. Edwards that he is not going to present a problem. He can be heard to say the following: "I got no power or control. I've been peaceful for a long time. I know you guys are good cops. Just one or two bad apples somewhere I had trouble with, that's all…one or two bad apples I had trouble with, one or two bad apples I got angry about."[5]

Cst. Edwards can be observed at the Booking counter, completing forms, with his back to Mr. Hyde. His interaction with Mr. Hyde is clipped and business-like. He does not appear to look for or pick up on any cues about Mr. Hyde's emotional state. Mr. Hyde is seen endeavouring to comply with Cst. Edward's direction. When asked, he repeats the spelling of his name more slowly but hesitates a little over the year of his birth. He talks continuously to Cst. Edward's back. He seeks to have Cst. Edwards see him in a positive and non-threatening light. "I am a nice man. I did not assault my wife. I did not assault my common-law. This upset her and that perturbs me, I must say."[6]

Mr. Hyde's orientation to his situation is revealed by him telling Cst. Edwards that his legal aid lawyer is Malcolm Jeffcock.[7] He obviously recognized that he was in need of legal representation and later, once placed in the holding cell, took the opportunity provided to him by Cst. Edwards to call duty counsel.

The past was not far from Mr. Hyde's mind. He can be heard recalling an experience of a "bad nightmare" in Shelburne, and referencing something about "a cop." Cst. Edwards would not have known it, but Mr. Hyde was probably talking about the 2002 experience of being arrested by the RCMP and spending two years under psychiatric hospitalization.[8] It is reasonable to infer that memories of previous encounters with police and hospitalizations likely heightened Mr. Hyde's anxieties and his feeling of vulnerability in Booking.

As Cst. Edwards stands at the Booking counter with his back to Mr. Hyde, Mr. Hyde can be heard suggesting politely that he would appreciate the handcuffs being

adjusted. "By the way, sir, the cuffs are a little tight. I wouldn't mind having them loosened a little bit." Cst. Edwards is unresponsive and Mr. Hyde drops the issue.[9] The handcuffs are removed a couple of minutes later when Mr. Hyde is placed in the holding cell.

After a little more than an hour in the holding cell[10], during which time Mr. Hyde was permitted to make a telephone call to duty counsel, Cst. Edwards retrieved him for the finger-printing and photographing process. It was now shortly past 02:00 hours. Mr. Hyde is still in shorts and bare feet. He had been pacing in the holding cell but otherwise appears calm. He gives Cst. Edwards no trouble when he emerges: Cst. Edwards tells Mr. Hyde to remove a chain he is wearing around his neck and he does so, putting it on the counter as directed.

Cst. Edwards saw nothing unusual about Mr. Hyde's chattering[11] or his pacing[12]. S/Cst. Shannon Coombs, the Booking matron responsible for female prisoners, also observed Mr. Hyde. She thought he seemed upset and noted that he was barefoot and only wearing what seemed to be "underwear."[13] She had been on the job approximately three months and had never seen anyone pace so much.[14] It looked to her as though Mr. Hyde was speaking to himself.[15]

S/Cst. Gregory MacCormick and Cst. Benjamin Mitchell were also in Booking when Mr. Hyde was brought in. They were occupied with other tasks; Cst. Mitchell was there working on one of his own files, and did not pay much attention to Mr. Hyde. S/Cst. MacCormick, noticing that Mr. Hyde was bare-chested, asked him where his shirt was but received no answer.[16]

Mr. Hyde continued to comply, following Cst. Edwards to the LiveScan roomas directed. He indicated he had been fingerprinted and photographed before. Cst. Edwards advised that the procedure had to be done each time.[17] When Mr. Hyde was led by Cst. Edwards into the LiveScan room, Cst. MacCormick went in to receive him. He had asked Cst. Edwards if Mr. Hyde would be spending the night in cells at Booking.[18] But he knew nothing about Mr. Hyde's diagnosis of schizophrenia or the fact that he was off his medication.[19] There was nothing on the Versedex system to prompt a search that would have disclosed previous mental health-related calls.[20] All Cst. MacCormick learned from Versedex prior to Mr. Hyde going into the LiveScan room was that Mr. Hyde was a "known offender."[21] The designation "known offender" did not necessarily mean the person had been previously charged criminally, and could indicate parking or speeding tickets or public intoxication.[22] It was also a typical descriptor for "99 percent" of the people that S/Cst. MacCormick dealt with in Booking. [23]

The LiveScan room had no camera. Voices were picked up by the surveillance system for the main Booking area where Cst. Mitchell can be seen working at the desk. The voices in the LiveScan room are hard to hear or distinguish, in part because of music playing loudly on a radio in Booking at the time.

No one, not the officers or Mr. Hyde, anticipated the chain of events about to be ignited in the LiveScan Room. Cst. Edwards can be heard telling Mr. Hyde: "Take a seat in there, bud."[24] At this point, Cst. Edwards noticed that Mr. Hyde was asking some questions that did not make sense.[25] This was not uncommon and did not suggest the presence of a mental illness to Cst. Edwards.[26] Mr. Hyde was asked to remove the string from his shorts. He wasn't able to, prompting S/Cst. MacCormick to observe: "We'll have to cut one of those balls off"[27] referring to the knots at the ends of the string. These words lit the fuse for the explosive events that followed.

Cst. MacCormick was intending to use the small fixed blade enclosed in a lace-

cutting tool[28] to cut the knots on the string in Mr. Hyde's shorts. The evidence indicates that the large, hinged blade of the tool was closed.[29] This bigger serrated blade was used to cut down prisoners who had hanged themselves.[30] Even so, Mr. Hyde immediately became agitated [31]at the mention of "balls" being cut off. S/Cst. MacCormick thought Mr. Hyde seemed "scared."[32] Cst. Edwards thought Mr. Hyde looked "antsy" and "jumpy"; "[it] didn't seem like he wanted that to happen."[33] Up to this point, Mr. Hyde had been "very compliant."[34]

The situation in the LiveScan room started to unspool. According to Cst. Edwards' notes, S/Cst. MacCormick cut one of the knots and Mr. Hyde began to pull away.[35] Cst. Edwards urged Mr. Hyde to sit down: "Howard, Howard, take a seat, Howard."[36] He tried to lower the temperature, endeavouring to get Mr. Hyde's attention and "put him back to a place where he was calm seconds before."[37] It didn't work.

Cst. Edwards described for the first time in his evidence at the Inquiry that when S/Cst. MacCormick approached Mr. Hyde with the lace-cutting tool, Mr. Hyde made a motion toward the tool.[38] There is no reference to this in any documentation prepared by Cst. Edwards in relation to the events in Booking or in his November 25 RCMP statement.[39] I do not have the benefit of any video recording for the events in the LiveScan room.

The audio in the main Booking area picked up Mr. Hyde's reaction, several seconds after S/Cst. MacCormick's comment and likely at the point S/Cst. MacCormick approached with the lace-cutting tool: "Fuck that, no, fuck that, man, fuck it, fuck that, man." A voice can be heard asking: "What are you doing?" It is reasonable to infer that at this point, Mr. Hyde was backing away from the officers.[40] Seconds later, he had run toward them and tumbled through the doorway from the LiveScan room into the area behind the Booking counter, with Cst. Edwards and S/Cst. MacCormick coming out after him, an image captured by the surveillance camera.[41] Trying to flee, Mr. Hyde had pushed by the officers to get through.[42] Csts. MacCormick and Edwards struggled briefly to contain Mr. Hyde, with Cst. Mitchell racing in to help them, and then they all spilled out into the area behind the Booking counter.[43]

Just before Mr. Hyde and the officers hurtle out of the LiveScan room, a voice can be heard saying something that sounds like: "You are going to have me do the fucking dance…" One of the officers – Cst. Edwards – can be heard saying: "Howard, Howard", a response to Mr. Hyde's rising agitation[44], in an attempt to get him to refocus and pulled back from the brink.

I have been urged by the Blairs and the Schizophrenia Society of Nova Scotia to find that it was S/Cst. MacCormick who uttered the "fucking dance" words, and to infer from those words a confrontational, antagonistic stance by an aggressive bully intimidating a frightened man. However I am unable to conclude that it was S/Cst. MacCormick who said those words. Discerning definitively what was said in the LiveScan room, and by whom, on the basis of marginally audible audio is very difficult. S/Cst. MacCormick suggested that it was Mr. Hyde who uttered the "fucking dance" words in reaction to being approached with what he believed was a knife to cut off one of "his balls."[45] I accept that as a possibility. What is absolutely clear to me is that Mr. Hyde believed he was about to be harmed and felt threatened. His response was to try and get away from the officers. He was not attacking the officers, and although S/Cst. MacCormick chose to use these words in his RCMP statement[46], they do not accurately describe Mr. Hyde's behaviour. There is no evidence

he threatened the officers or assaulted them in the LiveScan room.[47] Already paranoid about the police, and terrified, Mr. Hyde was simply trying to escape to safety.

Although S/Cst MacCormick recalls he repeatedly told Mr. Hyde that he only had to cut off the knot at the end of the string[48], Cst. Edwards testified there were no repeated assurances to Mr. Hyde in the LiveScan room by the officers about what was going to be done.[49] S/Cst. MacCormick can be heard to say to Mr. Hyde, once: "I've got to get the string out, right?"[50] The situation escalated rapidly and the focus became control. It was looking as though Mr. Hyde would have to be handcuffed. Words of reassurance were not uppermost in the officers' minds, and in Cst. Edwards' view afterwards, would not likely have made any difference.[51] In any event, once the words indicating that "balls" had to be cut off had been uttered, the damage was already done.

It was only after the events in Booking when he was preparing the Controlled Response Report [52] at 05:00 that S/Cst MacCormick concluded Mr. Hyde must have been "suffering from a mental illness." Nothing else explained his reaction; he was plainly not drunk and didn't seem high on drugs. [53]S/Cst. MacCormick had never had any prisoner react to the lace-cutting tool the way Mr. Hyde did.[54] He did not note his conclusion that Mr. Hyde had a mental illness in any of the documentation he completed: not his notes, his can-say statement, the Crown brief or his supplemental report, because it was only an assumption.[55]

Notes

1 Exhibit 121A, view 1: Halifax Regional Police Service (HRPS) Booking Video from November 21, 2007, 01:01:42. There is no transcript of the audio portion from the video surveillance. What I have reproduced in this Report are my own interpretations of the audio portions of the video surveillance DVD's, based on my review of this evidence.

2 Testimony of Cst. Jonathan Edwards, pages 1045, 1049, 1050

3 Exhibit 121A, view 1: Halifax Regional Police Service (HRPS) Booking Video from November 21, 2007, 01:01:56

4 Testimony of Dr. Joseph Noone, page 9176

5 Exhibit 121A, view 1: Halifax Regional Police Service (HRPS) Booking Video from November 21, 2007, 01:02:02 – 1:02:33.

6 Exhibit 121A, view 1: Halifax Regional Police Service (HRPS) Booking Video from November 21, 2007

7 Exhibit 121A, view 1:Halifax Regional Police Service (HRPS) Booking Video from November 21, 2007

8 See Part II, Chapter 2

9 Exhibit 121B: Halifax Regional Police Service (HRPS) Booking Video from November 21, 2007, with enhanced audio. Cst. Edwards testified he did not hear this request at the time. (Testimony of Cst. Jonathan Edwards, page 1062)

10 Exhibit 121A, Halifax Regional Police Service (HRPS) Booking Video from November 21, 2007, view 2

11 Testimony of Cst. Jonathan Edwards, page 924

12 Testimony of Cst. Jonathan Edwards, page 1075

13 Testimony of S/Cst. Shannon Coombs, pages 1418–1419, referring to her RCMP statement of November 25, 2007

14 Testimony of S/Cst. Shannon Coombs, pages 1407; 1418; 1663

15 Testimony of S/Cst. Shannon Coombs, page1407

16 Exhibit 121A, view 1: Halifax Regional Police Service (HRPS) Booking Video from

November 21, 2007

17 Exhibit 121A, view 1: Halifax Regional Police Service (HRPS) Booking Video from November 21, 2007

18 Testimony of S/Cst. Gregory MacCormick, page 1925

19 Testimony of S/Cst. Gregory MacCormick, page 1933: "I don't recall talking to [Csts. Edward, Gillis or Jardine] at all; page 1765: "I didn't know [about Ms. Ellet telling police that Mr. Hyde was a schizophrenic who had not taken his medication.]"

20 Testimony of S/Cst. Gregory MacCormick, page 1783

21 Testimony of S/Cst. Gregory MacCormick, page 1935

22 Testimony of S/Cst. Gregory MacCormick, pages 1935–1936

23 Testimony of S/Cst. Gregory MacCormick, page 1956

24 Exhibit 121A, view 3:Halifax Regional Police Service (HRPS) Booking Video from November 21, 2007

25 Testimony of Cst. Jonathan Edwards, page 923 referring to his RCMP statement of November 25, 2007; page 1123, referring to his notes in Exhibit 125, page 44

26 Testimony of Cst. Jonathan Edwards, page 1372

27 Exhibit 121A, view 3:Halifax Regional Police Service (HRPS) Booking Video from November 21, 2007: Cst. MacCormick thinks he said: "I just have to cut one of those balls off there." (Testimony of S/Cst. MacCormick, page 2005) Although Cst. Edwards testified that he was the one who made the comment (Testimony of Cst. Jonathan Edwards, page 1090) he was inconsistent on this issue, saying earlier in his evidence that S/Cst. MacCormick had said them. (Testimony of Cst. Jonathan Edwards, page 893)

28 Exhibit 66

29 Testimony of S/Cst. Shannon Coombs, pages 1431; 1564: "I clearly remember seeing it [in S/Cst. MacCormick's hand] for…briefly, like a split second." Testimony of Cst. Jonathan Edwards, page 1004: "At no time was that blade opened." Testimony of S/Cst. Gregory MacCormick, page 1845

30 Testimony of S/Cst. Gregory MacCormick, page 1845

31 Testimony of S/Cst. Gregory MacCormick, page 2008

32 Testimony of S/Cst. Gregory MacCormick, page 1791

33 Testimony of Cst. Jonathan Edwards, page 894

34 Testimony of Cst. Jonathan Edwards, page 1033

35 Testimony of Cst. Jonathan Edwards, page 1147, referring to his notes in Exhibit 125, page 44

36 Exhibit 121A, view 3:Halifax Regional Police Service (HRPS) Booking Video from November 21, 2007

37 Testimony of Cst. Jonathan Edwards, page 1096

38 Testimony of Cst. Jonathan Edwards, pages 1006, 1022

39 Testimony of Cst. Jonathan Edwards, page 1091

40 Cst. MacCormick testified that Mr. Hyde backed away in response to the lace-cutting tool, asking what the officers were doing. (Testimony of S/Cst. Gregory MacCormick, page 1791; Testimony of Cst. Jonathan Edwards, page 897)

41 Exhibit 121A, view 3:Halifax Regional Police Service (HRPS) Booking Video from November 21, 2007

42 Testimony of S/Cst. Gregory MacCormick, page 1792

43 Testimony of S/Cst. MacCormick, page 1941

44 Testimony of Cst. Jonathan Edwards, page 1092

45 Testimony of S/Cst. MacCormick, pages 1868–1869 He did not report this statement in any documentation he prepared. (Testimony of S/Cst. MacCormick, pages 1867–

1868)

46 Testimony of S/Cst. Gregory MacCormick, pages 2035, 2037

47 Testimony of S/Cst. Gregory MacCormick, pages 1811–1812, 1853; Testimony of Cst. Jonathan Edwards, page 1024

48 Testimony of S/Cst. Gregory MacCormick, page 1849; 2008

49 Testimony of Cst. Jonathan Edwards, page 1098

50 Exhibit 121A, view 4: Halifax Regional Police Service (HRPS) Booking Video from November 21, 2007: Testimony of Cst. Jonathan Edwards, page 1098

51 Testimony of Cst. Jonathan Edwards, page 1098

52 Exhibit 69

53 Testimony of S/Cst. Gregory MacCormick, pages 1851–1852; 2096; 2120

54 Testimony of S/Cst. Gregory MacCormick, page 1901

55 Testimony of S/Cst. Gregory MacCormick, page 1902

The Altercation in Booking/Use of the Conducted Energy Weapon

Everything that happened between S/Cst. MacCormick's casual mention of having to "cut one of those balls off" and Mr. Hyde scrambling over the Booking counter happened in one minute.[1] Mr. Hyde tumbled out of the LiveScan room with Csts. Edwards and Mitchell and they wrestled him to the floor by the front Booking counter. S/Cst. MacCormick moved in behind them, saying "Get him down"[2] as Mr. Hyde can be heard repeatedly telling the officers that he is sorry. No one seems to have heard that although it is audible even on the unenhanced audio.[3] He cries out to the officers: "I didn't do nothin'!"

S/Cst, MacCormick wasted no time looking for a CEW as Csts. Edwards and Mitchell struggled with Mr. Hyde on the floor.[4] Twelve seconds after Mr. Hyde burst from the LiveScan Room, S/Cst. MacCormick was rooting around the Booking counter, just before Cst. Edwards asked Cst. Mitchell if he had a taser on him.[5] He did not. The Booking CEW was in a gun locker bolted to the bottom of the Booking counter.[6] He found the CEW[7], "I got it, I got it" a couple of seconds later, and warned the officers to mind their legs, "Watch out", as he prepared to deploy the current.[8] Eighteen seconds after Mr. Hyde was brought to the floor by the Booking counter, S/Cst. MacCormick told the other officers he was "going to go darts, darts!".[9] This meant that he was going to deploy the CEW probes and not just use a "touch tase."[10] Csts. Edward and Mitchell needed to get out of the way to avoid being jolted.[11] At this point, S/Cst. Coombs heard Mr. Hyde screaming.[12]

No warning was given to Mr. Hyde that the CEW was about to be used on him. CEW warnings are HRPS policy:

> Whenever possible, without jeopardizing safety of any person involved, suspects should be warned Taser will be used to gain compliance. If appropriate, an arc demonstration should be done prior to deployment. Often compliance can be gained without actually having to apply current to the subject.[13]

The officers concluded they did not have time to warn Mr. Hyde.[14] S/Cst. MacCormick also wanted to exploit the advantage of surprise by not telling Mr. Hyde what to expect.[15]

S/Cst. MacCormick did not touch Mr. Hyde or attempt to restrain him as Csts. Edwards and Mitchell struggled with him.[16] He concentrated on finding and then deploying a CEW. As he did so, Csts. Edwards and Mitchell moved off Mr. Hyde to avoid getting shocked [17], letting him get to his feet. S/Cst. MacCormick continued to direct the CEW at him.

The CEW shocked Mr. Hyde with an electric current[18] but failed to have the

desired effect of incapacitating him.[19] He can be heard and seen to react in extreme pain and distress, shrieking: "Don't do it!" As S/Cst. MacCormick continued to apply the CEW, Mr. Hyde yelled: "My lawyer!" and cried out to the officers: "What are you doing?" His face is contorted by pain and fear.[20] He tried to fend off the weapon, but failing to do so, turned and scrambled over the Booking counter, running off down the adjacent hallway. It is obvious he just wanted to get away.

It is apparent from the video surveillance footage that Csts. Edwards and Mitchell had little difficulty getting Mr. Hyde to the floor, being able to do so in one second,[21] and were attempting to gain control of Mr. Hyde's arms so that he could be positioned on his stomach and handcuffed.[22] This was challenging because the shirtless Mr. Hyde was hard to grab hold of.[23] Cst. Mitchell recalls that Mr. Hyde was sweating heavily making him slippery[24] however there is no evidence that either Cst. Edwards or S/Cst. MacCormick observed this despite being well-situated to do so. The officers found him to be "incredibly strong."[25] Cst. Edwards tried unsuccessfully to pull Mr. Hyde's left arm behind his back but "his resistance [was] overwhelming my force pushing down."[26]

Cst. Edwards "after struggling for a few seconds…knew immediately…" that neither he nor Cst. Mitchell was going to be able to get Mr. Hyde's hands behind his back to be cuffed.[27] Mr. Hyde was "actively resisting…actively trying to get away from [the police officers] and resisting being put in handcuffs…"[28] Mr. Hyde was not perceived as trying to assault the officers, just trying to get away.[29]

Cst. Edwards sped through the use of force options in his mind, eliminating OC spray because of the danger that in such a confined space it would contaminate himself and the other officers.[30] Other possibilities were "pressure points, joint locks, stuns or strikes."[31] There wasn't enough room to back up and strike with a baton.[32] S/Cst. MacCormick eliminated these options as well.[33]

Cst. Edwards figured that if he let go, Mr. Hyde might take the opportunity to escape.[34] Cst. Edwards testified: "If myself and Cst. Mitchell had let go, [Mr. Hyde] would have escaped immediately.[35] S/Cst. MacCormick echoed a similar concern, that there was no telling what would have happened if they had just backed off Mr. Hyde.[36]

In fact, as S/Cst. MacCormick was moving in to use the CEW, the officers did let go, getting off Mr. Hyde and standing up. This allowed Mr. Hyde to get to his feet. But it was not until he was shocked several times with the CEW, that he tried to escape by leaping over the counter.[37]

Although Cst. Edwards recalls Mr. Hyde being incredibly strong and "pushing up" against the officers struggling to keep him on the floor[38], the video surveillance shows that Mr. Hyde was able to stand up by the Booking counter because Csts. Edwards and Mitchell got off him and backed away as S/Cst. MacCormick moved in.[39]

Verbal de-escalation techniques were not employed to try to defuse the situation. In the view of the officers, they were past the point of any such techniques being effective.[40] None of the officers talked to Mr. Hyde or tried to calm him down. Cst. Edwards told him: "Get on the ground."[41] Otherwise, they gave him no directions and were focused on gaining control.[42] Cst. Edwards testified that the struggle took the wind out of him although this is not apparent from the video surveillance.[43] The officers would have reduced the intensity of their response only if Mr. Hyde had given up the struggle and complied with being handcuffed.[44] Mr. Hyde crying out that he was sorry would have had no bearing on the officers' response as long as he continued to actively resist.[45] They were concerned that if they backed

off, Mr. Hyde would have fled out the Booking door into the street [actually a parking lot[46]] or grabbed "any number of things" in Booking that could have been used as weapons.[47]

S/Cst. MacCormick made the decision to employ the CEW to subdue Mr. Hyde within seconds of him bursting out of the LiveScan room.[48] Mr. Hyde was flailing his arms about but not kicking or punching.[49] There were hazardous items within reach.[50] His intention was to "lock up" Mr. Hyde's muscles so he could be handcuffed.[51] He shot the probes right between Mr. Hyde's shoulder blades and then tried to hold the CEW on Mr. Hyde's thigh area but due to Mr. Hyde's frantic movements it was hard to make the contact.[52] Somehow S/Cst. MacCormick got some of the shock.[53] This happened when Mr. Hyde, acting defensively, tried to move S/Cst. MacCormick's hand and the CEW away from his legs.[54]

During the twelve seconds from when Mr. Hyde went to the floor by the Booking counter and the CEW being applied to him, he did not reach for anything that could be used as a weapon against the three officers.[55] There were potential weapons visible[56] nearby; an assortment of knives, screwdrivers, scissors and other dangerous objects carelessly stashed in an unlocked drawer[57] and a collection of batons[58], but there is nothing to suggest that Mr. Hyde noticed these items. There is no way he could have known they were there.[59] The evidence from the video surveillance shows a man who tried to apologize to the officers when they tackled him to the floor and then did what he could to flee the terror and pain inflicted by the CEW.

Even though S/Cst. MacCormick completed the Controlled Response Report to indicate that Mr. Hyde had "intentionally attempt[ed] to injure officer",[60] this did not reflect what the officers actually thought of Mr. Hyde's actions. Cst. Edwards did not believe that Mr. Hyde kicked him intentionally.[61] He did not observe any assaultive behaviour by Mr. Hyde toward S/Cst. MacCormick or Cst. Mitchell nor did Mr. Hyde threaten any of the officers.[62] S/Cst. MacCormick also did not see Mr. Hyde assault any of the officers.[63] He thought that Mr. Hyde's fending off the CEW could have constituted an assault "in a way" although he testified: "…I don't feel that I was assaulted."[64] The video surveillance makes it clear that Mr. Hyde was just desperately trying to ward off another painful application of the CEW.

Cst. Edwards did not know until after the events in Booking that Mr. Hyde had a diagnosis of schizophrenia and previous encounters with police.[65] Knowing that Mr. Hyde was paranoid of the police and traumatized by a previous tasering would have had no influence on Cst. Edwards' approach with him in the LiveScan room.[66] It would have made no difference to how Cst. Edwards would have dealt with him at any point.[67] He reacted to Mr. Hyde's behaviour.[68]

S/Cst. MacCormick felt he had no alternative to using the CEW in the circumstances[69] In his view, there was nothing else he could have done.[70] It was not an option to back off once the struggle was on in the Booking area. "Once something is started, we never stop it. You can't stop something halfway. So once something is rolling, once you're in a struggle…once it's going, you have to win. You can't stop until everything's safe."[71]

Notes

1 Exhibit 121A, view 4: Halifax Regional Police Service (HRPS) Booking Video from November 21, 2007: 02:08:28 – 02:09:31

2 Testimony of Cst. Jonathan Edwards, page 1100

3 Exhibit 27A: Halifax Regional Police Service (HRPS) Booking Video from November 21, 2007; Testimony of Cst. Jonathan Edwards, page 945: "During the struggle I didn't

hear him say he was sorry." Testimony of Cst. Benjamin Mitchell, page 2132: "I don't recall anything he was saying." Testimony of S/Cst. Gregory MacCormick, page 1870: "I don't recall him saying that then at all."

4 Exhibit 121A, view 1: Halifax Regional Police Service (HRPS) Booking Video from November 21, 2007: 02:09:10

5 Testimony of Cst. Jonathan Edwards, pages 902; 1106; Testimony of Cst. Benjamin Mitchell, pages 2130; 2229

6 Testimony of S/Cst. Gregory MacCormick, page 1785

7 Exhibit 24, M26 Taser. The Halifax Regional Police Service now uses a newer Taser model, the X26.

8 Exhibit 121A, view 4: Halifax Regional Police Service (HRPS) Booking Video from November 21, 2007: 02:09:10 – 02:09:14

9 Exhibit 121A, view 4: Halifax Regional Police Service (HRPS) Booking Video from November 21, 2007: 02:09:18

10 Testimony of Cst. Jonathan Edwards, page 962

11 Testimony of Cst. Jonathan Edwards, page 1153

12 Testimony of S/Cst. Shannon Coombs, page 1411

13 Exhibit 82, Halifax Regional Police Service Policy and Procedures, Tab D, 17.3 Incidents Involving Use of A Taser, B - Policy

14 Testimony of Cst. Jonathan Edwards, page 927; Testimony of S/Cst. Gregory MacCormick, page 1862

15 Testimony of S/Cst. Gregory MacCormick, pages 1862, 2021

16 Exhibit 121A, view 4: Halifax Regional Police Service (HRPS) Booking Video from November 21, 2007: Testimony of Cst. Jonathan Edwards, page 1104–1105; Testimony of S/Cst. Gregory MacCormick, page 1855

17 Testimony of Cst. Benjamin Mitchell, page 2228

18 Testimony of S/Cst. Gregory MacCormick, page 2090: "When you watch the tape, behind the booking desk, there's a portion where we're standing, and you can hear [the CEW] quiet down. And I would say that was the only portion throughout the entire thing where [the CEW] was working properly…if you can't hear the snapping sound [of the CEW], then the subject would be getting the effects." Cst. Edwards also testified to the CEW "cracking quite a bit" which indicated it was not working. (Testimony of Cst. Jonathan Edwards, page 1347) See, also: Exhibit 121A, view 4: Halifax Regional Police Service (HRPS) Booking Video from November 21, 2007

19 Testimony of Cst. Jonathan Edwards, page 1012: Testimony of Cst. Benjamin Mitchell, page 2325

20 Exhibit 121A, view 4: Halifax Regional Police Service (HRPS) Booking Video from November 21, 2007: 02:09:26

21 Testimony of Cst. Benjamin Mitchell, page 2224

22 Testimony of Cst. Benjamin Mitchell, page 2129

23 Testimony of Cst. Benjamin Mitchell, page 2196

24 Testimony of Cst. Benjamin Mitchell, page 2130

25 Testimony of Cst Benjamin Mitchell, pages 2130–2131, page 2195; Testimony of Cst. Jonathan Edwards, page 1007

26 Testimony of Cst. Jonathan Edwards, page 1007

27 Testimony of Cst. Jonathan Edwards, page 898

28 Testimony of Cst. Jonathan Edwards, pages 898–899

29 Testimony of Cst. Benjamin Mitchell, pages 2132, 2140; 2244–2245; 2301; Testimony of Cst. Jonathan Edwards, page 898–899

30 Testimony of Cst. Jonathan Edwards, page 961

31 Testimony of Cst. Jonathan Edwards, page 900

32 Testimony of Cst. Jonathan Edwards, pages 901, 961

33 Testimony of S/Cst. Gregory MacCormick, pages 1793–1794

34 Testimony of Cst. Jonathan Edwards, page 901

35 Testimony of Cst. Jonathan Edwards, page 903

36 Testimony of S/Cst. Gregory MacCormick, page 1943

37 Exhibit 121A, view 4: Halifax Regional Police Service (HRPS) Booking Video from November 21, 2007, 02:09:31

38 Testimony of Cst. Jonathan Edwards, page 904

39 Exhibit 121A, view 4: Halifax Regional Police Service (HRPS) Booking Video from November 21, 2007, 02:09:22

40 Testimony of Cst. Jonathan Edwards, pages 912, 1009: Testimony of Cst. Benjamin Mitchell, page 2144; Testimony of S/Cst. Gregory MacCormick, page 2025

41 Testimony of Cst. Jonathan Edwards, page 911

42 Testimony of Cst. Jonathan Edwards, page 911; Testimony of Cst. Benjamin Mitchell, page 2246

43 Testimony of Cst. Jonathan Edwards, page 1107

44 Testimony of Cst. Benjamin Mitchell, page 2146

45 Testimony of Cst. Jonathan Edwards, page 1113

46 Testimony of Cst. Jonathan Edwards, page 933

47 Testimony of Cst. Benjamin Mitchell, page 2320

48 Testimony of S/Cst. Gregory MacCormick, page 1793

49 Testimony of S/Cst. Gregory MacCormick, page 1793

50 Testimony of S/Cst. Gregory MacCormick, pages 1794–1795

51 Testimony of S/Cst. Gregory MacCormick, page 1804

52 Testimony of S/Cst. Gregory MacCormick, page 1805

53 Testimony of S/Cst. Gregory MacCormick, page 1807

54 Testimony of S/Cst. Gregory MacCormick, page 1809 referring to Exhibit 121A, view 4: Halifax Regional Police Service (HRPS) Booking Video from November 21, 2007, 02:09:27: "He's moving my arms away from his legs."

55 Testimony of Cst. Benjamin Mitchell, page 2245; Testimony of S/Cst. Gregory MacCormick, page 1800

56 Testimony of Cst. Jonathan Edwards, page 1020: Testimony of S/Cst. Gregory MacCormick, pages 2218–2219

57 Testimony of S/Cst. Gregory MacCormick, pages 1796–1797; Testimony of S/Cst. Shannon Coombs, pages 1422, 1428: in both cases referring to Exhibit 67

58 Testimony of S/Cst. Gregory MacCormick, pages 1798–1799

59 Testimony of S/Cst. Gregory MacCormick, page 1801

60 Exhibit 69, page 1

61 Testimony of Cst. Jonathan Edwards, page 1127

62 Testimony of Cst. Jonathan Edwards, pages 1160, 1167, 1813

63 Testimony of S/Cst. Gregory MacCormick, page 1812

64 Testimony of S/Cst. Gregory MacCormick, page 1812

65 Testimony of Cst. Jonathan Edwards, pages 1308, 1344

66 Testimony of Cst. Jonathan Edwards, page 1309

67 Testimony of Cst. Jonathan Edwards, page 931, 932, 1059, 1085

68 Testimony of Cst. Jonathan Edwards, page 931

69 Testimony of S/Cst. Gregory MacCormick, page 1793, 1871

70 Testimony of S/Cst. Gregory MacCormick, page 1874

71 Testimony of S/Cst. Gregory MacCormick, page 1943

The HRPS Booking Hallway and Mr. Hyde's Collapse

Leaping over the Booking counter, Mr. Hyde raced off and down the adjacent hallway with Csts. Edwards and Mitchell in hot pursuit, Cst. Mitchell having vaulted over the counter after him.[1] S/Cst. MacCormick was a few seconds behind as he changed the CEW cartridge before running into the hallway.[2]

Just before the door leading out to the parking lot, Mr. Hyde turned to face his pursuers. The video surveillance does not show him making any attempt to reach for or open the door.[3]

Cst. Mitchell testified to having taken Mr. Hyde's stance at the end of the hallway as "a fighting stance", with his fists clenched and feet planted.[4] The video footage shows an entirely different image: Mr. Hyde turns, exhibiting no "threat cues"[5] and the pursuing officers grapple him to the floor in seconds. There are also the sounds picked up by the audio – lasting for 25 seconds[6] – from the video surveillance at the Booking counter. The words "sorry" and "innocent" are audible, plainly coming from Mr. Hyde. S/Cst. MacCormick warns: "Darts, darts", there is the sound of the CEW crackling and Mr. Hyde's cry of pain and distress. Neither the video nor audio evidence supports an inference that Mr. Hyde was combative. As was the case at the Booking counter, he was continuing his attempts to apologize to the officers and, as he apparently saw it, defend himself from their use of force.

The struggle in the hallway was brief but intense. It took Csts. Edwards and Mitchell about 4 seconds to get Mr. Hyde to the floor.[7] Their objective was to handcuff him.[8] He continued to struggle and thwart their efforts to control him.[9] S/Cst. MacCormick queried about going "darts" again[10] and tried the same method as before – close deployment and a "touch tase" for a three point circuit.[11] The CEW seemed to have no effect.[12] S/Cst. MacCormick could hear that the batteries were running down[13] which meant the unit had no power. S/Cst. MacCormick disgarded the CEW on a radiator. Cst. Mitchell radioed for assistance and EHS[14] and the officers held Mr. Hyde down until back up arrived.[15]

There were "enough hands" on Mr. Hyde, in the form of Cst. Edwards and S/Cst. MacCormick, to restrain him so Cst. Mitchell stood up.[16] Cst. Edwards also stood up at one point, needing to catch his breath after the heavy physical exertion.[17]

Cst. Mitchell and S/Cst. MacCormick were able to get Mr. Hyde handcuffed once other officers responding to the call for assistance had arrived.[18] There is no evidence that any of the additional officers contributed to the actual handcuffing. Coming in through the Booking door[19], Cst. Foster witnessed Csts. Mitchell and Edwards and S/Cst. MacCormick on the floor around Mr. Hyde. His arms and legs were flailing. Mr. Hyde was actively resisting and the three officers were having a

very difficult time getting him under control. Cst. Foster tried to assist by holding Mr. Hyde's head so he would not smash it on the floor as he struggled.[20]

Cst. McMahon came into Booking with Cst. Foster and positioned himself by Mr. Hyde's head. He observed Mr. Hyde on the floor kicking and while he testified that the kicking appeared to be intentional[21], none of the other police officers took this view, and regarded the flailing of Mr. Hyde's arms and legs as just an effort to resist being restrained. The video footage is unambiguous: Mr. Hyde can be seen struggling with his arms and legs windmilling about but there is no indication that he is trying to land any kicks or blows.[22]

Cst. Buchanan, responding to a radio request for officer assistance, walked into the Booking hallway and observed Mr. Hyde prone on the floor. He grabbed Mr. Hyde's left leg to control that part of his body. S/Cst. MacCormick was controlling Mr. Hyde's other leg. They succeeded in bringing Mr. Hyde's legs together, crossed his ankles and applied and tightened a zip tie.[23] They then tried to get Mr. Hyde's feet positioned up toward his buttocks when he kicked back and snapped the tie.[24] Mr. Hyde's ability to push back and snap the zip tie was surprising and showed considerable strength. He momentarily displaced S/Cst. MacCormick and Cst. Buchanan who had applied the zip tie. Although Cst. Edwards was "there at that time" all he had done was hand the zip tie to S/Cst. MacCormick.[25] I do not find that he was pushed off by Mr. Hyde when Mr. Hyde flexed his legs and broke the zip tie.[26]

Shackles were then obtained and applied.[27] As Mr. Hyde was being hoisted for placement in the restraint chair[28], S/Cst. MacCormick noticed he wasn't moving. Someone said he was turning blue: S/Cst. MacCormick registered that there was no further resistance coming from Mr. Hyde and he appeared to be unconscious.[29] After checking to see if Mr. Hyde was breathing, S/Cst. MacCormick tried unsuccessfully to find a pulse. Mr. Hyde was "most definitely a bluey-grey colour" by this point.[30]

Sgt. Cecchetto noticed that as Mr. Hyde was lifted to the restraint chair, the purple colour from the top part of his body flowed straight down his back like the pulling down of a blind on a window. It was obvious because of the contrast with the pale lower part of Mr. Hyde's body. "The purple colour went down his back just like a line."[31] The memory of this stood out clearly in Sgt. Cecchetto's mind when he gave evidence at the Inquiry 20 months after the event.[32] The Emergency Department physicians who treated Mr. Hyde upon his arrival at hospital testified that this was probably blood flowing into Mr. Hyde's back again after it was restricted from the restraint and pressure that may have operated "like a tourniquet."[33]

The assembled police officers[34] noticed Mr. Hyde's cyanosed appearance and the fact that he did not appear to be breathing. At this time Cst. Foster and S/Cst. MacCormick heard a snoring sound from Mr. Hyde. Sgt. Cecchetto could see that Mr. Hyde was not breathing and needed CPR immediately.[35]

Cst. Carter observed that Mr. Hyde had turned a blue-purple colour from his shoulders up.[36] He saw that Mr. Hyde was not moving and appeared unconscious. S/Cst. MacCormick looked in his direction and said: "I can't get a pulse and I don't think he's breathing."[37] Even with Mr. Hyde in the restraint chair, Cst. Carter immediately started chest compressions and mouth-to-mouth resuscitation. It wasn't working. Mr. Hyde was quickly removed from the chair and placed back on the floor. Cst. Carter continued CPR including mouth-to-mouth resuscitation without the benefit of a mask.[38]

There is some question about body weight being placed on Mr. Hyde once he

was in a prone position on the floor and handcuffed. Cst. Edwards testified that he did not put "all" his body weight on Mr. Hyde[39] and then explained that he meant he didn't put "any" body weight on him,[40] which is what he said initially: "My body weight was not on Mr. Hyde."[41] Cst. Mitchell did not put his "entire body weight" on Mr. Hyde's chest or back in the hallway.[42] His description of holding Mr. Hyde down while they waiting for other officers to arrive[43] was a reference to holding down Mr. Hyde's arms and legs.[44]

Cst. Edwards knew not to put weight on the back of a person lying in a prone position because it could cause positional asphyxia.[45] He acknowledged the risks for Mr. Hyde, winded from the struggling and with a large abdomen.[46] Cst. Mitchell was also aware of the dangers of positional asphyxia.[47]

While Mr. Hyde was "proned out" on his stomach, Cst. McMahon placed his right foot on his back, at the ready in case Mr. Hyde tried to roll over. "If he tried to roll over, at that point I would…place pressure on his back to stop him from rolling over…"[48] He heard someone say that Mr. Hyde was not breathing.[49] Mr. Hyde's face started to turn blue and he was making grunting noises.[50] Cst. McMahon took his foot off Mr. Hyde's back.[51]

Cst. McMahon had his foot on Mr. Hyde's back for 37 seconds.[52] He testified that he applied no weight to Mr. Hyde in this position.[53] He acknowledged the risks associated with putting a significant amount of pressure on a prone person with a large belly.[54]

Cst. Carter was successful in reviving Mr. Hyde who told S/Cst. MacCormick several times, "that scared me".[55] S/Cst. MacCormick was unsure if Mr. Hyde was referring to the episode of unconsciousness and loss of breathing or the cutting tool or the entire event. The officers reassured Mr. Hyde until EHS arrived.

When EHS arrived,[56] Cst. Carter told the paramedics that they had "potentially…lost him…at one point", that he had no pulse and was not breathing.[57] He was of the view that Mr. Hyde had had a near death experience and a medical crisis. He was upset to learn later that Mr. Hyde was not kept in hospital and subsequently died.[58]

Cst. Foster made three radio calls from Booking while events unfolded with Mr. Hyde: an "all in order" call to advise that they had enough police officers on scene, and a call to EHS advising that they had a "male unconscious and breathing" who had been tasered. She made a third call at 02:14:55 to ask EHS to "step up" their response.[59] When EHS arrived, four CEW probes were removed from Mr. Hyde's back.[60]

After it was all over, Csts. Mitchell and Edwards and S/Cst. MacCormick were exhausted.[61] Cst. Mitchell had never been involved in a comparable struggle.

Notes

1 Exhibit 121A, view 4: Halifax Regional Police Service (HRPS) Booking Video from November 21, 2007, 02:09:36

2 Testimony of Cst. Jonathan Edwards, page 970

3 Exhibit 121A, view 5: Halifax Regional Police Service (HRPS) Booking Video from November 21, 2007, 02:10: 15 – 02:10:17. This is clear from the video notwithstanding the suggestion by counsel for HRPS to Cst. Jonathan Edwards that Mr. Hyde had his hand on the door just before the police officers were able to grab hold of him. (Testimony of Cst. Jonathan Edwards, page 1386)

4 Testimony of Cst. Benjamin Mitchell, page 2133

5 Testimony of Cst. Jonathan Edwards, page 1166

6 Exhibit 121A, view 4: Halifax Regional Police Service (HRPS) Booking Video from November 21, 2007, 02:09:34 – 02:09:59

7 Testimony of Cst. Benjamin Mitchell, page 2267 referring to 121A, view 4: Halifax Regional Police Service (HRPS) Booking Video from November 21, 2007, 02:10:18 – 02:10:22

8 Testimony of Cst. Jonathan Edwards, page 992; Testimony of Cst. Benjamin Mitchell, page 2196

9 Testimony of Cst. Jonathan Edwards, page 905; Testimony of Cst. Benjamin Mitchell, page 2133

10 Testimony of S/Cst. Gregory MacCormick, page 1815 referring to Exhibit 121A, view 4: Halifax Regional Police Service (HRPS) Booking Video from November 21, 2007

11 Testimony of S/Cst. Gregory MacCormick, page 1816, referring to Exhibit 121A, view 4: Halifax Regional Police Service (HRPS) Booking Video from November 21, 2007, 02:10:32. A description of the three point technique is found in S/Cst. Gregory MacCormick' testimony at page 1794.

12 Testimony of Cst. Benjamin Mitchell, page 2133

13 Testimony of S/Cst. Gregory MacCormick, pages 1817, 2093

14 Testimony of Cst. Benjamin Mitchell, page 2198

15 Testimony of Cst. Benjamin Mitchell, page 2134

16 Testimony of Cst. Benjamin Mitchell, page 2134

17 Testimony of Cst. Jonathan Edwards, page 1170

18 Testimony of Cst. Benjamin Mitchell, page 2134

19 Exhibit 121A, view 5: Halifax Regional Police Service (HRPS) Booking video from November 21, 2007, 02:12:04

20 Testimony of Cst. Karen Foster, page 2419

21 Testimony of Cst. Christopher McMahon, page 2529

22 Exhibit 121A, view 5: Halifax Regional Police Service (HRPS) Booking Video from November 21, 2007

23 Testimony of S/Cst. Gregory MacCormick, page 1823 referring to Exhibit 121A, view 5: Halifax Regional Police Service (HRPS) Booking Video from November 21, 2007, 02:13:14; page 1945, "…it [the zip tie] was pulled tight."

24 Testimony of S/Cst. Gregory MacCormick, page 1825 referring to Exhibit 121A, view 5: Halifax Regional Police Service (HRPS) Booking Video from November 21, 2007, 02:13:52; Testimony of Cst. Jonathan Edwards, page 1014

25 Testimony of S/Cst. Gregory MacCormick, pages 2043–2044: Cst. Edwards handed S/Cst. MacCormick the zip tie and Cst. Buchanan tightened it.

26 I do not accept S/Cst. MacCormick's description that Mr. Hyde displaced "700 pounds", the weight of three police officers, because the evidence does not indicate to me that Cst. Edwards was trying to physically restrain Mr. Hyde at the time. (Testimony of S/Cst. Gregory MacCormick, page 1945)

27 Testimony of S/Cst. Gregory MacCormick, pages 1826–1827, referring to Exhibit 121A, view 5: Halifax Regional Police Service (HRPS) Booking Video from November 21, 2007, 02:14:14 & 02:14:26: Testimony of Cst. Jonathan Edwards, page 1318

28 Testimony of Cst. Jonathan Edwards, page 1319, referring to Exhibit 121A, view 5: Halifax Regional Police Service (HRPS) Booking Video from November 21, 2007, 02:14:48

29 Testimony of S/Cst. Gregory MacCormick, pages 1827–1828, referring to Exhibit 121A, view 5: Halifax Regional Police Service (HRPS) Booking Video from November 21, 2007, 02:14:42

30 Testimony of S/Cst. Gregory MacCormick, pages 1831–1832, referring to Exhibit

121A, view 5: Halifax Regional Police Service (HRPS) Booking Video from November 21, 2007, 02:15:15 and following

31 Testimony of Cst. Michael Cecchetto, page 2335

32 Testimony of Cst. Michael Cecchetto, page 2335

33 Testimony of Dr. Stephen Curry, page 4574

34 Testimony of Csts. Karen Foster (page 2433); Jeffrey Buchanan, (page 2480); Michael Carter (pages 2368–2369), Benjamin Mitchell (page 2197) and Sgt. Michael Cecchetto (page 2335)

35 Testimony of Cst. Michael Cecchetto, page 2335

36 Testimony of Cst. Michael Carter, page 2369

37 Testimony of Cst. Michael Carter, page 2369

38 Testimony of Cst. Michael Carter, pages 2375–2376, referring to referring to Exhibit 121A, view 5: Halifax Regional Police Service (HRPS) Booking Video from November 21, 2007, 02:15:15

39 Testimony of Cst. Jonathan Edwards, page 1172

40 Testimony of Cst. Jonathan Edwards, pages 1172-1173

41 Testimony of Cst. Jonathan Edwards, page 1171

42 Testimony of Cst. Benjamin Mitchell, page 2324

43 Testimony of Cst. Benjamin Mitchell, page 2134. I understand this to have been before Mr. Hyde was handcuffed.

44 Testimony of Cst. Benjamin Mitchell, page 2325

45 Testimony of Cst. Jonathan Edwards, page 1171

46 Testimony of Cst. Jonathan Edwards, page 1177

47 Testimony of Cst. Benjamin Mitchell, page 2284

48 Testimony of Cst. Christopher McMahon, page 2517

49 Testimony of Cst. Christopher McMahon, page 2555

50 Testimony of Cst. Christopher McMahon, page 2518

51 Testimony of Cst. Christopher McMahon, page 2555

52 Testimony of Cst. Christopher McMahon, pages 2554 & 2555, referring to Exhibit 121A, view 5: Halifax Regional Police Service (HRPS) Booking Video from November 21, 2007, 02:13:54 – 02:14:31

53 Testimony of Cst. Christopher McMahon, page 2524

54 Testimony of Cst. Christopher McMahon, page 2556

55 Testimony of S/Cst. Gregory MacCormick, page 1837

56 Exhibit 121A, view 5: Halifax Regional Police Service (HRPS) Booking Video from November 21, 2007, 02:18:48

57 Testimony of Cst. Michael Carter, page 2414

58 Testimony of Cst. Michael Carter, page 2375

59 Testimony of Cst. Karen Foster, pages 2421–2422: Exhibit 120, HRP Radio Communications

60 Testimony of S/Cst. Gregory MacCormick, page 1841

61 Testimony of Cst. Benjamin Mitchell, page 2322

Attendance of Emergency Health Services (EHS) at Booking

The dispatch for the ambulance to HRPS Booking indicated an unknown problem or traumatic injury[1] and it was not until the paramedics approached the gates to the police station compound that they received information of a "post cardiac arrest" and that "a male had been tasered."[2]

Three paramedics attended the call – Stephen Crocker, Aaron Parsons, and Maureen Sturgeon[3]. It took them about three minutes to get the HRPS Booking.[4] They were met at the back door of Booking and in the hallway by a number of concerned police officers. The officers seemed relieved that EHS had arrived.[5] Aaron Parsons testified that the police who met them at Booking told them that "buddy was gone", that they could not confirm a carotid pulse or that he was breathing. Mr. Parsons understood the police to be saying they thought Mr. Hyde had died.[6]

Mr. Hyde was lying on the floor in a recovery position.[7] His bladder had let go and his shorts were wet.[8] He appeared to be awake and was agitated and talking non-stop in sentences that made sense but were really out of context. His voice was very loud and aggressive.[9] When Mr. Parsons saw Mr. Hyde on the floor he noticed that his cheeks were flushed and he was cyanosed around his lips.[10]

Mr. Hyde told Ms. Sturgeon that he had stopped taking his medication for schizophrenia, which he said was olanzapine, two days before. She noted this in her Patient Care Record.[11] Mr. Hyde did not answer Ms. Sturgeon's questions in a wholly linear manner: he would respond but it seemed at times to be a continuation of a conversation Mr. Hyde was already having and not responsive to the question.[12]

Stephen Crocker obtained a history of what had happened from the police officers and established Mr. Hyde on oxygen. The policy for a tasering was to transport the individual to hospital, and the paramedics began the process of readying Mr. Hyde for this. Mr. Crocker knelt down beside Mr. Hyde to ask him his name and how he was feeling. The response from Mr. Hyde was that he felt fine. He went on to say: "It felt like I died and I'm back again…"

Mr. Crocker then removed three CEW darts from Mr. Hyde's upper back. He asked police where the fourth dart had gone and was advised that one of the darts had not connected with Mr. Hyde. Mr. Hyde was lifted on to the EHS stretcher once the police had uncuffed Mr. Hyde's hands from behind his back and re-cuffed them in the front.[13] Mr. Hyde had leg shackles on as well.[14]

Mr. Crocker recalls checking Mr. Hyde's radial pulse in Booking and noticing that he had a fast heart rate.[15] This was recorded as "tachy" to denote tachycardia in the EHS records.[16]Mr. Parsons noticed that Mr. Hyde was "hyperventilating" when they went to attend to him as he lay on the floor in Booking. The paramedics "guesstimated" Mr. Hyde's heart rate at 24 respirations per minute.[17] This was the

high end of normal.[18] Cst. Edwards noticed on the EHS heart monitor that Mr. Hyde's heart rate was above 200 beats per minute.[19]

Mr. Hyde was observed to be using accessory muscles to breathe, an indication that he was short of breath and employing additional muscles to assist with respiration.[20] He showed no signs of an impending respiratory arrest.[21] He may have suffered a cardiac arrest[22] although one of the paramedics thought that syncope – a fainting episode – could also explain Mr. Hyde's symptoms.[23]

Notes

1 Exhibit 262, RCMP Interview, July 23, 2009 – Stephen Crocker, Advanced Care Paramedic, pages 1–2. The other two paramedics recall the dispatch being for a traumatic injury.

2 Exhibit 262, RCMP Interview, July 23, 2009 – Stephen Crocker, pages 1–2

3 Ms. Sturgeon's name at the time was Maureen Leslie.

4 Exhibit 262, RCMP Interview, July 23, 2009 – Stephen Crocker, page 3

5 Exhibit 262, RCMP Interview, July 23, 2009 – Stephen Crocker, pages 8–9

6 Testimony of Aaron Parsons, page 3368

7 Testimony of Maureen Sturgeon, page 3414

8 Exhibit 164, EHS Patient Contact Record; Testimony of Maureen Sturgeon, page 3421

9 Testimony of Maureen Sturgeon, page 3414

10 Testimony of Aaron Parsons, page 3345

11 Testimony of Maureen Sturgeon, page 3439; Exhibit 164

12 Testimony of Maureen Sturgeon, page 3415

13 Exhibit 262, RCMP Interview, July 23, 2009 – Stephen Crocker, pages 4–5

14 Testimony of Aaron Parsons, page 3359; Testimony of Maureen Sturgeon, page 3402

15 Exhibit 262, RCMP Interview, July 23, 2009 – Stephen Crocker, page 11

16 Testimony of Maureen Sturgeon, page 3404; Exhibit 164

17 Exhibit 164, EHS Patient Contact Record; Testimony of Aaron Parsons, page 3376–3377: Maureen Sturgeon testified that Mr. Hyde's respiration rate was difficult to calculate precisely because he was speaking so much. (Testimony of Maureen Sturgeon, page 3423)

18 Testimony of Aaron Parsons, page 3372; Testimony of Maureen Sturgeon, page 3424

19 Testimony of Cst. Jonathan Edwards, page 909

20 Testimony of Aaron Parsons, pages 3371–3372

21 Testimony of Aaron Parsons, page 3372

22 Testimony of Maureen Sturgeon, page 3426: "My impression was that Mr. Hyde has suffered a cardiac arrest."

23 Testimony of Aaron Parsons, pages 3389–3390: "We did not conclude there had been a cardiac arrest."

Transport to the QEII Emergency Department, Transfer of Care and Admission

The Ambulance Trip

Mr. Hyde made the short trip from HRPS Booking to the QEII Emergency Department with Cst. Edwards on board. He was alert and did not seem to be in any real medical distress.[1] However his heart rate was fast as evidenced by the reading from the heart monitor the paramedics were able to connect him to in the ambulance. The paramedics regarded Mr. Hyde's elevated heart rate of 170 – 210[2] beats per minute as an indication of supra-ventricular tachycardia (SVT)[3]. Upon arrival at the hospital, Mr. Hyde's heart rate was about 120.[4]

During the drive, Mr. Hyde became agitated and was flailing his arms which made it impossible to start safely an intravenous line.[5] He seemed confused.[6] He struck the inside wall of the ambulance with his cuffed hands. The paramedics decided to pull over out of a concern that Mr. Hyde was becoming too agitated but Mr. Hyde settled down somewhat and they continued to the hospital.[7] Talking to the paramedics, he mentioned "peaceful schizophrenia"[8] which did not make much sense to them. The paramedics were not alarmed by Mr. Hyde's agitation and did not feel he was intentionally trying to hit them.[9]

Cst. Edwards who was accompanying the paramedics in the ambulance called for police back-up[10] and the ambulance was met at the hospital by a couple of additional police officers.

Transfer of Care

At the QE II Hospital, the paramedics met the charge nurse in the Emergency Department and transferred Mr. Hyde to a hospital gurney.[11] There was a brief discussion with the nurse, advising that the chief complaint was a suspected cardiac arrest. This was information the paramedics had been given by the police officers in Booking.[12] Other information provided to the charge nurse was that Mr. Hyde had been tasered at the police department an unknown number of times, that he had received CPR, that he had been in an SVT rhythm in the ambulance but now had a heart rate of about 120.[13]

A verbal report was also provided by the paramedics to Dr. Stephen Curry, the doctor on duty in the ER, during a brief five minute conversation.[14] Dr. Curry was given the same information as the charge nurse, with more precise vital signs. He was also told that Mr. Hyde was a person with schizophrenia.[15]

The paramedics did not retain the EKG strip from the EHS cardiac monitor

and it was given to either Dr. Curry or the charge nurse.[16] The EHS report[17] was printed off at the hospital and provided to the hospital staff.

Admission by QE II Hospital Staff

Glenda Keyes, R.N., was the charge nurse on duty at the QEII Emergency Department on November 21, 2007 when Mr. Hyde was admitted. She had been called by the triage staff who indicated that a post cardiac arrest was arriving by ambulance. She entered the information provided by the paramedics – "Tasered several times. Unresponsive pulse. CPR initiated. Rhythm SVT." – into the EDIS database for the Emergency Department.[18] She assigned Mr. Hyde a bed.[19] She triaged him as a priority so there was no delay.[20] Triaging is the charge nurse's responsibility where the patient arrives by ambulance.[21] Soon after Mr. Hyde's admission, Ms. Keyes learned that Mr. Hyde was a person with schizophrenia.[22]

Ms. Keyes did not get any information about medications that Mr. Hyde may have been prescribed. It was the kind of information the nurses caring for him could obtain later. Information about previous hospital visits, including discharge summaries, would have been available electronically on the Horizons Patient Folder (HPF) although no one checked this.[23] The determination to check existing medical records for the patient on HPF is made by the ER doctor.[24]

Mr. Hyde arrived in the Emergency Department at 02:30. The nurses assigned to his care were Laura Morgan and Susan Hedley.

When Ms. Keyes was finished her shift at 07:00, Mr. Hyde was still in the Emergency Department.[25] She does not remember if she spoke to any of the police officers who were at the ER with Mr. Hyde and only recalls that there were officers in the department.[26]

Notes

1 Exhibit 262, RCMP Interview, July 23, 2009 - Stephen Crocker

2 Testimony of Maureen Sturgeon, page 3425

3 Testimony of Aaron Parsons, page 3346

4 Testimony of Maureen Sturgeon, page 3409; Testimony of Aaron Parsons, page 3350 ("I believe it was about 110.")

5 Testimony of Aaron Parsons, pages 3356–3357; Testimony of Maureen Sturgeon, page 3407

6 Testimony of Cst. Jonathan Edwards, page 1232

7 Testimony of Maureen Sturgeon, pages 3418–3419: Aaron Parsons was concerned about the SVT. (Testimony of Aaron Parsons, page 3349)

8 Testimony of Aaron Parsons, pages 3346, 3354

9 Testimony of Aaron Parsons, page 3380

10 Testimony of Cst. Jonathan Edwards, page 1016

11 Testimony of Aaron Parsons, pages 3346–3347

12 Testimony of Maureen Sturgeon, pages 3442–3443

13 Testimony of Maureen Sturgeon, page 3409

14 Testimony of Maureen Sturgeon, page 3443

15 Testimony of Maureen Sturgeon, page 3411

16 Testimony of Maureen Sturgeon, page 3410

17 Exhibit 79A, Tab 1

18 Exhibit 79A, Tab 1, page 5

19 Testimony of Glenda Keyes, pages 3758–3759
20 Testimony of Glenda Keyes, page 3773
21 Testimony of Glenda Keyes, page 3798
22 Testimony of Glenda Keyes, page 3760
23 Testimony of Glenda Keyes, pages 3787, 3792
24 Testimony of Glenda Keyes, page 3802
25 Testimony of Glenda Keyes, page 3778
26 Testimony of Glenda Keyes, page 3782

Nursing Care at the QEII – November 21, 2007, 02:30 – 07:00 hours

Mr. Hyde was settled into Bed 7 and placed in the care of two experienced nurses, Susan Hedley, R.N. and Laura Morgan, R.N. Vital signs were taken and routine blood tests were done. A cardiac monitor indicated a slightly elevated heart rate of 120. His blood pressure was 130/80.[1] Mr. Hyde's oxygen saturation was charted as 94 percent. This was below normal but not so low as to cause concern. [2]

The nurses found Mr. Hyde to be restless and slightly agitated. He was loud and he was not making much sense. They were unable to understand what he meant. He talked about a range of subjects and seemed confused. He did not know where he was. The nurses thought he was probably delusional.[3] Despite this, Mr. Hyde was rated as a 14 out of a normal score of 15 on the Glasgow Coma Score. This score indicates that Mr. Hyde was oriented to time, place and person. It confirms that Mr. Hyde was not significantly delusional at this time.[4]

Mr. Hyde did not display any aggression to the staff during his stay in the department [5] and was very cooperative when asked to permit his blood to be drawn and his blood pressure taken.[6] It was a comfort to staff to have police officers present with Mr. Hyde although he was not aggressive and did not have to be placed in four-point restraints.[7]

The verbal report from the paramedics told the nurses that Mr. Hyde had been tasered and experienced a cardiac arrest before being brought to the ER.[8] He seemed to calm down once he was rolled over to the hospital gurney.[9] Laura Morgan noted that his demeanor changed and he settled "Once we got him in to our stretcher and we talked to him…as time passed, he settled more."[10] Susan Hedley was told by the paramedics that Mr. Hyde was a person with schizophrenia and had been off his medications for 2 – 3 days. Ms. Hedley had no information as to what those medications would have been.

Dr. Curry saw Mr. Hyde almost immediately. He ordered 10 mgs. of olanzapine, to be injected to deal with Mr. Hyde's agitation. Although no thought appears to have been given to obtaining Mr. Hyde's consent to the injection, Mr. Hyde appeared to understand what was happening and did not object.[11]

After the administration of the olanzapine at 02:50, Mr. Hyde slept in naps.[12] This appeared to be the medication working although Mr. Hyde must have been tired out after such an exhausting night and so many hours awake.

When the blood test results came back, Mr. Hyde's creatinine and creatinine kinase levels were elevated. Elevated creatinine kinase indicated some kind of muscle damage.[13] A troponin test had been done but it was indicative of nothing. (Tropo-

nin is a cardiac marker of myocardial infarction.)[14] The nurses knew that assessing troponin levels in the blood requires additional testing. It was typical to do three troponin tests over time.[15] Those tests, spaced by eight hours, would have to be ordered by the ER doctor.[16] Mr. Hyde also had a high white blood cell count and high platelets.[17]

The normal practice was for doctors and nurses to check the blood test results as they come back. Susan Hedley does not recall alerting the ER doctors about any blood test results for Mr. Hyde.[18]

An EKG result at 03:23 showed sinus tachycardia and T wave abnormality. It was an abnormal result.[19]

Mr. Hyde was connected to a cardiac monitor during the night. The nurses could check the monitor in his room and also at the nurses' station. The monitor alarms did not go off and nothing happened to give rise to a concern about Mr. Hyde.[20] Susan Hedley was not surprised by Mr. Hyde having an elevated heart rate when he arrived at the ER, given the information about there having been a struggle and tasering.[21] She charted that it dropped below 100 and Mr. Hyde stayed pretty calm for the rest of the shift.[22] By 06:15, Mr. Hyde's heart rate had dropped to between 70 – 80.[23]

In the opinion of Nurse Laura Morgan, Mr. Hyde did not manifest symptoms of cardiac arrest. He did not have chest pain or any symptoms to indicate that he was having a heart attack.[24] His heart rate and other vital signs improved during his hospital stay.[25] Mr. Hyde's treatment at the ER department for someone with a potential heart issue was routine.[26] Ms. Morgan was very surprised to learn later of Mr. Hyde's death.[27]

Laura Morgan made a chart notation at 06:15 that Mr. Hyde remained "confused, delusional and flighty."[28] She had awakened him to check his blood pressure and his responses to questions she asked did not make sense.[29]

The nurses had other patients to care for so they were in and out of Mr. Hyde's room. Police officers stayed with him, beside his bed. Had any concerns been raised about Mr. Hyde's condition by the officers, these concerns would have been brought to the attention of the ER doctor and charted.[30]

Susan Hedley does not recall having any discussions with the police officers or the ER doctors about Mr. Hyde going to court. She has no recollection of the police expressing any urgency about getting Mr. Hyde to court.[31] Ms. Morgan did not hear any discussions between the police officers and ER doctors. Mr. Hyde was still in the department when she and Ms. Hedley finished their shift at 07:00 hours.[32] The dose of olanzapine administered on Dr. Curry's orders was probably wearing off at this point.[33]

Notes

1 Exhibit 79A, Tab 1, page 8

2 Testimony of Susan Hedley, R.N., page 3490 (The oxygen saturation level was information obtained from EHS.)

3 Testimony of Susan Hedley, R.N., pages 3501–3502; Testimony of Laura Morgan, R.N., page 3589

4 Testimony of Susan Hedley, pages 3508–3509

5 Testimony of Susan Hedley, R.N., page 3555; Testimony of Laura Morgan, R.N., page 3605

6 Testimony of Laura Morgan, R.N., page 3595

7 Testimony of Laura Morgan, R.N., page 3603

8 Testimony of Laura Morgan, R.N., page 3588

9 Exhibit 79A, Tab 1, page 9 (Susan Hedley's notation)

10 Testimony of Laura Morgan, R.N., page 3652

11 Testimony of Laura Morgan, R.N., pages 3667–3669

12 Exhibit 79A, Tab 1, page 8

13 Exhibit 79A, Tab 1, page 11; Testimony of Laura Morgan, R.N., page 3591

14 Testimony of Laura Morgan, R.N., page 3592

15 Testimony of Laura Morgan, R.N., page 3599

16 Testimony of Laura Morgan, R.N., page 3618

17 Exhibit 79A, Tab 1, pages 11 & 13

18 Testimony of Susan Hedley, R.N., page 3575

19 Testimony of Susan Hedley, R.N., pages 3511–3513; Exhibit 79A, Tab 1, page 10, EKG record

20 Testimony of Susan Hedley, R.N., pages 3534–3535

21 Testimony of Susan Hedley, R.N., page 3541

22 Testimony of Susan Hedley, R.N., page 3541

23 Exhibit 79A, Tab 1, page 8; Testimony of Laura Morgan, R.N., page 3639

24 Testimony of Laura Morgan, R.N., page 3641

25 Testimony of Laura Morgan, R.N., page 3641

26 Testimony of Susan Hedley, R.N., page 3540

27 Testimony of Laura Morgan, R.N., page 3646

28 Exhibit 79A, Tab 1, page 9

29 Testimony of Laura Morgan, R.N., page 3654

30 Testimony of Laura Morgan, R.N., pages 3642–3643

31 Testimony of Susan Hedley, R.N., page 3485

32 Testimony of Laura Morgan, R.N., page 3608

33 Testimony of Laura Morgan, R.N., page 3666

Attendance by Dr. Stephen Curry

It was a busy night at the Emergency Department[1] when Mr. Hyde arrived. Upon admission he became one of 10 – 20 patients – some of whom were more seriously ill – under the care of Dr. Stephen Curry, an experienced ER physician.[2] Dr. Curry had worked since 1989 in emergency departments in the Maritimes and had been at the QEII Emergency Department since 2003.[3] He was a staff emergency physician on contract at the QEII hospital and held privileges there.[4]

Dr. Curry's ER shift was coming to an end at 04:30. He was due to be relieved by Dr. Janet MacIntyre, another well-qualified ER physician.[5] It was sometime between 02:45 and 03:00 that Dr. Curry left seeing another patient to go and assess Mr. Hyde.[6] Mr. Hyde was handcuffed to the bed. He was "quite verbose" and although speaking clearly, his thoughts were "a little disorganized"[7] and his speech patterns, erratic.[8] He would start a sentence that seemed to make sense and then veer off to an unrelated topic. At one point, Mr. Hyde made a grandiose comment to one of the police officers that he was going "over there and kick [his] ass".[9]

Dr. Curry understood Mr. Hyde's presentation to be consistent with a diagnosis of schizophrenia.[10] Right around the time Dr. Curry entered the room to assess Mr. Hyde he had been told that Mr. Hyde was diagnosed with schizophrenia and had not been taking his medications which was evident to Dr. Curry even from his brief examination of Mr. Hyde.[11] He knew that Mr. Hyde had been tasered although not how many times.[12]

Dr. Curry examined Mr. Hyde for about five to ten minutes[13] during which time he tried to examine him "from head to toe."[14] He listened to Mr. Hyde's chest and heart and as he proceeded with the examination, Mr. Hyde attempted to kick him a couple of times. He stopped when Dr. Curry admonished him.[15]

Dr. Curry tried asking Mr. Hyde what had happened but Mr. Hyde was unable to answer his questions. Dr. Curry didn't bother to make any chart entries about the contents of what Mr. Hyde said because Mr. Hyde was making no sense. He did note that Mr. Hyde was "grandiose" and "disorganized."[16] It was Dr. Curry's opinion that Mr. Hyde was acutely psychotic, in other words, "detached from reality."[17] He based this on what he had observed of Mr. Hyde and what the police officers had told him about the events at Booking.[18] Wanting Mr. Hyde to be "comfortable, safe and settled down"[19], Dr. Curry ordered 10 mgs. of olanzapine to be administered intramuscularly.[20] He recognized that being psychotic was "pretty unpleasant" for Mr. Hyde, "…he's off his meds and he's unaware of what's happening."[21] Mr. Hyde had started to settle already, but the medication made the process much smoother and quicker.[22] Not knowing what medications Mr. Hyde had been taking, olanzapine was "more of a rescue drug…"[23] The intention was to treat his "burgeoning psychoses" and "get him back into a safe place…"[24] Dr. Curry did see the potential – in Mr. Hyde's attempts to kick him – for Mr. Hyde

"ramping up"[25] which was a factor in prescribing the olanzapine injection.[26]

The pressures of a busy Emergency Department limited what Dr. Curry had time to do. He did not speak to any of the paramedics and did not see their report[27] which indicated: "Clinical Impressions: cardiovascular palpitations, irregular heart beat…" He also did not have time to ask the paramedics for their cardiac strip.[28] This was not of concern: the cardiac strip reported results from only one lead and was not as accurate as an EKG. It would not have assisted Dr. Curry in treating Mr. Hyde. Dr. Curry assessed Mr. Hyde on the basis of his presentation on examination.[29] Blood work had been ordered by the nursing staff and Dr. Curry's review of it[30] did not lead him to conclude that additional tests or blood work needed to be ordered.[31]

Dr. Curry understood that Mr. Hyde had had a rapid heart beat, having been told that at one point it had been over 170[32], but did not know it had been irregular.[33] Dr. Curry acknowledged that if accurate, that was significant information.[34] When he examined Mr. Hyde he noted a heart beat a little over 100, but "nowhere near" 170.[35]

After his initial assessment, which was abbreviated by Dr. Curry having to attend to a near-dying patient,[36] Dr. Curry peeked into Mr. Hyde's room for 30 seconds on a couple of occasions and spoke to nursing staff.[37] Mr. Hyde was very sedated from the olanzapine[38] and Dr. Curry observed him to be sleeping and looking well. The cardiac monitor showed an acceptable heart rate. He was, in Dr. Curry's opinion, definitely improving. "…his vital signs were all good and [the nurses] were quite happy with him. They felt he was in a good place."[39]

Dr. Curry had tried to examine Mr. Hyde "as best as possible" on the basis of how he presented and what little information there was available.[40] Decisions had to be made fairly quickly, because the ER was busy. Dr. Curry felt that Mr. Hyde's recovery was "going in the right direction."[41] The more neutral environment of the hospital likely contributed, along with the olanzapine, to Mr. Hyde being able to settle. He was in a different environment and didn't feel threatened as he may have in police cells.[42]

In addition to treating Mr. Hyde's psychotic state (with the olanzapine[43]), Dr Curry was addressing the possible cardiac event Mr. Hyde had experienced as a result of the tasering by listening to his heart and viewing the cardiac monitor.[44] At 03:23 Mr. Hyde's EKG was satisfactory, his heart rate was down to 100 from 120, his blood pressure was good and he was sleeping comfortably.[45] The EKG was the best determinant that Mr. Hyde was "not having an acute event secondary to tasering."[46]

Although Dr. Curry could not absolutely rule out the possibility that Mr. Hyde had had a cardiac arrest[47], in his opinion, the likelihood was very low down on the scale.[48] He was happy with Mr. Hyde's electrocardiogram and made a clinical assessment that Mr. Hyde was improving substantially.[49] He was unable to obtain a medical history from Mr. Hyde[50] but thought whatever had caused Mr. Hyde's collapse was more likely to have been a metabolic event.[51] The blood test results and Mr. Hyde's cyanosis in Booking were consistent with a struggle involving someone who was "not in terrific shape."[52]

Dr. Curry also thought it was unlikely that Mr. Hyde had been pulse-less, testifying that the pulse taker may not have felt in the right place or the pulse may have been "thready."[53]

Despite the encouraging signs, in Dr. Curry's opinion, Mr. Hyde was not ready to be returned to police custody. Within an hour of Mr. Hyde's arrival at the ER,

a police officer approached Dr. Curry to ask whether they could take him back to Booking. In Dr. Curry's view, this was not worth even discussing. He took the position that he was not ruling out Mr. Hyde being able to return to cells at some point but he was "not going to cells during my watch."[54] Dr. Curry described Mr. Hyde's condition as he saw it at the time:

> …we had a psychotic man who required handcuffs to be settled and he was just starting to settle with an antipsychotic medication. And certainly by four o'clock, he was not ready to go anywhere.[55]

Dr. Curry observed that Mr. Hyde had just had the "very traumatic experience" of struggling with, and being tasered by, the police and was "in a psychotic episode."[56] While Dr. Curry testified that he did not feel pressured by the police to discharge Mr. Hyde[57], he found it "somewhat surprising" that they would be raising the issue of Mr. Hyde's arraignment so soon after his admission to hospital.[58] He recognized they had responsibilities (to bring Mr. Hyde before the court)[59] but he wanted to see how Mr. Hyde did as the night progressed.[60]

Although Mr. Hyde was no longer in an acute condition from the events at Booking, including the tasering, his psychosis was still acute. A psychiatric resident could have seen him but Dr. Curry saw no advantage to be obtained from disturbing a resident in the middle of the night or for Mr. Hyde, who was resting comfortably. There was nothing that couldn't be done just as well at 09:00.[61] There was an element of professional courtesy in this decision[62] although Dr. Curry also did not feel Mr. Hyde needed to have an immediate assessment by a psychiatric resident[63] and did not need to be disturbed when he was finally calming down from a very traumatic experience.[64] Dr. Curry's objectives were to treat Mr. Hyde's psychosis and get him settled and then, after he was stabilized, the "imperative" was to have his psychiatric illness treated.[65] Dr. Curry described a psychiatric assessment for Mr. Hyde as being "absolutely necessary."[66]

It was Dr. Curry's opinion that Mr. Hyde needed a psychiatric assessment to determine what had triggered the psychotic episode, whether non-compliance with medication was the problem or whether his medications were failing him. These issues and the fact that Mr. Hyde had an ongoing psychiatric illness needed to be explored.[67]

It must be that Dr. Curry was leaving it to Dr. MacIntyre to determine the approach to be taken to Mr. Hyde's psychiatric issues. Dr. Curry believed that Mr. Hyde needed a psychiatric assessment. He knew Mr. Hyde could get one through a consultation with the psychiatric nurse at 09:00 or thereabouts. Yet he indicated in his evidence that he did not order such an assessment. When Dr. Curry finished his shift, "There were no plans [for Mr. Hyde to receive a psychiatric assessment via the psychiatric liason nurse at the ER.]" Dr. Curry testified that he would have had to initiate that consultation and did not do so.[68] Dr. MacIntyre also did not make the database entry for a psychiatric consult for Mr. Hyde.[69]

A psychiatric consultation was requested for Mr. Hyde, by someone at the ER.[70] Anyone in the Department can access EDIS.[71] While the decision to consult the psychiatric liason nurse is made by the ER physician, the request for a consult could be typed in to EDIS by one of the ER nursing staff who has overheard the doctor discussing this option[72] or has been directed to do so.[73]

Dr. Curry was under the impression that Mr. Hyde's arraignment would be early in the morning and brief[74] and that he would in all likelihood be sent by the

court for a "forensic" assessment.[75] In his mind he was "convinced" that if Mr. Hyde did not get sent for a court-ordered assessment, "he would make his way back to our department as per our wishes/orders."[76]

It was Dr. Curry's opinion that if Mr. Hyde continued to improve and was "…cooperative and making a lot more sense and looking well physically…" there would not be a problem with him going to court for his arraignment, "provided he was going to get his psychiatric assessment."[77] It was not going to be his decision in any event: he knew the decision to discharge Mr. Hyde from hospital for court would be made by Dr. MacIntyre, several hours later.[78] Dr. Curry also understood that it would be Dr. MacIntyre who would determine what any discharge instructions for Mr. Hyde would be.[79]

Had Dr. Curry known then what he learned later that Mr. Hyde would not be arraigned until late in the day, he would not have suggested an approach that contemplated Mr. Hyde being discharged from hospital.[80] His discussion with Dr. MacIntyre about Mr. Hyde was premised on Mr. Hyde being well enough to attend for a brief court appearance early in the morning and then getting "the proper psychiatric treatment."[81] This, he felt, would balance Mr. Hyde's needs with the priorities of the police.[82] Dr. Curry was mindful of the criminal justice system's interest in Mr. Hyde:

> …I didn't want to overstep, you know, there's two processes going on. There's the psychiatric medical process and there's also the domestic process. And I mean we have to assimilate all these things in a very short period of time and you can't necessarily step on other people's toes to, you know, if that has to be done. Certainly we're trying to facilitate.

In Dr. Curry's view, Mr. Hyde was ultimately going to be back in hospital for his psychiatric illness.[83] Part of his reasoning for not involuntarily committing Mr. Hyde to hospital at that time was because he did not want the police to leave the ER.[84] "…if I involuntarily commit him, all of a sudden the police leave and he's left to our security guard. And the place, like I said, was already extremely busy…"[85]

Dr. MacIntyre arrived at the ER at 04:00 to assume responsibility for the patients in the Department and anyone else who arrived during her shift.[86] It continued to be busy with several acutely ill patients.[87] Dr. Curry briefed Dr. MacIntyre on Mr. Hyde. He quickly explained what he knew about Mr. Hyde being involved in an altercation at police cells that included being tasered, after which he may have been pulseless and CPR was performed.[88] Dr. Curry informed Dr. MacIntyre that Mr. Hyde had a history of schizophrenia, was off his medications, appeared to be suffering from acute psychosis and had been given 10 mgs. of olanzapine.[89]

Dr. Curry told Dr. MacIntyre that Mr. Hyde looked quite well on examination. His heart rate had slowed down, his cardiogram looked fine and his blood work was consistent with the struggle and tasering he had experienced.[90] Dr. MacIntyre understood that Mr. Hyde's blood work was normal.[91] On the information Dr. Curry provided, she too thought it unlikely that Mr. Hyde had experienced a cardiac arrest at the police station.[92]

Dr. Curry described to Dr. MacIntyre how the police had asked about Mr. Hyde going back to cells and his firm position that Mr. Hyde was not going anywhere for the time being while he recovered. Dr. Curry passed along to Dr. MacIntyre his impression that the police were anxious to get Mr. Hyde returned to their custody.[93]

Operating under the impression that Mr. Hyde's arraignment would be at

08:00 or 09:00, Dr. Curry indicated to Dr. MacIntyre his view that if Mr. Hyde continued to improve there would be no reason why he could not go to court.[94] Whether this happened was dependent on Mr. Hyde not deteriorating, something Dr. Curry could not predict.[95] Dr. MacIntyre agreed that it was reasonable to consider discharging Mr. Hyde for court subject to Mr. Hyde being monitored on the cardiac monitor and continuing to improve.[96]

Dr. Curry shared with Dr. MacIntyre his opinion that Mr. Hyde needed a psychiatric assessment, to be obtained either through the court or by being returned to the ER.[97] He and Dr. MacIntyre discussed these two options.[98] Dr. Curry assumed that the police would transport Mr. Hyde to his arraignment and that the critical information about Mr. Hyde needing a psychiatric assessment would be communicated to the court.[99] There was no discussion with Dr. MacIntyre about what authority the police had to bring Mr. Hyde back to the ER for a psychiatric assessment if the court did not order one.[100]

Neither Dr. Curry nor Dr. MacIntyre foresaw that Mr. Hyde would not get a psychiatric assessment, either through the courts or by Mr. Hyde being returned to the QEII for an in-house one.[101] They both felt that a psychiatric assessment was very important[102] although there was no discussion of when one should occur.[103] The two doctors did not discuss sending any medication with Mr. Hyde in the event Dr. MacIntyre discharged him from hospital to go to court.[104]

Notes

1 Testimony of Dr. Stephen Curry, page 4415

2 Testimony of Dr. Stephen Curry, pages 4415–4415, 4514

3 Testimony of Dr. Stephen Curry, pages 4412–4413

4 Testimony of Dr. Stephen Curry, page 4646. Dr. Curry was not an employee of the Capital District Health Authority or the Queen Elizabeth II Health Sciences Centre.

5 Testimony of Dr. Janet MacIntyre, page 4731

6 Testimony of Dr. Stephen Curry, pages 4415, 4554

7 Testimony of Dr. Stephen Curry, pages 4416–4417

8 Testimony of Dr. Stephen Curry, page 4515

9 Testimony of Dr. Stephen Curry, page 4516

10 Testimony of Dr. Stephen Curry, page 4417

11 Testimony of Dr. Stephen Curry, pages 4424, 4515

12 Testimony of Dr. Stephen Curry, page 4419

13 Testimony of Dr. Stephen Curry, pages 4426, 4467, 4514

14 Testimony of Dr. Stephen Curry, page 4426

15 Testimony of Dr. Stephen Curry, page 4426

16 Exhibit 79A, Tab 1, page 5, Dr. Curry's chart notes

17 Testimony of Dr. Stephen Curry, page 4425

18 Testimony of Dr. Stephen Curry, page 4425

19 Testimony of Dr. Stephen Curry, page 4425

20 Testimony of Dr. Stephen Curry, pages 4424 & 4425

21 Testimony of Dr. Stephen Curry, page 4470

22 Testimony of Dr. Stephen Curry, page 4425

23 Testimony of Dr. Stephen Curry, page 4697

24 Testimony of Dr. Stephen Curry, page 4470

25 Testimony of Dr. Stephen Curry, page 4517

26 Testimony of Dr. Stephen Curry, page 4517

27 Exhibit 79A, Tab 1

28 Testimony of Dr. Stephen Curry, page 4464

29 Testimony of Dr. Stephen Curry, pages 4532–4533

30 Testimony of Dr. Stephen Curry, page 4430

31 Testimony of Dr. Stephen Curry, pages 4432, 4671

32 Testimony of Dr. Stephen Curry, page 4423

33 Testimony of Dr. Stephen Curry, pages 4422, 4534

34 Testimony of Dr. Stephen Curry, page 4534

35 Testimony of Dr. Stephen Curry, page 4423

36 Testimony of Dr. Stephen Curry, pages 4580, 4715–4716

37 Testimony of Dr. Stephen Curry, pages 4479, 4489

38 Testimony of Dr. Stephen Curry, page 4608

39 Testimony of Dr. Stephen Curry, page 4479

40 Testimony of Dr. Stephen Curry, page 4467

41 Testimony of Dr. Stephen Curry, page 4467

42 Testimony of Dr. Stephen Curry, page 4726

43 Testimony of Dr. Stephen Curry, page 4462

44 Testimony of Dr. Stephen Curry, page 4471

45 Testimony of Dr. Stephen Curry, pages 4482–4484

46 Testimony of Dr. Stephen Curry, page 4491

47 Dr. Curry explained the distinction between a cardiac arrest and a myocardial infarction, which is a heart attack. He did not think Mr. Hyde had a myocardial infarction. (Testimony of Dr. Stephen Curry, page 4493) He could not categorically determine if Mr. Hyde had had a cardiac arrest which is a "monitor-driven diagnosis." A cardiac arrest is where the heart stops or becomes non-functioning due to going into ventricular fibrillation. Myocardial infarction occurs when the arteries become obstructed and there is a restriction of oxygen to the heart muscle. (Testimony of Dr. Stephen Curry, page 4522)

48 Testimony of Dr. Stephen Curry, pages 4521, 4633–4634, 4641. Dr. Curry would have expected Mr. Hyde to have complained about chest pain and to have exhibited signs of sweating if he had had a cardiac arrest. (Testimony of Dr. Stephen Curry, page 4623)

49 Testimony of Dr. Stephen Curry, page 4639

50 Testimony of Dr. Stephen Curry, pages 4622–4623

51 Testimony of Dr. Stephen Curry, page 4642

52 Testimony of Dr. Stephen Curry, pages 4526–4527

53 Testimony of Dr. Stephen Curry, page 4569

54 Testimony of Dr. Stephen Curry, page 4477

55 Testimony of Dr. Stephen Curry, page 4477

56 Testimony of Dr. Stephen Curry, page 4540

57 Testimony of Dr. Stephen Curry, page 4541

58 Testimony of Dr. Stephen Curry, page 4557

59 Testimony of Dr. Stephen Curry, page 4541

60 Testimony of Dr. Stephen Curry, page 4542

61 Testimony of Dr. Stephen Curry, pages 4481–4482

62 Testimony of Dr. Stephen Curry, page 4606

63 Testimony of Dr. Stephen Curry, page 4683

64 Testimony of Dr. Stephen Curry, page 4723

65 Testimony of Dr. Stephen Curry, page 4549

66 Testimony of Dr. Stephen Curry, page 4557

67 Testimony of Dr. Stephen Curry, pages 4727–4728

68 Testimony of Dr. Stephen Curry, page 4543

69 Testimony of Dr. Janet MacIntyre, page 4745, referring to Exhibit 79A, Tab 2, page 6, EDIS [Emergency Department Information System] "consultations" screen indicating a request on November 21, 2007 at 07:30 for a consulation with the QEII psychiatry liason nurse.

70 Exhibit 79A, Tab 2, page 6; see also, Testimony of Deborah Phillips, R.N., page 9772

71 Testimony of Dr. Stephen Curry, page 4687; Testimony of Dr. Janet MacIntyre, page 4745

72 Testimony of Dr. Stephen Curry, page 4687

73 Testimony of Dr. Stephen Curry, page 4688; Testimony of Dr. Janet MacIntyre, pages 4833–4837

74 Testimony of Dr. Stephen Curry, page 4561

75 Testimony of Dr. Stephen Curry, page 4546

76 Testimony of Dr. Stephen Curry, page 4544

77 Testimony of Dr. Stephen Curry, page 4536

78 Testimony of Dr. Stephen Curry, page 4539

79 Testimony of Dr. Stephen Curry, page 4695, referring to Exhibit 79A, Tab 1, page 5, his chart notes

80 Testimony of Dr. Stephen Curry, pages 4561, 4562

81 Testimony of Dr. Stephen Curry, page 4563

82 Testimony of Dr. Stephen Curry, page 4563

83 Testimony of Dr. Stephen Curry, page 4598

84 Testimony of Dr. Stephen Curry, pages 4507, 4602. The police were at the hospital because Mr. Hyde was a prisoner in their custody. Involuntary committal would place him under the authority of the hospital and the police would leave. (Testimony of Dr. Stephen Curry, pages 4444, 4604)

85 Testimony of Dr. Stephen Curry, page 4507. The QE Emergency Department and CDHA psychiatric services had, and has, their own security staff. (Testimony of Deborah Phillips, pages 9755–9757)

86 Testimony of Dr. Stephen Curry, page 4441; Testimony of Dr. Janet MacIntyre, pages 4735–4736

87 Testimony of Dr. Janet MacIntyre, page 4819

88 Testimony of Dr. Stephen Curry, page 4442; Testimony of Dr. Janet MacIntyre, pages 4738, 4848

89 Testimony of Dr. Janet MacIntyre, page 4739

90 Testimony of Dr. Stephen Curry, page 4442, Testimony of Dr. Janet MacIntyre, page 4739

91 Testimony of Dr. Janet MacIntyre, page 4803; See also: Exhibit 176, Dr. MacIntyre's handwritten notes, page 1

92 Testimony of Dr. Janet MacIntyre, pages 4848–4849

93 Testimony of Dr. Stephen Curry, pages 4559–4560, responding to a question about his interview with Inquiry Counsel, Dan MacRury, Q.C. on June 23, 2009 where he stated:

"I said to Janet that, you know, I don't know what happened there exactly but I said, you know, they really want to get this guy, They kept saying can we take him to jail and I kept, and I was saying no, he's staying the night…" See also: Testimony of Dr. Janet MacIntyre, page 4863

94 Testimony of Dr. Stephen Curry, pages 4443, 4502

95 Testimony of Dr. Stephen Curry, pages 4474, 4501

96 Testimony of Dr. Janet MacIntyre, pages 4740, 4826

97 Testimony of Dr. Stephen Curry, page 4443

98 Testimony of Dr. Stephen Curry, page 4450, referring to his chart notes in Exhibit 79A, Tab 1, page 5: "Psych consult in a.m. versus court-appointed psych assessment". See also: Testimony of Dr. Stephen Curry, pages 4544–4545. See also: Exhibit 176, Dr. Janet MacIntyre's handwritten notes, page 1

99 Testimony of Dr. Stephen Curry, pages 4495–4496

100 Testimony of Dr. Stephen Curry, page 4545

101 Testimony of Dr. Stephen Curry, pages 4500, 4501

102 Testimony of Dr. Stephen Curry, page 4537; Dr. Janet MacIntyre pages 4740, 4747, 4917

103 Testimony of Dr. Stephen Curry page 4686

104 Testimony of Dr. Stephen Curry, page 4499

Attendance by Dr. Janet MacIntyre

Dr. MacIntyre was on shift in the ER, as the sole physician, from 04:00 to 11:30[1], during which time she continued to manage several seriously ill patients. At the start of her rotation, what was to happen to Mr. Hyde remained an open question, dependent on what his clinical status was in the morning.[2] Dr. MacIntyre was not expecting Mr. Hyde's condition to deteriorate.[3] She undertook various steps to re-assess Mr. Hyde over the approximately 5 hours he remained in the Department: she checked the cardiac monitors[4] on several occasions to make sure Mr. Hyde was still in normal sinus rhythm and not tachycardic. Looking in or walking by[5], Dr. MacIntyre observed him speaking to the police officers at his bedside and the nurses who came into the room.[6] He did not appear agitated and at times was sleeping. She also saw him eating breakfast. She checked with the nurses to see if they had any concerns or had noted any changes in his condition. The reports were good.[7] Dr. MacIntyre did not speak with Mr. Hyde herself.[8]

Although a request for a consultation with the psychiatric liason nurse was entered into the ER database[9], Dr. MacIntyre did not initiate this.[10] She has no recollection of asking anyone to make the entry. It was her evidence that a nurse, aware of the potential of a consultation occurring in the morning, may possibly enter a consultation in the database as a reminder.[11] Except that Mr. Hyde was discharged at approximately 09:30[12] on November 21, the psychiatric liaison nurse would likely have followed up the consult request in EDIS and he would have been seen by her that morning.[13]

Dr. MacIntyre was comfortable monitoring Mr. Hyde in the ER without the need to consult with a cardiologist. There was no information to make her think such a consultation was necessary.[14] As for a psychiatric assessment, she did not think it was appropriate until Mr. Hyde was medically stable. Further cardiac monitoring was required: usually it would continue for approximately 6 hours following an event such as an electrical injury or tasering.[15]

It was obvious to Dr. MacIntyre that Mr. Hyde needed a psychiatric assessment.[16] She had information that Mr. Hyde had a known diagnosis of schizophrenia. She also knew that he was not taking his medication, had "very disorganized" thought processes and "somewhat bizarre behavior."[17] She viewed the altercation at Booking to be an indication that he could be a threat to someone else or even potentially harmful to himself. She thought it very unlikely that her opinion about Mr. Hyde needing a psychiatric assessment and care would change.[18] And by the time Mr. Hyde was discharged, it had not.

Like Dr. Curry, Dr. MacIntyre had concerns about invoking IPTA because she believed once she did so, the police would leave. Ultimately however, it was not the determining factor in her decision.[19]

Dr. MacIntyre's Discussions with the Police

There was nothing eventful in Mr. Hyde's care at the ER from when Dr. MacIntyre took it over until his discharge. The big issue was whether he would be well enough to leave the hospital for court. Sometime around 07:00, Nurse Roberts approached Dr. MacIntyre to advise that the police officers wanted to inquire about Mr. Hyde's discharge. She went to speak with them, aware that the issue had previously been raised with Dr. Curry prior to the start of her shift.[20]

Dr. MacIntyre spoke with Cst. John Haislip[21] and her recollection of the conversation closely matches that of the officer. Initially Cst. Haislip wanted to know how Mr. Hyde was doing and "what was the plan", if he would be discharged from the hospital and able to attend court in the morning.[22] Dr. MacIntyre inquired with nursing staff if there were any concerns about Mr. Hyde being discharged. There weren't.[23]

A subsequent discussion indicated to Dr. MacIntyre that the police were keen to get Mr. Hyde to his arraignment:

> Question: …did you feel pressure by the police to release HH?
>
> Answer: I don't know if I felt pressure, but I certainly felt that there was a sense of urgency that Mr. Hyde was required in court that morning…that that was a relatively important thing and that they were concerned… he get to that court appointment.[24]

Dr. MacIntyre was concerned to have Mr. Hyde receive a psychiatric assessment. Mr. Hyde needed to be under the care of a psychiatrist and professionals trained to deal with "psychiatric patients." She thought this meant he needed to be either in a hospital or a forensic psychiatric unit rather than a jail.[25] Presented with a situation that she understood was viewed by the police as "urgent and time-sensitive"[26], Dr. MacIntyre was reassured to think that a psychiatric assessment would be facilitated through his court appearance:

> Question: How did [the sense of urgency] factor into your decision to send him to court without an in-house psychiatric assessment being done?
>
> Answer: …in any situation in the emergency department, you have to take all the information that's available to you and do a global assessment. …I felt that Mr. Hyde definitely required a psychiatric assessment, that there were several ways, maybe, that that could be achieved, [and] that after speaking to the police officers…would likely be achieved by him attending court and having a court-appointed forensic psychiatric assessment. So that would likely attain one of my goals to get him assessed…[and]… under psychiatric care.[27]

One of the reasons Dr. MacIntyre spoke with Cst. Haislip was to gain a better understanding of whether Mr. Hyde would receive a court-ordered assessment.[28] She assumed the police would be able to tell her from experience what was likely to happen and would inform her if they didn't know.[29] She knew that in the course of their discussions, Cst. Haislip had spoken to a supervising officer and seemed confident about the information he was supplying.[30] She recalls being told that a forensic psychiatric assessment was very probable given Mr. Hyde's history and the events of the previous evening.[31] There was no guarantee of a court-ordered

assessment but Cst. Haislip expected it was "highly likely" Mr. Hyde would be sent for one.[32] It surprised Dr. MacIntyre to learn that Cst. Haislip's testimony at the Inquiry revealed he actually knew very little about the process for court-ordered assessments.[33]

Dr. MacIntyre considered and weighed the relative advantages and disadvantages of the in-house psychiatric assessment and the court-ordered psychiatric assessment options for Mr. Hyde. She recalls trying to better inform herself through an extensive conversation with Cst. Haislip about the forensic psychiatric assessment option.[34] She believed that a forensic psychiatric assessment was a full substitute for an in-hospital psychiatric assessment through the QEII.[35] She understood there were differences: under a court-ordered assessment, the issues of fitness to stand trial and NCR would be assessed but she believed that Mr. Hyde would receive the same care and treatment under either option.[36] She believed that a court-ordered assessment would result in Mr. Hyde going to the MIOU at the ECFH where there would be a psychiatrist available to provide him with care or obtain it for him.[37]

There were a variety of ways Dr. MacIntyre could achieve the objective of getting Mr. Hyde a psychiatric assessment. He could remain in police custody at the ER while the hospital's psychiatric team was consulted. The provisions of the IPTA could be invoked and then Mr. Hyde would have a psychiatric consultation in the Emergency Department. The third option was for him to attend court and then possibly be sent for a forensic psychiatric assessment. Dr. MacIntyre looked at all these options. She chose the court-ordered assessment route on the strength of Cst. Haislip's indication that it was a highly likely outcome.[38]

Like Dr. Curry, Dr. MacIntyre wanted to try and satisfy co-existing objectives: Mr. Hyde's need for psychiatric assessment and care and the police's interest in getting him to court.[39] She knew she could refuse to discharge Mr. Hyde[40] and that decisions about Mr. Hyde's care were medical not police-driven.[41]

Dr. MacIntyre acknowledged that had Mr. Hyde arrived at the ER exhibiting the same symptoms but without a police escort, he likely would have received an in-hospital psychiatric assessment.[42]

Based on what she was told, Dr. MacIntyre felt "quite certain" that Mr. Hyde would be sent for a forensic psychiatric assessment in a timely fashion by the court,[43] following a relatively short process that would occur that morning.[44] This seemed to her to be a reasonable outcome for him, that he would be placed in a psychiatric facility with trained professionals without much delay and would be assessed and given appropriate care for his psychiatric illness.[45]

Dr. MacIntyre inquired of Cst. Haislip about the possibility of having Mr. Hyde returned to the ER if he was not sent by the court for a forensic psychiatric assessment. There was no indication that this could not be done[46] although there was plenty of opportunity for the police to inform Dr. MacIntyre that they would not have the authority to bring Mr. Hyde back.[47]

The risk of Mr. Hyde being remanded into custody without a court-ordered assessment was not a concern for Dr. MacIntyre. She understood from Cst. Haislip "that really wouldn't happen"[48] She thought that if Mr. Hyde was going to be sent to jail and not a forensic psychiatric unit that he would be brought back to the Emergency Department.[49] Dr. MacIntyre did not feel that Mr. Hyde would be safe in jail without being under psychiatric care. In her opinion, the only viable options were a forensic psychiatric unit under the care of mental health professionals or a

return to the emergency department so that psychiatric care and treatment could be arranged.[50]

After sorting out with Cst. Haislip that Mr. Hyde could be discharged provided that he was returned to hospital in the event he was not sent for a court-ordered assessment, Dr. MacIntyre insisted upon having a proper HIT Form to complete and refused to sign Cst. Haislip's notebook.[51]

Dr. MacIntyre reassessed Mr. Hyde at 09:20[52] and determined that Mr. Hyde was medically stable "from both a physical and a psychiatric standpoint" but still had ongoing conditions that required assessment and treatment.[53] He had no cardiac issues that concerned her.[54] Dr. MacIntyre did not review Mr. Hyde's chart or review his blood work, relying heavily on the information provided by Dr. Curry.[55] He did not tell her he had not seen all the blood work for Mr. Hyde nor did he ask her to do so.[56] When Dr. MacIntyre discharged Mr. Hyde she assessed his blood pressure and heart rate to be normal and he did not appear to be in any distress.[57]

Although Dr. MacIntyre could see that Mr. Hyde was not agitated, aggressive or violent[58], he still had the unresolved medical issues of schizophrenia and psychosis.[59] It was Dr. MacIntyre's opinion that Mr. Hyde required an "urgent assessment" of his psychiatric condition.[60] She believed discharging Mr. Hyde into the custody of the police was a safe option for him, and that he would be monitored for any changes in his physical or mental condition. In her opinion he certainly had the potential to decompensate[61] – she couldn't say with certainty what Mr. Hyde's mental condition would be at the end of the day on November 21 – which is why she felt he required psychiatric care when he left the department.[62] Dr. MacIntyre "really believed" she was discharging Mr. Hyde to a safe environment where he would be under psychiatric care and likely receive psychiatric treatment.[63]

In explaining her decision to discharge Mr. Hyde, Dr. MacIntyre analogized to a person admitted with an acute asthma exacerbation, who was treated and determined to be safe for discharge with a follow-up appointment to see a respirologist.[64] She believed that by discharging Mr. Hyde into the custody of the police officers for court, she was discharging him "in a medically stable state to a safe environment where he would receive the care that he needed."[65]

Dr. MacIntyre's direction on Mr. Hyde's HIT Form stated: **"Patient discharged in police custody for court appearance. If patient not sent for forensic psychiatric assessment police are to return patient to Emergency Department."** She added her signature, "J.K. MacIntyre, MD."[66]

Dr. MacIntyre understood the HIT Form was to accompany Mr. Hyde as "a method to ensure continuity of medical care" for a person in custody[67] by transferring information about his health and the directions for his health care.[68] Dr. MacIntyre filled out Mr. Hyde's HIT Form to indicate he had medical issues that required ongoing attention – psychosis and schizophrenia – with her direction at the bottom, "as a bit of a safeguard"[69], that he was to be returned to the ER if he was not sent for a court-ordered assessment.[70] She saw this as "a safety net to ensure that at some point that day [Mr. Hyde] would receive psychiatric assessment and care" as Cst. Haislip had told her there was no "100 percent guarantee" the court would order a forensic psychiatric assessment even though he thought such an order was likely.[71] She was trying to maintain some control over what happened to Mr. Hyde in the event he was not sent for court-ordered assessment.[72]

Dr. MacIntyre assumed that Mr. Hyde's HIT Form with its notations about "psychosis" and "schizophrenia" and the direction for his return to the ER would

be seen and acted upon by justice system personnel and that Mr. Hyde's health care needs would be met.[73] She referred to the "police" returning Mr. Hyde to the ER because she believed that is who would be responsible for doing so if he was not sent for a court-ordered assessment.[74]

She was unfamiliar with the Crown disclosure process but Dr. MacIntyre expected the HIT Form to be included in the communication between the police and the court or the Crown Attorney.[75] The police did not tell her that the HIT Form was not provided to the Crown and Defence.[76]

Dr. MacIntyre did not specify on the HIT Form a time in which the psychiatric assessment of Mr. Hyde should be done. She did not consider indicating a time for Mr. Hyde to be returned to the ER because the ER is open 24 hours a day.[77] She did envision Mr. Hyde's return to the ER happening in a fairly timely manner if he did not receive a court-ordered assessment.[78]

Although Dr. MacIntyre placed the HIT Form on Mr. Hyde's chart because it contained her discharge instructions,[79] its accessibility was uncertain once Mr. Hyde left the ER.[80] Dr. MacIntyre does not recall if she provided any specific instructions to the charge nurse on what was to take place should Mr. Hyde come back to the ER. She was unable to say in her testimony if she had any discussion with the charge nurse about the plan for Mr. Hyde.[81]

Dr. MacIntyre was not exactly sure how that process worked but she wanted Mr. Hyde to get the psychiatric assessment and care he needed.[82] It was her understanding that somehow the justice system would bring about the result that Mr. Hyde would be returned to the emergency department in the event he was not sent to be assessed at the ECFH.[83]

Had Dr. MacIntyre known that the police were not going to be able to bring Mr. Hyde back to the ER if he was not sent for a court-ordered assessment then she would not have discharged him from the hospital. She would not have had the certainty that he "would be getting the urgent treatment he required."[84] Instead, she would have kept him at the hospital and ordered an in-house assessment.[85] She would also have kept Mr. Hyde at the ER if she had known the police intended to take him to cells.[86]

It is clear from Dr. MacIntyre's evidence that she thought Mr. Hyde would be making an immediate and brief appearance in court – something he was physically well enough to do – where a decision would be made for a psychiatric assessment or not and if not, that the police would bring him back to the ER for assessment and care there. It is her belief that "the system failed Mr. Hyde…this [was] a man who had a medical condition that required ongoing attention and he didn't receive that."[87]

Dr. MacIntyre did not discharge Mr. Hyde with any further psychiatric medication because she thought he was going to be in the care of a psychiatrist that day either due to being sent for a forensic psychiatric assessment or being returned to the ER. She felt it was more appropriate for that psychiatric team to determine what medication he should be put on for his chronic illness.[88] Dr. Curry knew that the half-life of olanzapine was 21 – 54 hours.[89] Presumably Dr. MacIntyre knew this as well.

Notes

1 Testimony of Dr. Janet MacIntyre, page 4736

2 Testimony of Dr. Janet MacIntyre,page 4740

3 Testimony of Dr. Janet MacIntyre, page 4741

4 Testimony of Dr. Janet MacIntyre, page 4774

5 Testimony of Dr. Janet MacIntyre, pages 4773–4774

6 Testimony of Dr. Janet MacIntyre, page 4743

7 Testimony of Dr. Janet MacIntyre, page 4743

8 Testimony of Dr. Janet MacIntyre, page 4773

9 Testimony of Laura Morgan, RN pages 3655 & 3656, referring to Exhibit 79A, Tab 2, pages 6 & 8, EDIS [Emergency Department Information System] "consultations" screens indicating a request on November 21, 2007 at 07:30 for a consultation with the QEII psychiatry liason nurse.

10 Testimony of Dr. Janet MacIntyre at page 4745, referring to Exhibit 79A, Tab 2, page 6, EDIS [Emergency Department Information System] "consultations" screen indicating a request on November 21, 2007 at 07:30 for a consultation with the QEII psychiatry liason nurse. "This isn't a screen I would routinely use in my daily work."

11 Testimony of Dr. Janet MacIntyre, pages 4746, 4833–4834. This does contrast to the testimony of Laura Morgan, RN who indicated in her evidence that only physicians order consultations, never nursing staff. (Testimony of Laura Morgan, RN, at page 3661) "The physician types it in as a consult and it shows up [on the screen]. They click on "consults" and the appropriate consulting service. (Testimony of Laura Morgan, RN, page 3660)

12 According to Mr. Hyde's "Patient Care Record", he was reassessed by Dr. MacIntyre at 09:20 and determined to be "OK to go to court with officers." Exhibit 79A, Tab 1, page 9

13 Testimony of Dr. Janet MacIntyre, pages 4835–4836

14 Testimony of Dr. Janet MacIntyre, page 4741

15 Testimony of Dr. Janet MacIntyre, pages 4750–4751

16 Testimony of Dr. Janet MacIntyre, page 4756

17 Testimony of Dr. Janet MacIntyre, page 4768

18 Testimony of Dr. Janet MacIntyre, page 4768

19 Testimony of Dr. Janet MacIntyre, page 4749

20 Testimony of Dr. Janet MacIntyre, page 4862

21 Testimony of Dr. Janet MacIntyre, page 4787

22 Testimony of Dr. Janet MacIntyre, pages 4753, 4891–4892; See also, Exhibit 176, Dr. MacIntyre's handwritten notes prepared on November 23, 2007, page 1 "Police want to D/C [discharge] (Testimony of Dr. Janet MacIntyre, page 4856)

23 Testimony of Dr. Janet MacIntyre, pages 4860–4861, referring to Exhibit 176, Dr. MacIntyre's handwritten notes prepared on November 23, 2007, page 2

24 Testimony of Dr. Janet MacIntyre, page 4755

25 Testimony of Dr. Janet MacIntyre, pages 4758–4759

26 Testimony of Dr. Janet MacIntyre, page 4864

27 Testimony of Dr. Janet MacIntyre, pages 4755–4756

28 Testimony of Dr. Janet MacIntyre, page 4778

29 Testimony of Dr. Janet MacIntyre, page 4778

30 Testimony of Dr. Janet MacIntyre, page 4786

31 Testimony of Dr. Janet MacIntyre, page 4753

32 Testimony of Dr. Janet MacIntyre, pages 4755–4756; See also: Exhibit 176, Dr. MacIntyre's handwritten notes prepared on November 23, 2007, page 2 "Police – judge will send to forensic psych"

33 Testimony of Dr. Janet MacIntyre, page 4829

34 Testimony of Dr. Janet MacIntyre, page 4828

35 Testimony of Dr. Janet MacIntyre, page 4776

36 Testimony of Dr. Janet MacIntyre, page 4779

37 Testimony of Dr. Janet MacIntyre, pages 4779, 4921–4922, 4923

38 Testimony of Dr. Janet MacIntyre, page 4748

39 Testimony of Dr. Janet MacIntyre, page 4890

40 Testimony of Dr. Janet MacIntyre, page 4890

41 Testimony of Dr. Janet MacIntyre, page 4759

42 Testimony of Dr. Janet MacIntyre, pages 4759–4760

43 Testimony of Dr. Janet MacIntyre, page 4756

44 Testimony of Dr. Janet MacIntyre, page 4920

45 Testimony of Dr. Janet MacIntyre, page 4758

46 Testimony of Dr. Janet MacIntyre, page 4766

47 Testimony of Dr. Janet MacIntyre, page 4867

48 Testimony of Dr. Janet MacIntyre, page 4898

49 Testimony of Dr. Janet MacIntyre, page 4898

50 Testimony of Dr. Janet MacIntyre, page 4924

51 Testimony of Dr. Janet MacIntyre, page 4858

52 Dr. MacIntyre went and checked Mr. Hyde's cardiac monitor to make sure that, from a cardiac standpoint, he still remained stable. She observed his behaviour to ensure that he wasn't agitated or aggressive, that he was able to talk, and eat, and communicate with people in an appropriate manner. She then had a discussion with the nurses to see if they had observed anything different or had any concerns with Mr. Hyde's physical or mental status.(Testimony of Dr. Janet MacIntyre, page 4827)

53 Testimony of Dr. Janet MacIntyre, pages 4810, 4917–4918

54 Testimony of Dr. Janet MacIntyre, page 4809

55 Testimony of Dr. Janet MacIntyre, pages 4742, 4744

56 Testimony of Dr. Janet MacIntyre, page 4773

57 Testimony of Dr. Janet MacIntyre, page 4808

58 Testimony of Dr. Janet MacIntyre, page 4811

59 Testimony of Dr. Janet MacIntyre, page 4810

60 Testimony of Dr. Janet MacIntyre, page 4811

61 Testimony of Dr. Janet MacIntyre, page 4926

62 Testimony of Dr. Janet MacIntyre, pages 4927–4928

63 Testimony of Dr. Janet MacIntyre, page 4762

64 Testimony of Dr. Janet MacIntyre, pages 4810–4811. This would not appear to be a comparable situation as Mr. Hyde was released to go to court on the basis of his physical health having stabilized. Dr. MacIntyre's testimony and her notation on the HIT Form clearly establish that she viewed Mr. Hyde as requiring further medical care on an urgent basis, that day

65 Testimony of Dr. Janet MacIntyre, page 4757

66 Exibit 159, Tab 4, The Health Information Transfer Form signed by Dr. Janet MacIntyre; Also filed as Exhibit 68

67 Testimony of Dr. Janet MacIntyre, pages 4833, 4842

68 Testimony of Dr. Janet MacIntyre, page 4900

69 Testimony of Dr. Janet MacIntyre, page 4756

70 Testimony of Dr. Janet MacIntyre, page 4810

71 Testimony of Dr. Janet MacIntyre, pages 4756–4757

72 Testimony of Dr. Janet MacIntyre, page 4866

73 Testimony of Dr. Janet MacIntyre, pages 4839, 4896, 4900

74 Testimony of Dr. Janet MacIntyre, page 4868

75 Testimony of Dr. Janet MacIntyre, page 4793

76 Testimony of Dr. Janet MacIntyre, page 4792

77 Testimony of Dr. Janet MacIntyre, page 4843

78 Testimony of Dr. Janet MacIntyre, page 4844

79 Testimony of Dr. Janet MacIntyre, pages 4846–4847

80 Testimony of Dr. Janet MacIntyre, pages 4869–4870

81 Testimony of Dr. Janet MacIntyre, page 4938

82 Testimony of Dr. Janet MacIntyre, pages 4784–4785

83 Testimony of Dr. Janet MacIntyre, page 4833

84 Testimony of Dr. Janet MacIntyre, page 4868

85 See also, Testimony of Dr. Janet MacIntyre, pages 4766–4767

86 Testimony of Dr. Janet MacIntyre, page 4869

87 Testimony of Dr. Janet MacIntyre, page 4768

88 Testimony of Dr. Janet MacIntyre, page 4757

89 Testimony of Dr. Stephen Curry, page 4487. Half-life means that the olanzapine is "metabolized to half the original dose" in 21–54 hours from administration. (Testimony of Dr. Stephen Curry, page 4519)

Nursing Care at the QE II – November 21, 2007, 07:00 – 09:15 hours

At the end of their shift, Nurses Hedley and Morgan handed care of Mr. Hyde over to Taryn Roberts, R.N. when she came on duty at 07:00. They provided a verbal report outlining the fact that he had been brought in as a possible cardiac arrest, his condition when he arrived and his condition when they last assessed him.[1] They informed Ms. Roberts that Mr. Hyde had been agitated on admission, that he had been given medication, had settled during the night and was quiet and cooperative.[2]

Ms. Roberts had limited interaction with Mr. Hyde. It consisted of getting him a drink when he complained of being thirsty and taking him in breakfast at 07:30.[3] There were two police officers with Mr. Hyde. They later told Ms. Roberts that Mr. Hyde wanted to use the bathroom requiring her to unhook him from the cardiac monitor so he could get out of bed.[4] Ms. Roberts did not observe Mr. Hyde being confused, delusional or flighty as noted by Nurse Morgan at 06:15. She asked him direct questions and he appeared to answer them appropriately.[5] In her very brief interaction with Mr. Hyde his behaviour did not indicate a mental health issue.[6]

The police were wondering what the hospital's plans were for Mr. Hyde. Ms. Roberts was asked if he would be staying all day or getting more testing or if he could go to court with them. Ms. Roberts did not feel the police were pressuring for Mr. Hyde's discharge. As far as she was concerned the police officers just wanted to know what to expect.[7] She went to Dr. Janet MacIntyre who had assumed ER duties from Dr. Curry and asked her what the plan was for Mr. Hyde.[8]

Dr. MacIntyre spoke to the officers and Ms. Roberts was advised that Mr. Hyde would be going to court with the police officers. She charted at 09:20 that Mr. Hyde was re-assessed by Dr. MacIntyre and "okay to go to court with officers."[9] It was Ms. Roberts' impression that when Mr. Hyde left the hospital he would go to court.[10]

Ms. Roberts had no concerns about Mr. Hyde nor were any brought to her attention while he was in her care. Had she become aware of any issues she would have informed Dr. MacIntyre.[11]

Ms. Roberts has no recall of a psychiatric consultation being requested. There was no discussion of this that she was privy to. There was also no discussion of when Mr. Hyde should receive another dose of olanzapine [12] or of discharging him with any medication.[13]

Notes

1 Testimony of Taryn Roberts, page 3808

2 Testimony of Taryn Roberts, page 3828

3 Testimony of Taryn Roberts, page 3823

4 Testimony of Taryn Roberts, page 3809. The precise timing of Mr. Hyde's breakfast and bathroom visit is unclear as it was Cst. Gyles Gillis who informed Ms. Roberts that Mr. Hyde was thirsty which resulted in breakfast and juice being brought to him. Cst. Gillis went off shift with his partner, Cst. Jardine, at 07:00 when they were relieved by Csts. Hillier and Haislip.

5 Testimony of Taryn Roberts, R.N., pages 3822–3823

6 Testimony of Trayn Roberts, R.N., page 3836

7 Testimony of Taryn Roberts, R.N., page 3830

8 Testimony of Taryn Roberts, R.N., page 3809

9 Exhibit 79A, Tab 1, page 9; Testimony of Taryn Roberts, R.N., page 3811

10 Testimony of Taryn Roberts, R.N., page 3821

11 Testimony of Taryn Roberts, R.N., pages 3831–3832

12 Testimony of Taryn Roberts, R.N., page 3812

13 Testimony of Taryn Roberts, R.N., page 3814

HRPS Officers at the Emergency Department

While searching police records for information about Mr. Hyde, Cst. Gillis got a call from Cst. Edwards in the ambulance to go to the hospital to assume custody of Mr. Hyde.[1] He and Cst. Jardine arrived at the hospital at 04:00[2], relieving Cst. Edwards. Cst. Edwards told the officers that Mr. Hyde was at the hospital because his heart had stopped.[3] None of the doctors or nurses told the officers that this is what had happened.[4]

Cst. Jardine asked Cst. Carter, who was also at the hospital, to spot him off while he went to the police station to finish his report writing.[5] Cst. Carter didn't pay much attention to Mr. Hyde who would speak intermittently, blurting out things that did not make any sense.[6]

Cst. Jardine wasn't gone long and once back at the QEII, stayed with Cst. Gillis to guard Mr. Hyde until their shift ended.[7]

During the Gillis/Jardine shift, sometime between 04:00 – 05:00[8], Staff Sergeant Auld called the hospital to inquire about Mr. Hyde's condition. Cst. Gillis wasn't able to tell him anything so he called the nurses' station.[9] S/Sgt. Auld was concerned that Mr. Hyde might die[10] which would trigger certain protocols for an in-custody death.[11] A nurse told him that Mr. Hyde was "okay" and "in all probability" would be released into police custody sometime that day.[12] S/Sgt. Auld passed this information along to S/Sgt. Donald Fox[13] and requested relief for Csts. Gillis and Jardine.[14] He needed to make sure that the officers who had worked all night were relieved by the incoming day shift members.

Neither S/Sgt. Auld nor S/Sgt. Fox saw any urgency in having Mr. Hyde released from the hospital back into police custody as resources are not "typically…a problem on day shift..."[15] The requirement that a prisoner be arraigned within 24 hours of arrest could be satisfied by a telephone bail hearing through the justice of the peace centre or by having a judge attend at the hospital.[16]

The Gillis/Jardine shift at Mr. Hyde's bedside was uneventful. Mr. Hyde had one wrist cuffed to the hospital bed.[17] His feet were not restrained.[18] He was not at all violent or disruptive at the hospital.[19]

Gillis formed the view that Mr. Hyde had severe emotional problems once he learned from Cst. Edwards at the hospital about the incident at booking – that Mr. Hyde had became very agitated and fought with police and tried to flee the booking area. Cst. Gillis understood Mr. Hyde had erupted "over nothing, it just kind of happened" and he fought with three officers.[20] Gillis does not recall now but believes Cst. Edwards indicated that Mr. Hyde had been tasered.[21]

Csts. Gillis and Jardine did not speak to any medical staff while they were at the hospital with Mr. Hyde.[22] While they were in his room, Mr. Hyde received an

injection that sedated him.[23] He fell asleep for about 45 minutes.[24] While he was sleeping, Cst. Jardine noticed on the cardiac monitor that Mr. Hyde's heart rate spiked up over 200. This concerned him; he inquired about it with a nurse and was reassured.[25] While Cst. Edwards was with him, Mr. Hyde's heart rate was never this high: "…sitting there calm…talking to police, doctors…" his heart rate was 114.[26] Cst. Edwards did not see or hear of a heart rate higher than that for Mr. Hyde during the time Mr. Hyde was in the hospital.[27]

When Mr. Hyde woke up at 06:00, Csts. Gillis and Jardine spoke to him for about an hour.[28] During their discussions, Mr. Hyde swung between being lucid at times to being quite bizarre. He confirmed he had schizophrenia and was off his medications because he didn't like what they did to him.[29] He said they made him "fat" and "impotent."[30] The officers had a light-hearted exchange with Mr. Hyde, suggesting it was "better to be fat and happy at home" than arrested and in hospital.[31]

Mr. Hyde told Cst. Gillis that the "fella had come after him with a knife" and scared "the beejeesus out of him."[32] Cst. Gillis understood this related to the attempt in Booking to cut the drawstring in Mr. Hyde's shorts.[33] Mr. Hyde also recalled being tasered, saying to Cst. Gillis that he did not know why that had happened and that it had hurt and scared him.[34]

Mr. Hyde's statements about his illness and medications and the events in Booking were coherent and grounded in reality. His comments that there should be "eight" [or seven] gods" were not.[35] These peculiar references came toward the end of the conversation with Csts. Gillis and Jardine when Mr. Hyde was getting very tired.[36] The "gods" reference had some relationship to Mr. Hyde wondering why God was angry with him for "fighting with his girlfriend."[37]

Csts. Gillis and Jardine also talked to Mr. Hyde about his love of music and how he played basketball at the YMCA. Cst. Gillis liked Mr. Hyde and, from their discussions, formed the view that he was "a good man with a mental health disorder."[38] Cst. Jardine found him easy to talk to, and saw their discussion as a conversation with "the true Mr. Hyde, a normal guy."[39] The officers tried to reassure and comfort Mr. Hyde, pointing out to him that he was in the hospital and would be fine.[40]

Notwithstanding his conclusion about Mr. Hyde's mental state, Cst. Gillis did not consider invoking the provisions under IPTA for a psychiatric assessment of Mr. Hyde. He believed that Mr. Hyde was in the appropriate place and would get the medical help he needed, including a psychiatric assessment.[41] Cst. Jardine also concluded that Mr. Hyde would benefit from seeing a psychiatrist.[42]

Cst. Jardine also thought that Mr. Hyde was where he was supposed to be.[43] He did not think Mr. Hyde would be leaving for quite some time.[44] When he left the hospital with Cst. Gillis at the end of his shift he told Mr. Hyde that everything would be okay.[45] The memory of saying this to Mr. Hyde in the circumstances where everything did not end up being okay, was still painful for Cst. Jardine to recount.[46]

Cst. Gillis made no notes of his shift at the hospital.[47] He did not add the information about his observations of Mr. Hyde at the hospital, including the olanzapine injection, to any reports.

Cst. Jardine made notes including the statement, "Mr. Hyde has severe emotional mental health problems." He came to this conclusion after his "full" involvement with the file and Mr. Hyde[48], taking into account what he understood was Mr. Hyde's "very aggressive unprovoked behaviour" and his lapsing into delusional remarks at the bedside.[49] He expected his notes to be included in the Crown brief

and disclosure materials.[50] He did not re-enter the Versadex system to note his view that Mr. Hyde needed to be seen by a mental health professional.[51] He did not record anywhere that Mr. Hyde could alternate between lucidity and incoherence, information that could have been helpful to justice officials who would be dealing with Mr. Hyde "downstream".[52]

Mr. Hyde was sleeping at 07:00[53] Cst. Gillis thought he appeared to be getting better.[54] He knew that Mr. Hyde would have to be medically cleared before he could leave the hospital. But Cst. Gillis did not think there was any reason for Mr. Hyde to be released for court on November 21.[55] He could remain in hospital for as long as his medical condition required.[56] Cst. Jardine expected that due to the cardiac event, Mr. Hyde would be at the hospital for quite some time.[57] He would only be going to court after being medically cleared by the hospital.[58]

Csts. Gillis and Jardine went off shift around 07:00.[59] They were relieved by Csts. Stephen Hillier and John Haislip.[60] The new officers were told that Mr. Hyde had been arrested for assault and that an incident in Booking had led to him being revived after his heart stopped.[61]

Cst. Hillier was under the impression that he would be at the hospital until Mr. Hyde was cleared to leave with the police or until he was relieved by someone else at the end of his shift.[62] He does not recall there being any urgency for Mr. Hyde to be returned to Booking.[63] Neither he nor Cst. Haislip, to his knowledge, conveyed a sense of urgency to the ER staff about Mr. Hyde's release from hospital.[64]

In the time Cst. Hillier sat with him, Mr. Hyde was fairly quiet. He did talk about why he didn't want to take his medications, saying they made him feel "sad" and affected his sex life because he couldn't achieve an erection.[65] Discussing these issues made Mr. Hyde "a little upset."[66] Every so often Mr. Hyde would also talk to himself.[67]

When Cst. Gillis learned Mr. Hyde had died he was upset that someone who had been in their care had died, even though he knew Mr. Hyde had not been in police custody when he collapsed.[68] He was surprised to learn that Mr. Hyde did not receive the psychiatric assessment he had expected he would receive.[69]

Notes

1 Testimony of Cst. Gyles Gillis, pages 242, 276

2 Testimony of Cst. Gyles Gillis, page 242

3 Testimony of Cst. Bradley Jardine, page 832

4 Testimony of Cst. Bradley Jardine, page 832

5 Testimony of Cst. Bradley Jardine, pages 701, 803. Cst. Jardine had to "extend" his original report with the addition of the new charges being laid against Mr. Hyde for resisting the officers in Booking and attempting to escape.

6 Testimony of Cst. Michael Carter, pages 2372–2374

7 Testimony of Cst. Bradley Jardine, page 701

8 Testimony of S/Sgt. Sean Auld, page 3178

9 Testimony of S/Sgt. Sean Auld, page 3171

10 Testimony of S/Sgt. Sean Auld, page 3178

11 Testimony of S/Sgt. Sean Auld, pages 3171, 3177

12 Testimony of S/Sgt. Sean Auld, pages 3171, 3256

13 Testimony of S/Sgt. Sean Auld, page 3179

14 Testimony of S/Sgt. Sean Auld, page 3180

15 Testimony of S/Sgt. Sean Auld, page 3180

16 Testimony of S/Sgt. Sean Auld, pages 3273-3274

17 Testimony of Cst. Gyles Gillis, page 303

18 Testimony of Dr. Stephen Curry, page 4584, referring to his RCMP statement of January 10, 2008; see also, page 4463

19 Testimony of Cst. Gyles Gillis, page 313; Testimony of Cst. Benjamin Mitchell, page 724

20 Testimony of Cst. Gyles Gillis, page 275

21 Testimony of Cst. Gyles Gillis, pages 277, 283

22 Testimony of Cst. Gyles Gillis, pages 313-314

23 This was the injection of olanzapine administered by Laura Morgan, RN.

24 Testimony of Cst. Gyles Gillis, page 313

25 Testimony of Cst. Bradley Jardine, pages 552, 698, 734-735

26 Testimony of Cst. Jonathan Edwards, page 1281

27 Testimony of Cst. Jonathan Edwards, page 1282

28 Testimony of Cst. Gyles Gillis, pages 257, 312

29 Testimony of Cst. Gyles Gillis, page 257

30 Testimony of Cst. Gyles Gillis, page 435

31 Testimony of Cst. Gyles Gillis, pages 435–436; Testimony of Cst. Bradley Jardine, page 553

32 Testimony of Cst. Gyles Gillis, page 281

33 Testimony of Cst. Gyles Gillis, page 278

34 Testimony of Cst. Gyles Gillis, page 304

35 Testimony of Cst. Gyles Gillis, page 305; Testimony of Cst. Bradley Jardine, page 719

36 Testimony of Cst. Bradley Jardine, page 553

37 Testimony of Cst. Bradley Jardine, pages 726–727, referring to his RCMP statement of November 21, 2007

38 Testimony of Cst. Gyles Gillis, page 435

39 Testimony of Cst. Bradley Jardine, page 553

40 Testimony of Cst. Bradley Jardine, pages 553, 644

41 Testimony of Cst. Gyles Gillis, page 306

42 Testimony of Cst. Bradley Jardine, page 843

43 Testimony of Cst. Bradley Jardine, page 651

44 Testimony of Cst. Bradley Jardine, page 653

45 Testimony of Cst. Bradley Jardine, page 551

46 Testimony of Cst. Bradley Jardine, page 551

47 Testimony of Cst. Gyles Gillis, page 348

48 Testimony of Cst. Bradley Jardine, page 658

49 Testimony of Cst. Bradley Jardine, pages 708–709

50 Testimony of Cst. Bradley Jardine, page 659

51 Testimony of Cst. Bradley Jardine, page 643

52 Testimony of Cst. Bradley Jardine, pages 645–646

53 Testimony of Cst. Bradley Jardine, page 650

54 Testimony of Cst. Gyles Gillis, page 347

55 Testimony of Cst. Gyles Gillis, page 311

56 Testimony of Cst. Bradley Jardine, page 859
57 Testimony of Cst. Bradley Jardine, pages 554, 650, 653
58 Testimony of Cst. Bradley Jardine, page 812
59 Testimony of Cst. Gyles Gillis, page 307
60 Testimony of Cst. Stephen Hillier, page 2572
61 Testimony of Cst. Stephen Hillier, page 2623
62 Testimony of Cst. Stephen Hillier, page 2602
63 Testimony of Cst. Stephen Hillier, pages 2602–2603
64 Testimony of Cst. Stephen Hillier, page 2614
65 Testimony of Cst. Stephen Hillier, pages 2574–2575
66 Testimony of Cst. Stephen Hillier, page 2629
67 Testimony of Cst. Stephen Hillier, page 2628
68 Testimony of Cst. Gyles Gillis, page 436
69 Testimony of Cst. Gyles Gillis, page 308

The HIT Form and Mr. Hyde's Discharge from the QE II Emergency Department

Around 08:00[1] on November 21, Cst. Haislip received a call that Staff Sergeant Donald Fox wanted to speak to him. He called S/Sgt. Fox who was curious about what was going on at the hospital, how long the police would be there and what Mr. Hyde's status was. Cst. Haislip recalls telling him that he didn't really know. He believed Mr. Hyde "was waiting to be seen by psychiatry."[2] S/Sgt. Fox wanted him to find out and call him back. Acting on these instructions, Cst. Haislip located Dr. MacIntyre who told him that Mr. Hyde was "medically stable" and "waiting to be seen by psychiatry."[3]

Cst. Haislip had been informed that Mr. Hyde's heart had stopped in Booking and that he had stopped breathing and been revived through CPR.[4] He expected he was going to be all day at the hospital with Mr. Hyde.

Cst. Haislip called S/Sgt. Fox back and was advised that Mr. Hyde had not been taken to the ER for psychiatric reasons, "he'd been brought there for his physical issues." S/Sgt. Fox instructed that if Mr. Hyde was medically stable and medically cleared, then the police had a duty to get him to court.[5] When Cst. Haislip returned to speak to Dr. MacIntyre she told him that Mr. Hyde was medically stable and that she would clear him for discharge into police custody provided that once he went to court he would be seen by forensic psychiatry, if he was held.[6] S/Sgt. Fox assured Cst. Haislip in a further telephone call that was "no problem" provided the HIT Form was filled out accordingly.[7] S/Sgt. Fox further told Cst. Haislip to make sure, on returning Mr. Hyde to Booking, that Booking was aware of what was to happen "so that it can be taken care of when we get there."[8]

S/Sgt. Fox testified that Cst. Haislip made him aware of the direction Dr. MacIntyre was putting on the HIT Form and did not have a problem with this wording.[9]

Cst. Haislip relied on S/Sgt. Fox's assurances. He returned to Dr. MacIntyre and advised that if she was willing to medically clear Mr. Hyde, the police would have no problem – as long as they had the information filled out on the HIT Form – getting him through court and then he would be seen by psychiatry after that.[10] He told her the police had a duty to get Mr. Hyde to court within 24 hours[11] although he did not tell her Mr. Hyde would be going directly to court from the hospital.[12]

The police were intent on getting Mr. Hyde arraigned at court if it was possible to do so. The assault against Ms. Ellet was a serious charge, triggering the Intimate Partner Violence policy, and an expectation of getting Mr. Hyde to court to be arraigned on this charge was unsurprising.[13]

Getting Dr. MacIntyre's direction in an acceptable form presented something of a challenge. Cst. Haislip had no forms in his patrol car and there were none at the hospital. He suggested to Dr. MacIntyre that a notation be made in his police notebook and she sign it. She was unenthusiastic about this option.[14] This led to Cst. Haislip arranging for Booking to fax a blank HIT Form over to the ER.[15] It was not the updated version that had been brought in by legislation in 2006[16] although no one seemed aware of this at the time.

Mr. Hyde left the hospital at 09:26 in police custody.[17] It was Cst. Haislip who transported Mr. Hyde back to HRPS Booking. [18] Before he left the ER he read Dr. MacIntyre's notation at the bottom of the HIT Form.[19] Although he knew he had no authority over Mr. Hyde after Mr. Hyde was transferred out of police custody, he did not advise Dr. MacIntyre that he could not return Mr. Hyde to the hospital once this happened.[20] Cst. Haislip assumed Mr. Hyde would be remanded.[21] He knew that at the point when Mr. Hyde could be taken back to hospital in accordance with Dr. MacIntyre's direction, he would be in the custody of the Sheriffs or correctional service, and not the police.[22] His recollection is that the discussion with Dr. MacIntyre about Mr. Hyde being returned to hospital for a psychiatric assessment should have been reflected in the HIT Form by a reference to "peace or police officer".[23] "Word play" was not something he was focused on at that point.[24]

Cst. Haislip relied on S/Sgt. Fox's direction that he was to make sure the HIT Form was filled out to indicate that Mr. Hyde was to get a forensic psychiatric assessment if he was remanded.[25] He assumed S/Sgt. Fox knew how the process worked for getting Mr. Hyde dealt with according to Dr. MacIntyre's direction.[26] Cst. Haislip was, himself, a newly minted police officer having been hired in September 2006.[27] He had no experience with court-ordered assessments and no training on the criteria for them or the difference between a court-ordered forensic assessment and a psychiatric assessment under section 14 of IPTA.[28] He was confused by Dr. MacIntyre's direction.[29] His notes did not reflect his confusion.[30]

Cst. Haislip was not anticipating that the court would order an assessment of Mr. Hyde.[31] He expected the HIT Form would follow Mr. Hyde to the CNSCF and that a psychiatric assessment would happen once he got there.[32] He assumed that if a doctor requested something it would happen.[33] It seemed obvious that Dr. MacIntyre believed Mr. Hyde needed a psychiatric assessment sooner rather than later. "There would be zero point in putting that on the Form if you thought he could wait a week."[34] Cst. Haislip was quite confident that what was being requested on Mr. Hyde's HIT Form would be able to be done.[35]

From reading the HIT Form, Cst. Haislip knew that Mr. Hyde had a diagnosis of schizophrenia with an indication that his illness manifested itself through "aggression toward others" and "potential for self-harm." He acknowledged in his testimony that these are important risks to manage in the care of an ill person.[36]

When Cst. Haislip got to Booking at 09:50[37], he gave S/Cst. Fraser the information that was contained on the HIT Form[38] telling him that he had discussed Mr. Hyde's medical clearance with the ER physician and that once Mr. Hyde went to court he needed to be seen by psychiatry.[39] Cst. Haislip had no other information to provide to the Booking officers. He was not given any medication for Mr. Hyde and did not know that he had received a dose of olanzapine at the hospital.[40]

Cst. Haislip likely discussed the HIT Form direction with Cst. Hillier[41]; after all they were friends, having been in the same class at the Atlantic Police Academy.[42] They were at the hospital together for two and a half hours and did not spend that

time in complete silence.[43] The fact that Cst. Hillier now has no recollection of what was written on Mr. Hyde's HIT Form[44] does not persuade me that he was not informed of its contents by Cst. Haislip. I think it is highly probable he was.

Cst. Hillier was responsible for preparing the report entry on the Versadex system[45] and Cst. Haislip expected Dr. MacIntyre's direction to be reflected there. It was not.[46] Cst. Hillier's report, which he understood would be disclosed to the Crown that day,[47] indicated only that Mr. Hyde had been "medically released" and transferred to HRPS Booking "where he was being held for court."

Notes

1 Testimony of Cst. John Haislip, page 2738

2 Testimony of Cst. John Haislip, page 2675

3 Testimony of Cst. John Haislip, pages 2675, 2722, 2738

4 This was the same information provided to Cst. Steven Hillier (Testimony of Cst. Steven Hillier, page 2623) Cst. Hillier also recalls being told that Mr. Hyde had been tasered. (Testimony of Cst. Steven Hillier, page 2633)

5 Testimony of Cst. John Haislip, page 2675

6 Testimony of Cst. John Haislip, pages 2675–2676. When Dr. MacIntyre advised that Mr. Hyde was medically stable, Cst. Haislip asked if she was willing to discharge him. (Testimony of Cst. John Haislip, page 2730)

7 Testimony of Cst. John Haislip, page 2676

8 Testimony of Cst. John Haislip, page 2676: Cst. Haislip recalls the instructions of S/Sgt. Fox differently than S/Sgt. Fox recalls them. S/Sgt. Fox's recollection is that he gave Cst. Haislip no other direction than that the HIT Form was to follow Mr. Hyde. (Testimony of S/Sgt. Donald Fox, page 5383) He testified that he did not indicate to Cst. Haislip that the police had a duty to get Mr. Hyde to court. (Testimony of S/Sgt. Donald Fox, page 5385) I have concluded that Cst. Haislip's recall on these issues is more reliable than S/Sgt. Fox and it is Cst. Haislip's evidence that I accept.

9 Testimony of S/Sgt. Donald Fox, page 5398

10 Testimony of Cst. John Haislip, pages 2676–2677

11 Testimony of Cst. John Haislip, page 2730

12 Testimony of Cst. John Haislip, pages 2731, 2743

13 Testimony of Supt. William Moore, page 4131

14 Testimony of Cst. John Haislip, pages 2722–2723: Testimony of Dr. Janet MacIntyre, pages 4754–4755

15 Testimony of Cst. John Haislip, page 2723; Testimony of S/Cst. Daniel Pelletier, page 2925; Nurse Roberts was asked by the police if the ER had copies of the HIT Form that was required to accompany Mr. Hyde. As the HIT Form is not part of the hospital's record system, Ms. Roberts gave the police a fax number so they could have one from their department faxed to the ER. (Testimony of Taryn Roberts, R.N., page 3814)

16 Testimony of Diana MacKinnon, pages 7276–7277

17 Exhibit 79-A, Tab 2, page 2: Emergency Department Clinical Record

18 Testimony of S/Cst. Dan Fraser, page 2833

19 Testimony of Cst. John Haislip, pages 2677–2678

20 Testimony of Cst. John Haislip, pages 2679; 2684–2685

21 Testimony of Cst. John Haislip, page 2698

22 Testimony of Cst. John Haislip, page 2678

23 Testimony of Cst. John Haislip, pages 2686, 2749

24 Testimony of Cst. John Haislip, page 2749

25 Testimony of Cst. John Haislip, pages 2675–2676; 2681

26 Testimony of Cst. John Haislip, page 2679

27 Testimony of Cst. John Haislip, page 2682

28 Testimony of Cst. John Haislip, pages 2679–2680

29 Testimony of Cst. John Haislip, page 2687

30 Testimony of Cst. John Haislip, page 2695

31 Testimony of Cst. John Haislip, page 2748

32 Testimony of Cst. John Haislip, page 2732. Cst. Haislip was not aware that the CNSCF did not have a psychiatrist on staff. He also thought that because the ECFH was proximate to the CNSCF they were one and the same institution.

33 Testimony of Cst. John Haislip, pages 2769, 2784

34 Testimony of Cst. John Haislip, page 2746

35 Testimony of Cst. John Haislip, page 2752

36 Testimony of Cst. John Haislip, page 2779

37 Testimony of Cst. John Haislip, page 2743

38 Testimony of Cst. John Haislip, page 2687

39 Testimony of Cst. John Haislip, page 2742

40 Testimony of Cst. John Haislip, page 2753

41 Testimony of Cst. John Haislip, page 2690

42 Testimony of Cst. John Haislip, page 2683

43 Testimony of Cst. John Haislip, page 2719

44 Testimony of Cst. Steven Hillier, pages 2605–2606; 2657

45 Testimony of Cst. John Haislip, pages 2689, 2719

46 Testimony of Cst. John Haislip, page 2720

47 Testimony of Cst. Steven Hillier, page 2604

Back at HRPS Booking

Special Constable Dan Fraser had relieved S/Cst. McCormick in Booking between 05:00 – 05:30 on November 21. Dr. MacIntyre's direction on the HIT Form Cst. Haislip gave him for Mr. Hyde was unlike any he had ever seen before.[1] He had a discussion with Cst. Haislip about it and took away from that discussion the understanding that Dr. MacIntyre was "referring to the justice system having someone make sure [Mr. Hyde] comes back for the psychiatric evaluation."[2] S/Cst. Fraser knew that once Mr. Hyde was in the custody of the sheriffs or remanded to the correctional centre, the police service could not return him to the hospital and it would be the responsibility of the sheriffs department or corrections to do so.[3]

S/Cst. Fraser assumed that there were no urgent health issues to be concerned about or the hospital would not have discharged Mr. Hyde. Because of this he did not consider calling the ER to clarify Dr. MacIntyre's notation.[4] Had there been any indication of urgency, S/Cst. Fraser would have refused to accept Mr. Hyde into custody and he would have had to return to the hospital.[5] It was his understanding there was nothing urgent to be done; that once Mr. Hyde had gone through the court process, the hospital wanted him to return there for a psychiatric assessment.[6] He was convinced that Cst. Haislip had a good grasp of what Dr. MacIntyre wanted and assumed that, having been discharged with a HIT Form, Mr. Hyde was "safe to go to cells and safe to go to court".[7] He assumed that Mr. Hyde would either be sent by the court for a forensic assessment or returned to the QE II in accordance with Dr. MacIntyre's notation on the HIT Form.[8]

It surprised S/Cst. Fraser to learn from evidence given by Cst. Haislip to the Inquiry that he understood Dr. MacIntyre's direction on the HIT Form was to be followed sooner rather than later. S/Cst. Fraser would have found it useful to have known that on November 21, 2007 when he was receiving Mr. Hyde into custody at Booking.[9] Sooner rather than later indicates some urgency that S/Cst. Fraser was unaware of until he heard Cst. Haislip's testimony before the Inquiry.[10]

S/Cst. Fraser had never seen a qualified medical clearance. In his experience, prisoners were either cleared or they weren't.[11] It was his understanding that a HIT Form is not prepared unless the prisoner has been medically cleared for release to the institution they are being transported to.[12] Sheriffs Services and the CNSCF have the same understanding of what the HIT Form signifies.[13]

Although S/Cst. Fraser does not now recall reading the HIT Form entries indicating Mr. Hyde's principal diagnosis of psychosis/schizophrenia with psychosis and schizophrenia being conditions of ongoing concern and notations of "aggression toward others" and "potential for self-harm", he must have done so because he read the Form. These references did not cause him concern. Aggression was commonly identified on HIT Forms. What was relevant to S/Cst. Fraser was Mr. Hyde's presentation when Cst. Haislip brought him in. He was calm.[14] Due to the

HIT Form indicating a potential for self-harm, S/Cst. Fraser placed Mr. Hyde in a cell that was "up front" in the cell block, closer to the Booking desk.[15]

When Mr. Hyde returned to Booking, he was "very mellow, smiling, in good spirits."[16] To S/Cst. Fraser he seemed medicated.[17] From what he knew about the events of the previous night he expected Mr. Hyde to be far more agitated.[18]

S/Cst. Fraser was surprised to see Mr. Hyde back at Booking because he understood his heart had stopped. He had been briefed on Mr. Hyde by S/Cst. McCormick. He had also learned that Mr. Hyde had "mental issues."[19] S/Cst. Fraser noted, perceptively, that Mr. Hyde's "mental issues" were "possibly why he had reacted the way he did" the night before.[20]

Mr. Hyde's friendly, cooperative demeanor offered the potential for an uneventful fingerprinting and photographing session. S/Cst. Fraser suggested going ahead with the procedure given Mr. Hyde's positive frame of mind. It was all accomplished without incident.[21] Sometime after Mr. Hyde had been lodged in an empty cell, clothes were brought in from the Salvation Army because he had returned from the hospital in only a johnny shirt.[22]

Mr. Hyde had returned to Booking about 09:30. An hour or so after this, S/Cst. Fraser noticed that he was becoming a little more agitated and vocal. He assumed that the medication Mr. Hyde had received was wearing off.[23] He was used to seeing prisoners coming "down off something."[24] S/Cst. Fraser had experience with confirming, and then documenting by way of the HIT Form, information about medications that came with prisoners.[25] No medications had accompanied Mr. Hyde from the hospital nor any information about what medications he had received there.[26] There was nothing recorded on the HIT Form except an indication that Mr. Hyde was discharged without any medications.[27] S/Cst. Fraser assumed that the doctor responsible for Mr. Hyde being medicated at the hospital would have known it would wear off and would have provided medication to accompany Mr. Hyde if she felt it was required.[28] For this reason, he did not note anything about his observations on the HIT Form to go with Mr. Hyde to court.[29] Mr. Hyde seemed fine as he left Booking to go to court and S/Cst. Fraser knew that EHS would not transport a prisoner to the hospital just to get more medication.[30]

S/Cst. Fraser went and reassured Mr. Hyde that "whatever happened earlier, it wasn't the shift I was on. It's a whole new group of people." Mr. Hyde was talking about having been beaten up and how he was going to sue the police department. S/Cst. Fraser told him they were going to make sure he was dealt with appropriately and got to court so he could deal with his matters. The discussion succeeded in calming Mr. Hyde down.[31] S/Cst. Fraser did not regard Mr. Hyde as "anything more than fairly normal for a person that's been arrested, in a cell."[32] The Booking officers were used to prisoners being upset.[33] Mr. Hyde was not threatening, just upset.[34] S/Cst. Fraser noticed that he was able to calm Mr. Hyde down by talking to him.[35]

In the afternoon there was a call to Booking from HRPS court section that Mr. Hyde was ready to go to court. This meant that the file prepared by the police officers had been reviewed by the Quality Assurance sergeants and processed by the court section. Once the police file for court was on its way to the courthouse, the call was placed to advise Booking to arrange for the transport of the prisoner.[36]

S/Cst. Fraser did not instruct Cst. Haislip to make any report about Mr. Hyde's release from the hospital or the anomalous HIT Form. He assumed one of the officers who had been with Mr. Hyde at the hospital would make a report "since there's always a report about it if anything happens" but he would have no reason

to know anything about the specifics of such reports.[37] He knew at the time that the HIT Form would accompany Mr. Hyde to court and be passed on to the sheriffs and corrections if Mr. Hyde was remanded but would not be seen by the Crown.[38] When Mr. Hyde was released from Booking to go with the transporting police officers to the Dartmouth Courthouse, his HIT Form was stapled to his property bag and sent with him.[39]

Notes

1 Neither had S/Cst. Daniel Pelletier who was working with S/Cst. Fraser in Booking on November 21, 2007. (Testimony of S/Cst. Pelletier, pages 2928–2929)

2 Testimony of S/Cst. Dan Fraser, page 2810

3 Testimony of S/Cst. Dan Fraser, pages 2829; 2844–2845

4 Testimony of S/Cst. Dan Fraser, page 2810

5 Testimony of S/Cst. Dan Fraser, page 2852

6 Testimony of S/Cst. Dan Fraser, page 2811

7 Testimony of S/Cst. Dan Fraser, page 2826

8 Testimony of S/Cst. Dan Fraser, page 2905

9 Testimony of S/Cst. Dan Fraser, page 2893

10 Testimony of S/Cst. Dan Fraser, page 2893

11 Testimony of S/Cst. Dan Fraser, page 2851

12 Testimony of S/Cst. Dan Fraser, page 2849

13 Testimony of S/Cst. Dan Fraser, pages 2849–2850

14 Testimony of S/Cst. Dan Fraser, page 2853

15 Testimony of S/Cst. Dan Fraser, pages 2812–2813; 2854

16 Testimony of S/Cst. Dan Fraser, page 2803

17 Testimony of S/Cst. Dan Fraser, page 2803

18 Testimony of S/Cst. Dan Fraser, page 2804

19 Testimony of S/Cst. Dan Fraser, page 2804

20 Testimony of S/Cst. Dan Fraser, page 2804

21 Testimony of S/Cst. Dan Fraser, page 2805; Testimony of S/Cst. Daniel Pelletier, page 2923

22 Testimony of S/Cst. Dan Fraser, pages 2805–2806

23 Testimony of S/Cst. Dan Fraser, page 2806

24 Testimony of S/Cst. Dan Fraser, page 2818

25 Testimony of S/Cst. Dan Fraser, pages 2818, 2907

26 Testimony of S/Cst. Dan Fraser, pages 2818–2819

27 Testimony of S/Cst. Dan Fraser, page 2908

28 Testimony of S/Cst. Dan Fraser, page 2873

29 Testimony of S/Cst. Dan Fraser, page 2896

30 Testimony of S/Cst. Dan Fraser, page 2897

31 Testimony of S/Cst. Dan Fraser, pages 2806; 2862

32 Testimony of S/Cst. Dan Fraser, page 2817

33 Testimony of S/Cst. Daniel Pelletier, page 2938

34 Testimony of S/Cst. Dan Fraser, page 2863

35 Testimony of S/Cst. Dan Fraser, pages 2813, 2817, 2864

36 Testimony of S/Cst. Dan Fraser, page 2807

37 Testimony of S/Cst. Dan Fraser, page 2838

38 Testimony of S/Cst. Dan Fraser, page 2839

39 Testimony of S/Cst. Daniel Pelletier, pages 2945–2946

HRPS Booking and Transport to the Dartmouth Courthouse

Mr. Hyde was collected from Booking for transport to the Dartmouth Courthouse by Csts. Smith and Willett (then, Venedam). The officers arrived at 14:08[1] and departed for the Courthouse at 14:16.[2] He was supplied with a shirt which he buttoned up when encouraged by the officers to do so.[3] He was completely cooperative[4] and seemed fine, if a little agitated.[5] Csts. Smith and Willett transported another prisoner as well and handed Mr. Hyde and his HIT Form and personal property over to the Dartmouth Courthouse sheriffs at 14:34.[6]

In the video surveillance footage from the HRPS Booking area, Mr. Hyde can be seen at the counter in a hospital shirt which he then exchanges for a shirt to wear to court. Cst. Willett helps Mr. Hyde into the shirt and he removes some of the heart monitor leads still attached to his torso.[7] The overhead camera angle shows Mr. Hyde's feet to be quite wet: the floor is obviously dry until Mr. Hyde appears and leaves wet footprints. His feet seem to be clad in hospital slippers.[8] Neither Cst. Willett nor Cst. Smith recall Mr. Hyde's feet being wet[9] nor did they detect a smell of urine.[10] There is the possibility that Mr. Hyde tracked moisture from the halls having been mopped but this was only Cst. Smith's speculation.[11] Nothing indicated by the police officers or the video surveillance suggests that Mr. Hyde made any mention of being in discomfort.

Cst. Willett remembered Mr. Hyde from a previous contact. In 2006 she had dealt with him as a complainant and she thought then that he might have some mental health issues.[12] He recognized Cst. Willett and seemed almost relieved to see her.[13] He recalled the previous dealings she had had with him,[14] automatically connecting with her and directly addressing her.[15] He was somewhat agitated in the cell but he calmed down once removed.[16] She assumed his agitation had to do with now waiting to go to court after having a "rough night" in Booking and at the hospital.[17] The transport went smoothly[18] and Mr. Hyde was "present in the moment" and took direction well.[19]

The evidence suggests that utterances by Mr. Hyde to Cst. Willett in Booking, while appearing to be decontextualized and delusional, were in fact references to the interaction he had had with her in 2006.[20]

Cst. Willett recalls being told by S/Cst. Fraser in a brief conversation they had[21] that if Mr. Hyde was released by the courts, the hospital wanted him returned to them by the police.[22] Cst. Willett knew the HIT Form did not give her the authority to do this and told S/Cst. Fraser so. He shrugged his shoulders and said Mr. Hyde was due to appear in court. Okay then, Cst. Willett said, we'll take him.[23] She understood her duty was to transport Mr. Hyde in a manner that safeguarded his health (with the HIT Form assisting in providing the necessary information to achieve

this) although she was not aware at the time of the statutory regime governing the transfer of health information.[24]

Csts. Smith and Willett got most of their information about Mr. Hyde from the Watch Commander's briefing.[25] This indicated that Mr. Hyde had been in a struggle in Booking, was hard to control and was tasered, had to be revived when he stopped breathing and was taken to hospital.[26] The briefing also mentioned Mr. Hyde's diagnosis of schizophrenia, information that was included on the HIT Form, and the fact that he had not been taking his medication.[27]

While at Booking, Cst. Willett encountered Cst. Edwards who seemed upset. He looked to be in shock and briefly described the events of the night before with Mr. Hyde. Cst. Willett remembers Cst. Edwards saying something to the effect that "you've got three guys in an altercation with a guy and it's really scary when you feel like you're losing."[28] His comments gave her some concern.[29]

It was Cst. Willett who primarily dealt with Mr. Hyde. She paid close attention to him, watchful for any cues that might cause her to be more on her guard.[30] There had been the altercation in Booking and she knew Dr. MacIntyre was expecting Mr. Hyde to be returned to the hospital for a psychiatric assessment. These facts heightened her vigilance. She understood that to invoke the *Involuntary Psychiatric Treatment Act* she needed her own reasonable and probable grounds to do so. Had she observed these grounds in Mr. Hyde's behaviour she would have delayed Mr. Hyde's transport and contacted a sergeant to review and assess the situation.[31]

At the Dartmouth Courthouse, Cst. Smith relayed the information from the Watch Commander's briefing to the Dartmouth sheriffs.[32] He handed over the HIT Form to the sheriffs.[33] He told the sheriffs to keep a close eye on Mr. Hyde, for their safety given the Booking incident, and Mr. Hyde's, as he had experienced "some medical distress."[34] Cst. Willett also briefed the sheriffs who were searching Mr. Hyde, telling them what she knew from the Watch Commander's Report.[35]

Cst. Willett talked to the site supervisor, Deputy Sheriff Shirley Day, about the notation on the HIT Form for Mr. Hyde to be returned to the QE II. Deputy Sheriff Day noted that the sheriffs did not have the authority to transport Mr. Hyde to the hospital either which prompted Cst. Willett to suggest that they be called if Mr. Hyde was released – she and Cst. Smith would still be on duty when Mr. Hyde was finished in court[36] – so that the situation concerning his transport to the hospital could be re-assessed. Cst. Willett indicated that there were no grounds for her and Cst. Smith to wait for Mr. Hyde's court appearance and then transport him to hospital if he was not remanded into custody. [37] The officers understood it to be the role of the sheriffs to stay with the prisoner throughout the court proceedings.[38]

It was not communicated to Cst. Willett that Dr. MacIntyre intended that someone in the justice system transport Mr. Hyde back to the hospital, not necessarily the police. If this was understood by other police officers, as indicated in Cst. Haislip's testimony and that of S/Cst. Fraser, it was not what Cst. Willett was told.[39] What was communicated to Cst. Willett was the direction that appears on the HIT Form, that the police were to return Mr. Hyde to the hospital if the court did not order a forensic assessment.[40]

Cst. Willett relied on the doctor's assessment that Mr. Hyde was medically cleared for release from the hospital. She knew the police did not have the authority to return Mr. Hyde to the hospital if the court released him.[41] In her view, "If the doctor had the grounds to write those comments [on the HIT Form], then the doctor, I felt, had the grounds to keep him and...I thought that…would have taken

precedence over him continuing on with the court process."[42] Cst. Willett was confused about why Mr. Hyde would have been released if the doctor still wanted him to be seen at the hospital for a psychiatric assessment.[43] She did not understand why Mr. Hyde had been released from the hospital but had no reason to doubt that the medical clearance related to both Mr. Hyde's physical as well as his mental condition.[44] When she glanced at the HIT Form during the transport, she saw that "aggression toward others" and "potential for self-harm" had been indicated.[45] It surprised her that notwithstanding those indications, Mr. Hyde was medically cleared for release from the hospital.[46]

In Cst. Willett's experience as a police officer, medical clearance has always adverted to the patient's physical and mental states.[47] The HIT Form said to her that "mentally [Mr. Hyde was] not okay to be cleared."[48] She felt the HIT Form was "almost contradictory" with its notation about Mr. Hyde being required back for a psychiatric assessment.[49] She had never heard of a direction like the one on Mr. Hyde's HIT Form for him to be returned to the hospital.[50]

Cst. Willett felt the doctor would know what was required for the police to be able to bring someone to the hospital.[51] She knew the doctor could not compel her to return someone to the hospital where there were no grounds for an arrest and detention in custody to accomplish this.[52] She could not arrest Mr. Hyde under the *Involuntary Psychiatric Treatment Act* unless his behaviour presented her with the reasonable and probable grounds to do so.[53] She knew she could not use Dr. MacIntyre's observations of Mr. Hyde from the morning as a basis to arrest him under IPTA and take him to the hospital.[54] She needed fresh grounds.[55] Those fresh grounds would have to be established by her own first-hand observations of behaviour that met the legislative criteria.[56] She could not simply take a third person's opinions about Mr. Hyde's mental state, especially as what she observed did not indicate he was a candidate for involuntary committment.[57] It was Cst. Willett's observation that Mr. Hyde was in "good condition."[58]

Cst. Willett felt she had the information she needed and was very confident about her duties and role in relation to Mr. Hyde's transport.[59] Any additional information would not have changed how she executed her duties: she could only arrest Mr. Hyde under IPTA if he gave her reasonable and probable grounds to do so.[60]

It did not occur to Cst. Willett to pass on Dr. MacIntyre's HIT Form notation to her superiors. She expected Mr. Hyde would be remanded into custody.[61]

Notes

1 Testimony of Cst. Kathryn Willett, pages 3079–3080

2 Testimony of Cst. Kathryn Willett, pages 3080

3 Exhibit 62, video surveillance from HRPS Booking

4 Testimony of Cst. David Smith, page 3008

5 Testimony of Cst. David Smith, page 2961; "Rather good spirits." Concerning Mr. Hyde's demeanor at Booking and during transport, see also, Testimony of Cst. David Smith, page 3007

6 Exhibit 60, Tab 1 – G, Cst. Kathryn Willett's notes; Testimony of Cst. Kathryn Willett, page 3101

7 Exhibit 62, View #2

8 Exhibit 62, View #2

9 Testimony of Cst. David Smith, page 3017; Testimony of Kathryn Willett, page 3072

10 Testimony of Cst. David Smith, page 3021

11 Testimony of Cst. David Smith, page 3017

12 Testimony of Cst. Kathryn Willett, page 3032

13 Testimony of Cst. Kathryn Willett, page 3159

14 Testimony of Cst. Kathryn Willett, pages 3050–3051

15 Testimony of Cst. Kathryn Willett, page 3160

16 Testimony of Cst. Kathryn Willett, pages 3032, 3054

17 Testimony of Cst. Kathryn Willett, pages 3031–3032

18 Exhibit 60, Tab 10:2 Cst. David Smith's General Occurrence hard copy report prepared November 28, 2007

19 Testimony of Cst. Kathryn Willett, pages 3032, 3054

20 Testimony of Cst. David Smith, page 3013; Testimony of Cst. Kathryn Willett, page 3052–3053

21 Testimony of Cst. Kathryn Willett, pages 3089, 3090

22 Testimony of Cst. Kathryn Willett, page 3030: S/Cst. Fraser recalls explaining to Cst. Willett that the doctor intended her direction to be dealt with by someone in the justice system, not specifically the police, which is what Cst. Haislip has testified his understanding was. (Testimony of S/Cst. Daniel Fraser, page 2905; Testimony of Cst. John Haislip, page 2686)

23 Testimony of Cst. Kathryn Willett, page 3031

24 Testimony of Cst. Kathryn Willett, pages 3096–3097 (Cst. Smith's testimony in response to question about Exhibit 159, Tab 1 – Sharing of Health Information Regulations)

25 Exhibit 163

26 Testimony of Cst. David Smith, pages 2956–2957

27 Testimony of Cst. Kathryn Willett, page 3121

28 Testimony of Cst. Kathryn Willett, page 3058

29 Testimony of Cst. Kathryn Willett, page 3078

30 Testimony of Cst. Kathryn Willett, page 3078

31 Testimony of Cst. Kathryn Willett, page 3066

32 Testimony of Cst. David Smith, pages 3009–3010

33 Testimony of Cst. Kathryn Willett, page 3090

34 Testimony of Cst. David Smith, page 2959

35 Testimony of Cst. Kathryn Willett, page 3033

36 Testimony of Cst. Kathryn Willett, pages 3073–3074

37 Testimony of Cst. Kathryn Willett, page 3034

38 Testimony of Cst. David Smith, page 2999

39 Testimony of Cst. Kathryn Willett, page 3038

40 Testimony of Cst. Kathryn Willett, pages 3038–3039

41 Testimony of Cst. Kathryn Willett, page 3048

42 Testimony of Cst. Kathryn Willett, page 3037

43 Testimony of Cst. Kathryn Willett, pages 3040, 3041

44 Testimony of Cst. Kathryn Willett, page 3106

45 Testimony of Cst. Kathryn Willett, page 3090

46 Testimony of Cst. Kathryn Willett, page 3103

47 Testimony of Cst. Kathryn Willett, pages 3104–3105; 3106 (Cst. Willett was hired by

the Halifax Regional Police Service in 2005; Testimony of Cst. Willett, page 3024)

48 Testimony of Cst. Kathryn Willett, page 3105

49 Testimony of Cst. Kathryn Willett, pages 3068

50 Testimony of Cst. Kathryn Willett, pages 3113; 3135

51 Testimony of Cst. Kathryn Willett, page 3122

52 Testimony of Cst. Kathryn Willett, page 3123

53 Testimony of Cst. Kathryn Willett, page 3040

54 Testimony of Cst. Kathryn Willett, page 3100

55 Testimony of Cst. Kathryn Willett, page 3121 ("Those were [Dr. MacIntyre's] observations at the time of completing [the HIT Form.]; see also page 3126

56 Testimony of Cst. Kathryn Willett, page 3139

57 Testimony of Cst. Kathryn Willett, page 3161

58 Testimony of Cst. Kathryn Willett, page 3094

59 Testimony of Cst. Kathryn Willett, pages 3100–3101; 3136

60 Testimony of Cst. Kathryn Willett, pages 3118–3119

61 Testimony of Cst. Kathryn Willett, page 3137

Dartmouth Courthouse Cells

Mr. Hyde was brought into the Dartmouth Courthouse cells at 14:30[1] on November 21[2]. His stay there, punctuated by a brief court appearance at 16:06, ended around 16:30 when he was transported to the CNSCF.[3] He interacted primarily with Deputy/Sheriff Shirley Day and Deputy/Sheriff Jim Crook. D/S Day was the site supervisor at the Dartmouth Provincial Court. Her responsibilities included scheduling, threat assessments, maintaining sufficient coverage of the courtrooms by the sheriffs' services staff, and ensuring that the transportation requirements were met.[4] The principle duty of sheriffs' services was to maintain order within the courthouse.[5]

The sheriffs' officers routinely called Halifax Regional Police Booking in the morning before court to get information about who was being transported from police cells to the courthouse.[6] This enables sheriffs' services to determine how many prisoners are coming in to court and ensure a proper level of staffing to handle them.[7] On November 21, 2007, around 07:45 – 08:00, D/S Jim Crook made the call.[8] Possibly through these inquiries, D/S Day learned about Mr. Hyde and was informed that he had been tasered, his heart had stopped and he had been taken to the hospital.[9] It is possible that when D/S Crook called, he was told that Mr. Hyde was at the hospital which was the kind of information Booking would commonly pass along about a prisoner destined for court who might be delayed for some reason.[10]

When Mr. Hyde was brought into the Dartmouth cells, D/S Day recalls only the male police officer accompanying him, which would have been Cst. David Smith. She does not recall Cst. Willett, then known as Cst. Venedam. As D/S Day started to talk to Mr. Hyde, Cst. Smith quickly passed on the information about the previous night's events – that Mr. Hyde had been tasered, his heart had stopped and he had been taken to hospital.[11] Information being so important for the proper handling of the prisoners, D/S Day was impressed by Cst. Smith's thoughtfulness in ensuring she knew about Mr. Hyde's recent experiences.[12] She could tell Cst. Smith was concerned that she have this information before she got any further in her conversation with Mr. Hyde.[13]

D/S Day follows a practice of connecting with each prisoner right away as their custody is transferred from the escorting police to sheriffs' services. She tries to assess how the prisoner is feeling which is useful in making her threat assessment, and she recognizes that the process is intimidating which makes it important to relax the prisoner.[14] She also tried to get information from the prisoner about any current health issues.[15] Mr. Hyde seemed afraid to her: he was whispering and D/S Day considered that he may have felt overwhelmed by the officers standing around in uniform, towering above him.[16]

D/S Day looked over Mr. Hyde's HIT Form focusing in on "other conditions re-

quiring ongoing attention." She was concerned there might be cardiac issues given what Cst. Smith had told her about Mr. Hyde's heart having stopped the previous night.[17] She wanted to see if there was anything on the HIT Form to indicate that Mr. Hyde had heart problems.[18] With this concern in mind, she asked him about any medication he might be on.[19] D/S Day was looking to see if Mr. Hyde had received any medication, and if so when it needed to be administered again as this might be something she would have to facilitate.

There was nothing filled in for the dose, frequency and time references in the medication section of the HIT Form. The HIT Form made no reference to Mr. Hyde having received an intravenous dose of olanzapine at the hospital.[20] No one told D/S Day that Mr. Hyde had received medication while in the ER[21] nor was she told that S/Cst. Fraser thought that Mr. Hyde was coming off medication while he was in Booking before the transport to the Dartmouth courthouse.[22] Had she known this she probably would have called the Booking officer to find out what medication Mr. Hyde had been on and whether it should have been sent with him to the courthouse.[23] Those inquiries of the Booking officer may well have led D/S Day to make inquiries of the hospital as well.[24]

Mr. Hyde seemed "a little nervous" and confided in D/S Day that he was not taking his medication because it was poisoning him.[25] D/S Day recognized that a non-threatening approach needed to be taken with Mr. Hyde. Her concern was that he might be not taking prescribed heart medication.[26] She asked D/S Jim Crook to speak to Mr. Hyde in the less intimidating environment of a cell by himself and find out more about the medication he was not taking.[27] She thought a one-on-one with D/S Crook would relax Mr. Hyde who seemed "very scared."[28] D/S Crook was known to have a winning manner with prisoners, and was regarded as a very compassionate person with excellent interpersonal skills.[29]

By the time D/S Crook met with Mr. Hyde, he knew that Mr. Hyde had exhibited some mental health issues, possibly some aggressiveness and had been tasered.[30] He had observed Mr. Hyde when he arrived in cells and thought he appeared confused and "bedraggled".[31]

D/S Crook put his skills to good use with Mr. Hyde, and was observed sitting next to him on a bench in the cell, speaking "softly [and] comfortingly" to him.[32] He was accustomed to the role of calming prisoners, and had been doing it for years.[33] In total he spent most of Mr. Hyde's two hours in Dartmouth cells with him,[34] trying to establish a rapport and keep him calm. He found it much more difficult than usual: it was a significant challenge connecting with Mr. Hyde whose thinking was disjointed and distracted as evidenced by his conversation and the sporadic attention he paid to what D/S Crook was saying.[35]

The information D/S Crook got from Mr. Hyde was that his medication contained "nickel, mercury and cadmium" and was poisoning him.[36] That was all he would disclose. When D/S Crook tried to get more information about whom to contact concerning Mr. Hyde's medication, he was met either with silence or Mr. Hyde telling him: "I'm not taking anything…I'm being poisoned."[37] Mr. Hyde seemed "disturbed". He would talk rationally and then suddenly get off track and start mumbling or "clam up."[38] He would veer between telling D/S Crook to go away, he did not want to talk to him anymore, to seconds later, engaging in conversation with him again.[39]

D/S Day knew it was crucial for her to find out as soon as possible what was going to happen about Mr. Hyde's release. She informed Peter Planetta that Mr.

Hyde had mental health issues and had not been taking his medication and that she needed him to tell her as soon as he knew where Mr. Hyde was going.[40] She wanted Mr. Planetta to get the matter dealt with early in the afternoon's docket.[41] The approach to Mr. Planetta was part of trying to ensure Mr. Hyde got the best possible care. D/S Day did not show him the HIT Form which she considered to be confidential[42]; she just let him know there were issues that she had to deal with that related to keeping Mr. Hyde safe.[43] Having done so, D/S Day saw it as being open to Mr. Planetta to follow up with Mr. Hyde if he wanted more information.[44]

D/S Day assumed that at some point Mr. Hyde was going to need the medication he was supposed to be taking. She wanted to be able to notify whomever was going to next be dealing with him.[45] D/S Day may have refused to accept Mr. Hyde if he had told her he had been taking medication that he was out of or needed. She has done so in the past.[46]

There was no consideration given to having Mr. Hyde transported to the ER because he did not present with any health concerns that worried D/S Day at the time.[47] Mr. Hyde was not exhibiting any behavior that was outside the range of behaviours D/S Day was accustomed to seeing in cells.[48] She noticed no deterioration in Mr. Hyde's condition while he was in the custody of Sheriffs' Services. [49]

If Mr. Hyde had required medical attention, according to Sheriffs' Services policy,[50] EHS would have been called and he would have been transported by ambulance to the ER. Two Sheriffs' officers would have been assigned to accompany him. They would have remained with him until he was medically cleared for transport to the CNSCF or correctional officers arrived to assume custody.[51] If an extended hospital stay was called for, the police would be called to relieve the sheriffs' officers.[52] These steps were not taken because at no time while he was at the Dartmouth courthouse did D/S Day consider that Mr. Hyde required any medical care.[53]

D/S Day subsequently went into her office and it was then that she noted the references to "psychosis and schizophrenia"[54] and Dr. MacIntyre's direction on Mr. Hyde's HIT Form under "upcoming appointments." She was not sure if Mr. Hyde was released that the police would come back to take him to the hospital.[55] She had never seen a notation like Dr. MacIntyre's before, in twenty years of working as a Sheriffs' officer. She had seen HIT Form requests for the person to return to the hospital for x-rays or more blood work.[56] This was different. D/S Day figured that the hospital wanted to do some psychiatric follow-up with Mr. Hyde. She could see there was nothing mentioned in the HIT Form about cardiac issues or follow-up.[57] She would not expect a physician who was of the opinion that an individual was in urgent need of a psychiatric assessment to note that as an "upcoming appointment".[58]

D/S Day did not know from looking at Mr. Hyde's HIT Form who prepared it or when it was filled out. She did not know a doctor had completed it despite Dr. MacIntyre's signature at the bottom of the Form. She did not know if someone had written the Form to reflect what the doctor who signed it wanted or whether the doctor had completed it herself.[59] D/S Day did not even realize a doctor could fill out a HIT Form.[60] In her experience the police officer bringing the prisoner from the hospital would fill out the HIT Form to indicate the person had been medically cleared.[61]

She decided to call her supervisor, Laurel Purcell. D/S Day indicated to Sheriff Purcell that if Mr. Hyde was released by the court and she called the police but they did not return for him then she would be able to do nothing more than tell

Mr. Hyde he needed to go back to the hospital for follow-up.[62] She had no authority to hold him in custody if he had been released and could, at most, have only asked him to wait if the police indicated they were delayed but would come back to transport him to the hospital.[63] Sheriff Purcell agreed with her that Sheriffs' Services could not detain Mr. Hyde if he was released from custody. If Mr. Hyde was released, Sheriffs' Services could not even give him a drive to the hospital as that was against policy.[64] Sheriff Purcell suggested to D/S Day that the police be notified as soon as Mr. Hyde's bail status became clear.[65] Sheriff Purcell knew from her conversation with D/S Day that a deputy sheriff had spent some time with Mr. Hyde in cells "in an attempt to reassure him, to keep him calm so that no incidents occurred that might require a use of force."[66]

D/S Day did not consider that she had any authority to take Mr. Hyde back to the hospital to satisfy Dr. MacIntyre's directive.[67] She gave no consideration to calling the hospital for clarification. This was not something she had ever done in the past.[68] However if the HIT Form had indicated that Sheriffs' Services were to return Mr. Hyde to the hospital she would have called to advise that she did not have the authority to do this if he was released from custody.[69]

At first, D/S Day thought Mr. Hyde was going to be released with his sister signing as a surety. This was good news; Mr. Hyde would be able to get out that afternoon. When she learned this was not going to happen, she knew he would be very upset and she would need to explain to him what was happening.[70] When it became apparent that Mr. Hyde misunderstood the explanation for the location of the CNSCF and thought he was going to the Ramada hotel, D/S Day stepped back into the cell to talk to him. He calmed down and they "just talked."[71] She reassured him that he would be coming back to them in the morning.[72]

D/S Crook had tried to reassure Mr. Hyde by telling him that the accommodations at the CNSCF were more like the Ramada than the Dartmouth cells. He thought Mr. Hyde would be going to the MIOU.[73] He mentioned the MIOU because he wanted Mr. Hyde to know what the options were at the CNSCF.[74] He also told him that the facilities there were more comfortable than the cells, and felt the information eased Mr. Hyde's anxieties about being remanded overnight.[75]

Mr. Hyde's remand required Sheriffs' Services to transport him to the CNSCF.[76] D/S Day knew he would be seen there by Health Care before the institution would admit him.[77] Any health concerns apparent at that point would be dealt with by the correctional facility.[78]

D/S Day did not share the contents of the HIT Form with the Crown: she regarded the Form as confidential and for the purpose of enabling her to safeguard the health of the prisoner in her care.[79] D/S Day did not have any authorization to release information from the HIT Form to either the Crown or the Defence.[80] Had she taken any action in relation to Mr. Hyde's health, she would have recorded it on his HIT Form so that there would be a record for the receiving facility or entity who next dealt with him.[81]

Once Mr. Hyde's remand was ordered and it was apparent that he was going to be spending the night at the CNSCF, D/S Crook called Admissions at the institution and told them to expect Mr. Hyde and that he was "off".[82] He indicated that Mr. Hyde had "a history of violence" but had shown no such behavior while at Dartmouth cells. D/S Crook wanted the CNSCF to know that if Mr. Hyde acted out it would be due to his mental health issues.[83] There was nothing extraordinary about Mr. Hyde's mental health compared to other prisoners that Sheriffs' Services

handled, [84] so D/S Crook did not put a lot of emphasis on it in his conversation with the CNSCF.[85] On a scale of 1 – 10, D/S Crook would have ranked Mr. Hyde as a 4 "at his most disturbed."[86]

Even if he had known that Mr. Hyde had been described in terms of "aggression toward others" and "potential for self-harm", D/S Crook would not have regarded this as noteworthy as these are common descriptors for the population Sheriffs' Services deals with.[87] The sheriffs make their own assessment of a prisoner based on how the person presents when they arrive.[88]

D/S Crook had not seen the HIT Form and was not advised about its contents.[89] He has no recollection now of telling CNSCF Admitting staff that Mr. Hyde was a paranoid schizophrenic who had been tasered by police the night before, broken his handcuffs, been taken to hospital and medically cleared.[90] He does not think he would have used the term "paranoid schizophrenic" given his lack of training to diagnose a mental illness. Sheriff Purcell reported in an email of November 27, 2007 that D/S Crook had told her he passed all these details on to the CNSCF once Mr. Hyde was on his way there [91], and, with the exception of any reference to Mr. Hyde as a "paranoid schizophrenic", this is the information the Admissions officer at the CNSCF recalls receiving.[92]

D/S Day was concerned about the issue of Mr. Hyde being off his medication. Although she did not direct D/S Crook to pass this information on to the CNSCF Admitting officer when he called, he did so[93], which is what she would have expected of a well-trained officer.[94] There was no formalized protocol for conveying information relevant to a prisoner's health.[95] Neither D/S Day nor D/S Crook knew about the olanzapine dose given to Mr. Hyde at the QE II Emergency Department: this would have been important information to pass on to the CNSCF but she didn't have it.[96]

D/S Day knew the HIT Form would go with Mr. Hyde and inform the CNSCF that he was not accompanied by any medication.[97] The CNSCF would review all the paperwork with Mr. Hyde, including the HIT Form, before they would accept him and take over his custody from Sheriffs' Services.[98]

Mr. Hyde was transported without incident from the Dartmouth courthouse to the CNSCF, a trip that took about fifteen minutes.[99] He arrived with various documents, including the HIT Form, and no personal property.[100]

Notes

1 Testimony of D/S Shirley Day, page 4247, referring to Exhibit 112, the Daily Prisoner Log for November 21, 2007; Testimony of D/S James Crook, page 5228

2 Testimony of D/S Shirley Day, page 4247, referring to Exhibit 112, the Daily Prisoner Log for November 21, 2007

3 Testimony of D/S Shirley Day, pages 4212–4213; Testimony of D/S Brian Williams, page 5088

4 Testimony of D/S Shirley Day, page 4209

5 Testimony of D/S Shirley Day, page 4210

6 Testimony of D/S Shirley Day, page 4211

7 Testimony of D/S Shirley Day, page 4214

8 Testimony of D/S James Crook, page 5161

9 Testimony of D/S Shirley Day, page 4211

10 Testimony of D/S Shirley Day, page 5204

11 Testimony of D/S Shirley Day, page 4215

12 Testimony of D/S Shirley Day, page 4215

13 Testimony of D/S Shirley Day, page 4295

14 Testimony of D/S Shirley Day, page 4216

15 Testimony of D/S Shirley Day, page 4335

16 Testimony of D/S Shirley Day, page 4217

17 Testimony of D/S Shirley Day, page 4337

18 Testimony of D/S Shirley Day, pages 4258–4259

19 Testimony of D/S Shirley Day, pages 4218, 4259, 4265 "…I just asked him, Are you on any medications that I should know about?"

20 Testimony of D/S Shirley Day, page 4292

21 Testimony D/S Shirley Day, page 4322 "No, I was not told that."

22 Testimony of D/S Shirley Day, page 4322

23 Testimony D/S Shirley Day, pages 4393–4394

24 Testimony D/S Shirley Day, pages 4394–4395

25 Testimony D/S Shirley Day, page 4265

26 Testimony of D/S Shirley Day, page 4220

27 Testimony of D/S Shirley Day, page 4219

28 Testimony of D/S Shirley Day, page 4268

29 Testimony of D/S Shirley Day, pages 4219, 4291 "…he can de-escalate just about any situation that arises." Testimony of S/O Brian Williams, page 5087

30 Testimony of D/S James Crook, page 5131

31 Testimony of D/S James Crook, page 5132

32 Testimony of D/S Brian Williams, pages 5087, 5096, 5111

33 Testimony of D/S James Crook, page 5134

34 Testimony of D/S James Crook, page 5224

35 Testimony of D/S James Crook, page 5225

36 Testimony of D/S James Crook, page 5140

37 Testimony of D/S James Crook, page 5164

38 Testimony of D/S James Crook, pages 5141; 5183

39 Testimony of D/S James Crook, page 5184

40 Testimony of D/S Shirley Day, page 4234

41 Testimony of D/S Shirley Day, page 4235

42 Testimony of D/S Shirley Day, pages 4234–4235, 4326, 4328

43 Testimony of D/S Shirley Day, pages 4234–4235

44 Testimony of D/S Shirley Day, page 4311

45 Testimony of D/S Shirley Day, pages 4274–4275

46 Testimony of D/S Shirley Day, page 4384

47 Testimony of D/S Shirley Day, pages 4237, 4268

48 Testimony of D/S Shirley Day, pages 4289–4290

49 Testimony of D/S Shirley Day, page 4279

50 Exhibit 129, Tab 7, 20.27(a)

51 Testimony of D/S Shirley Day, page 4343

52 Testimony of Sheriff Laurel Purcell, page 5071

53 Testimony of D/S Shirley Day, page 4346

54 Testimony of D/S Shirley Day, page 4261

55 Testimony of D/S Shirley Day, page 4223

56 Testimony of D/S Shirley Day, page 4223

57 Testimony of D/S Shirley Day, page 4339

58 Testimony of D/S Shirley Day, page 4369

59 Testimony of D/S Shirley Day, pages 4267–4268; 4320

60 Testimony of D/S Shirley Day, page 4375

61 Testimony of D/S Shirley Day, pages 4395–4396

62 Testimony of D/S Shirley Day, page 4224–4225

63 Testimony of D/S Shirley Day, pages 4285; 4332

64 Testimony of Sheriff Laurel Purcell, page 4961

65 Testimony of Sheriff Laurel Purcell, pages 4958–4959; 4980–4981

66 Testimony of Sheriff Laurel Purcell, page 5017

67 Testimony of D/S Shirley Day, pages 4224–4225

68 Testimony of D/S Shirley Day, page 4225

69 Testimony of D/S Shirley Day, page 4340

70 Testimony of D/S Shirley Day, page 4386

71 Testimony of D/S Shirley Day, pages 4231–4232; 4387–4388

72 Testimony of D/S Shirley Day, pages 4387–4388

73 Testimony of D/S James Crook, page 5143

74 Testimony of D/S James Crook, page 5187

75 Testimony of D/S James Crook, page 5143

76 Testimony of D/S Shirley Day, page 4379; Testimony of Sheriff Laurel Purcell, pages 5030; 5083

77 Testimony of D/S Shirley Day, pages 4381–4382

78 Testimony of Sheriff Laurel Purcell, page 5042

79 Testimony of D/S Shirley Day, pages 4227–4228; pages 4371–4372, referring to Exhibit 159, Tab 1, section 2(g) "Transferring officer means any one of the following persons who is conducting a transfer: a police officer, a sheriff, an employee of a correctional facility." And also, Exhibit 129, Tab 5, Policy 14.09 "Sheriffs' officers are to only use the interdepartmental Health Information Transfer Form A as prescribed by regulation."

80 Testimony of D/S Shirley Day, pages 4228, 4325–4328, referring to Exhibit 129, Tab 5

81 Testimony of D/S Shirley Day, page 4229

82 Testimony of D/S James Crook, page 5147

83 Testimony of D/S Shirley Day, page 5147

84 Testimony of D/S James Crook, page 5195

85 Testimony of D/S James Crook, page 5148

86 Testimony of D/S James Crook, page 5157

87 Testimony of D/S James Crook, page 5216

88 Testimony of D/S James Crook, page 5217

89 Testimony of D/S Shirley Day, pages 5153–5154, 5199

90 Testimony of D/S James Crook, page 5152

91 Exhibit 112, page 12 Email from Laurel Purcell to Stephen Brown, November 27, 2007

92 Testimony of C/O Chris Dixon, pages 5433–5434

93 Testimony of C/O Christopher Dixon, pages 5433–5434

94 Testimony of D/S Shirley Day, page 4278

95 Testimony of D/S Shirley Day, page 4353 referring to the provisions of Exhibit 129, Tab 17 – Policy 63.14 "Sheriffs Officers are to separately convey with the person in custody (e) any information regarding health [of the prisoner]."

96 Testimony of D/S Shirley Day, page 4293

97 Testimony of D/S Shirley Day, pages 4278–4279

98 Testimony of D/S Shirley Day, page 4330

99 Testimony of S/O Brian Williams, page 5089

100 Testimony of S/O Brian Williams, page 5091

Howard Hyde's Arraignment and the Issue of Bail (Dartmouth Provincial Court)

Mr. Hyde's court appearance on November 21, 2007 took place late in the afternoon. The bail court Crown was Cheryl Byard and Duty counsel was Peter Planetta. Mr. Planetta had been working as duty counsel since June 2007.[1] His responsibilities were to provide summary advice and representation to everyone appearing in the bail (arraignment[2]) court. His clients were either before the court for the first time like Mr. Hyde or returning after a previous remand.[3]

Mr. Planetta had had no prior dealings with Mr. Hyde and Ms. Byard did not know him either.[4] The information they each had about Mr. Hyde came from the disclosure: Ms. Byard received the court file just before 13:30.[5] and provided a copy of it[6] to Mr. Planetta at an early opportunity although precisely when she cannot recall.[7] She also provided Mr. Planetta with a copy of Mr. Hyde's criminal record.[8]

Mr. Hyde was facing two charges of assaulting Ms. Ellet, including an assault with a telephone, resisting Csts. Edwards and Mitchell and S/Cst. MacCormick while they were engaged in the lawful execution of their duties, and escaping lawful custody.[9] Ms. Byard decided to proceed summarily on the charges[10] based on the nature of the allegations and Mr. Hyde's criminal record.

Prior to court re-convening in the afternoon, Ms. Byard thoroughly reviewed the Crown file in her office.[11] It included: the notes of Csts. Gillis, Jardine and Edwards and those of S/Csts. MacCormick and Coombs[12]; Mr. Hyde's CPIC criminal record[13]; the JEIN Bail Report[14]; the Emotionally Disturbed Person Form[15]; the PPS Disclosure cover sheet[16]; and the Domestic Violence Risk Assessment Form[17]. The police occurrence report told her that Mr. Hyde had a diagnosis of schizophrenia and had been off his medications for a week.[18] She saw the notation by the police "mental illness – unsafe to release."[19] This was not unusual to see and would sometimes be accompanied by the police proposing possible release conditions although none were suggested in relation to Mr. Hyde.[20]

Ms. Byard also saw Ms. Ellet's statement to Cst. Jardine. The statement Ms. Ellet gave to Cst. Gillis was not in the file.[21]

A decision had to be made by Ms. Byard about whether she was going to oppose or agree to Mr. Hyde's release. She tried to call Ms. Ellet using the number in the file but there was no answer. It was Ms. Byard's practice to try and get some background from the complainant in domestic assault matters and see if she wanted to have contact.[22]

The Public Prosecution Service has a policy regarding bail in cases of domestic violence. Ms. Byard's practice was to contact the complainant to find out if they

wished to have contact and advise them that they would need to come to court and give evidence to that effect if they did. This is not determinative: the Crown can still require a no-contact condition even where the complainant is not looking for one.[23]

In formulating her position on Mr. Hyde's release, Ms. Byard was alive to the *Charter* guarantee of reasonable bail and the fact that Mr. Hyde was entitled to the presumption of innocence.[24] As duty counsel, Mr. Planetta was well aware that the Crown was required to show cause as to why an accused should be detained or be subject to restrictive conditions.[25]

Other considerations were relevant to Ms. Byard's assessment concerning the issue of bail for Mr. Hyde. She looked at his criminal record to see if he had any convictions for failing to attend court. He did not. She was interested in whether he had prior convictions that raised public safety or administration of justice reputational concerns.[26] She saw that Mr. Hyde's criminal record was dated, with convictions in November 1992 for being unlawfully in a dwelling house and careless use of firearm and in October 1996 for threats.[27] Ms. Byard did not think there was a significant likelihood that if released Mr. Hyde would commit a criminal offence.[28] Noting the information from Ms. Ellet that she and Mr. Hyde had been involved romantically for three years, that he was a "diagnosed schizophrenic" and had not been taking his medication "for a week", and had hit Ms. Ellet in the face three weeks prior, Ms. Byard made the decision to agree to Mr. Hyde's release on a recognizance with a surety.[29] The NCR verdict in February 2002 factored into Ms. Byard's decision that Mr. Hyde should be released on this basis.[30]

In light of everything she had before her, Ms. Byard was not agreeable to Mr. Hyde being released on his own recognizance or undertaking. She wanted someone to be responsible for him, to ensure that he attended court and followed his conditions of release.[31] Ms. Byard was prepared for Mr. Hyde to be released on conditions that he: keep the peace and be of good behaviour; attend court as and when directed; confirm his address and telephone number with the court administration and notify the court administration office of any change in that address or telephone number within two business days of the change; remain in Nova Scotia; have no direct or indirect contact or communication with Karen Ellet except through a lawyer; and not be on or within 50 meters of the premises known as 175 Albro Lake Road except on one occasion in the company of a police officer to obtain personal belongings.[32] She would have also included a condition prohibiting Mr. Hyde from possessing weapons.[33]

Having decided the basis on which she was prepared for Mr. Hyde to be released, and around the time she gave him the disclosure, Ms. Byard provided Mr. Planetta with the Crown's Release Conditions Checklist that she had prepared after reviewing the file.[34]

Ms. Byard and Mr. Planetta went before the court at 16:06. Mr. Hyde was brought up from cells. Mr. Planetta indicated that having discussed the matter with Ms. Byard, an agreement on the issue of bail was in the works and Mr. Hyde would require a surety. With insufficient time left in the day to arrange for a surety to appear in court, the issue of Mr. Hyde's release had to be adjourned to the next morning on the basis of a consent remand.[35] It wasn't an option to seek a bail hearing if for no other reason than the Crown was entitled to request an adjournment of three days under section 516 of the *Criminal Code*.[36]

The court appearance lasted less than five minutes.[37] Mr. Hyde was calm, only showing a little dis-inhibition when he interrupted Ms. Byard's remarks to the court

to say he was "pleading innocent, by the way."[38] Mr. Planetta had met with Mr. Hyde in cells, both before and after speaking with Ms. Byard about bail. He found Mr. Hyde to be a little agitated which, in his experience, was not unusual for an accused person in custody.[39] Mr. Hyde did demonstrate an increased level of agitation when he learned, before going into court, that he was not going to be released.[40] The Sheriffs' officers intervened to calm him down.[41] Mr. Hyde was neither threatening nor, in Mr. Planetta's experience of clients in custody, exceptionally agitated.[42] Mr. Planetta was not concerned about Mr. Hyde spending the night at the CNSCF.[43]

Mr. Hyde's remand made Ms. Byard "wince".[44] She had seen what Mr. Hyde had already gone through – the tasering, his heart stopping, and the visit to the hospital – and she was not opposed to his release on a recognizance with a surety. Notwithstanding her position, there was no realistic opportunity for Mr. Hyde to get a surety in place so late in the afternoon so his remand was inevitable. The fact that Mr. Hyde would have to go to the CNSCF overnight did not cause Ms. Byard to re-think her position on release: given Mr. Hyde's criminal record, his mental health issues and her inability to reach Ms. Ellet, she was unprepared to consider a lesser form of release, such as an Undertaking from Mr. Hyde. She wanted to know where he would be going upon his release from custody. Without a heightened level of release such as a recognizance with a surety, she was concerned Mr. Hyde might just return to Ms. Ellet's apartment.[45] Even if Ms. Ellet had indicated she wanted contact with Mr. Hyde, Ms. Byard would probably have opposed it.[46]

It will never be known if Mr. Hyde would have been compliant on release with or without a surety. His mental illness played a role in the Crown's position that a higher standard of release was required in his case[47], although Ms. Byard indicated that the Crown does not, uniformly oppose the release of an accused with a mental illness.[48] "Individuals have a right to bail, whether they have mental health issues or not."[49] In Mr. Hyde's case, his release would have been secured if he had been able to arrange for a surety. It is not an option for the Crown to seek as a condition of bail that an accused with mental health issues, such as psychosis, be required to seek medical treatment of his/her condition.[50]

Ms. Byard was finished with court at 16:30 and reached Ms. Ellet by telephone at 16:44. She told Ms. Ellet she was agreeing to Mr. Hyde's release if he could get a surety. She gave Ms. Ellet the option of coming to court the next day to give evidence about why she wanted Mr. Hyde's release conditions to allow him to have contact with her, but Ms. Ellet said she did not want contact with Mr. Hyde because he was "psychotic."[51] Ms. Ellet expressed concern that Mr. Hyde had been remanded to the CNSCF. She told Ms. Byard he should not be going there due to his psychosis.[52] Ms. Byard was probably told by Ms. Ellet that Mr. Hyde needed treatment.[53]

Ms. Byard noted Ms. Ellet's comments in the file for the Crown to see the next morning.[54] Those notes indicate: "She confirmed she does not wish to have contact [with accused] and states 'he's psychotic.'"[55] Ms. Byard's notes do not record Ms. Ellet's concerns about Mr. Hyde being at the CNSCF when what he required was treatment for his psychosis. Ms. Byard did not think of contacting the CNSCF or Mr. Planetta at his office. She felt there was nothing further she could do: court had closed at 16:30.[56] Ms. Byard saw it as Mr. Planetta's role, not hers, to obtain information from Mr. Hyde and act on it.[57] Ms. Byard expected that by the next day Mr. Planetta would be able to secure a surety for Mr. Hyde and he would be released.[58]

Ms. Byard did not give any consideration to asking for a psychiatric assessment of Mr. Hyde under section 672.12 of the *Criminal Code* for fitness and NCR.[59] She

had no grounds for doing so.[60] In Ms. Byard's experience, the request for such an assessment usually came from Defence counsel and none was made by Mr. Planetta.[61] She had no reason to think that Mr. Hyde was unfit for trial.[62] She would have needed to call medical evidence to support a Crown application for a court-ordered assessment.[63] A simple conversation with the sheriffs would not have provided a sufficient basis.[64]

Nothing was brought to Ms. Byard's attention to make her think she should speak with the sheriffs about Mr. Hyde.[65] She did not see the HIT Form and there was nothing in the Crown file about Dr. MacIntyre's notation. There was nothing that red-flagged the need to seek a forensic psychiatric assessment under the provisions of the *Criminal Code*.[66] She had information that Mr. Hyde had a mental illness but the police occurrence report authored by Cst. Hillier[67] indicated that the hospital had medically cleared him. This was significant to Ms. Byard[68] because she was confident the hospital would not have released Mr. Hyde if he had been demonstrating "unusual behaviour."[69] Had Mr. Hyde not been at the QE II, Ms. Byard may have spoken to Mr. Planetta about his mental health. The medical clearance of Mr. Hyde by the hospital was a very influential factor in how Ms. Byard approached the issue of dealing with Mr. Hyde.

Ms. Byard would have done nothing differently had she seen Dr. MacIntyre's notation on the HIT Form or the references to the "schizophrenia/psychosis" diagnosis, "aggression toward others" and "potential for self-harm."[70] If the HIT Form notation had come to her attention, Ms. Byard would have asked the police to clarify with the doctor why she was recommending that Mr. Hyde be returned to the hospital when he had been medically cleared.[71] Had the Form recommended that Mr. Hyde be sent for a psychiatric assessment under the *Criminal Code*, Ms. Byard would have asked the police to contact the doctor for the purpose of having her testify as a witness on the Crown's application for the section 672.12 order.[72] But in Ms. Byard's view, Mr. Hyde's HIT Form was not recommending a court-ordered assessment[73], so had she seen it on November 21, 2007, it would not have suggested to her that she should present evidence to the court to support an application for an order under section 672.12 of the *Criminal Code*.

The sheriffs did not bring any specific concerns about Mr. Hyde's mental health to Mr. Planetta's attention that he can recall[74] but he was aware of the references in the disclosure to Mr. Hyde's mental health issues – that he was described as a "diagnosed schizophrenic" who had not been taking his medication for a week, that he had assaulted Ms. Ellet while she was on the telephone to the Mobile Mental Health Crisis Team and that she had told Cst. Jardine in her statement about Mr. Hyde becoming very unpredictable and walking around the apartment talking to himself during the previous night.[75] Asking for a court ordered assessment pursuant to section 672.12 of the *Criminal Code* was a consideration given the information Mr. Planetta had.[76] He did not request one. Describing the occasions when he would request such an assessment as "rare", Mr. Planetta noted that he would have to receive instructions to do so and would have to have concerns about a client's fitness to stand trial and/or criminal responsibility to the point where he felt that he had grounds that would satisfy a judge on a balance of probabilities of the appropriateness of ordering the assessment.[77] In Mr. Planetta's experience, clients rarely instruct him to seek a section 672.12 order.[78] Mr. Planetta noted in his testimony that his professional obligation is to get his clients released from custody as quickly as possible.[79]

Mr. Planetta did not have any concerns about taking instructions from Mr. Hyde on the afternoon of November 21, 2007. We do not know what those instructions may have been on the issue of an assessment: that discussion is subject to solicitor-client privilege and was not adverted to by Mr. Planetta in his testimony. All Mr. Planetta acknowledged is that he conducted himself in accordance with the instructions he received from Mr. Hyde.[80] Mr. Planetta may have not recommended making the request or may have recommended against it or Mr. Hyde may have instructed Mr. Planetta not to seek an assessment. There is no evidence concerning whether Mr. Planetta formed the opinion that Mr. Hyde's criminal responsibility might be an issue. Criminal responsibility aside, I think I can infer from the evidence I have heard about Mr. Hyde's interactions with justice officials and Mr. Planetta indicating he had no problem getting his instructions, that there was no issue of Mr. Hyde's fitness to stand trial. The fact that Mr. Hyde had been found NCR in 2002 was known to Mr. Planetta but it did not have the significance for him that the facts of the current offences did.[81]

Ms. Byard noted in her testimony that Dr. MacIntyre's direction on the HIT Form was unusual and unenforceable: once Mr. Hyde was remanded he could not have been returned to the hospital by the police or sheriffs.[82] The Warrant of Remand[83] required that he be sent to the CNSCF and then returned to court the next day. Ms. Byard had no authority to over-ride the remand order nor would the correctional officers have been able to do so.[84]

It does not appear that the HIT Form would have changed how counsel dealing with the issue of Mr. Hyde's bail analyzed their respective positions. The information that Ms. Byard subsequently saw in Mr. Hyde's HIT Form would not have changed her position on what she required for Mr. Hyde's release.[85] Mr. Planetta would not likely have taken a different view of the need for a court-ordered assessment if he had seen it when representing Mr. Hyde on November 21.[86] It would not have stirred concerns about Mr. Hyde going to the CNSCF: even with the notations on the HIT Form, Mr. Planetta would have been influenced by the fact that Mr. Hyde had been medically cleared by the hospital.[87]

When Ms. Byard testified before the Inquiry on October 19, 2009, she had seen her first HIT Form only two or three weeks earlier. It was included with the court file from the police. She asked her Dartmouth and Halifax Public Prosecution Service colleagues and none of them had seen one prior to November 21, 2007. She did not canvas them to determine if they have seen such Forms since then.[88]

Notes

1 Testimony of Peter Planetta, page 8652

2 Testimony of D/S James Crook, page 5169

3 Testimony of Peter Planetta, page 8653

4 Testimony of Cheryl Byard, page 5258; Testimony of Peter Planetta, page 8654

5 Testimony of Cheryl Byard, page 5260

6 Testimony of Cheryl Byard, pages 5305–5312 (Ms. Byard's review of which documents she provided as disclosure to Peter Planetta.)

7 Testimony of Cheryl Byard, page 5351

8 Exhibit 178 – A; Testimony of Cheryl Byard, page 5313

9 Exhibit 166, Information sworn November 21, 2007

10 Testimony of Cheryl Byard, pages 5260; 5290

11 Testimony of Cheryl Byard, pages 5260–2

12 Exhibit 125, pages 39–40, 41–42, 43–46, 47–52 and 53

13 Exhibit 125, page 82

14 Exhibit 178–B

15 Exhibit 125, page 58

16 Exhibit 125, page 59

17 Exhibit 125, page 57

18 Exhibit 125, page 84 (reverse side), Testimony of Cheryl Byard, page 5265

19 Testimony of Cheryl Byard, page 5295

20 Testimony of Cheryl Byard, page 5325

21 Testimony of Cheryl Byard, page 5261. Ms. Byard recollection is correct. She would have seen the statement Ms. Ellet gave Cst. Jardine at 00:55 hrs – 01:14 hrs on November 21 about the assault Ms. Ellet had just experienced. Although Exhibit 125 is said to contain the Crown Brief, the statement in the Exhibit is the one Ms. Ellet gave to Cst. Gillis on November 21, 2007 at 21:55 hrs – 22:12 hrs. which Ms. Byard obviously could not have seen on the afternoon of November 21. That statement dealt with Mr. Hyde assaulting Ms. Ellet on the way back from MicMac Mall. The wrong statement was included in the Exhibit: the statement Ms. Byard would have had in the Crown Brief, the Ellet to Jardine statement, is found in Exhibit 61, Tab 26.

22 Testimony of Cheryl Byard, page 5263

23 Testimony of Cheryl Byard, page 5275

24 Testimony of Cheryl Byard, page 5264

25 Testimony of Peter Planetta, page 8682, referring to section 515 of the *Criminal Code*

26 Testimony of Cheryl Byard, page 5264 (Ms. Byard was addressing her mind to the provisions of the *Criminal Code* in section 515 (10) (a), (b) and (c))

27 Testimony of Cheryl Byard, page 5267

28 Testimony of Cheryl Byard, page 5265

29 Testimony of Cheryl Byard, pages 5265–5266, referring to Exhibit 125, page 84 (reverse side); also, page 5267

30 Testimony of Cheryl Byard, page 5269, referring to Exhibit 178-B

31 Testimony of Cheryl Byard, pages 5266 & 5267

32 Testimony of Cheryl Byard, page 5277

33 Testimony of Cheryl Byard, page 5277 (prohibiting "possession of a firearm, crossbow, prohibited weapon, restricted weapon, prohibited device, ammunition or explosive substance.")

34 Testimony of Cheryl Byard, page 5291; Exhibit 178-D

35 Exhibit 245, Transcript of Court Proceedings, November 21, 2007, pages 3 & 4

36 Testimony of Peter Planetta, page 8674

37 Testimony of Cheryl Byard, page 5274

38 Exhibit 245, Transcript of Court Proceedings, November 21, 2007: Mr. Planetta did not regard this brief "outburst" as being particularly significant. (Testimony of Peter Planetta, pages 8714–8715)

39 Testimony of Peter Planetta, page 8658

40 Testimony of Peter Planetta, pages 8685, 8689

41 Testimony of Peter Planetta, page 8685: Testimony of Deputy Sheriff Shirley Day, at page 4232; and D/S James Crooks, page 5143

42 Testimony of Peter Planetta, pages 8690–8691 "Nothing…that would be out of the ordinary."

43 Testimony of Peter Planetta, page 8695

44 Testimony of Cheryl Byard, pages 5279; 5292

45 Testimony of Cheryl Byard, page 5292

46 Testimony of Cheryl Byard, page 5322

47 Testimony of Cheryl Byard, page 5292 "…I could not go behind what I had already agreed to. I had taken into consideration…his criminal record, the fact that he had mental health issues." See also, pages 5326–5327 "The police have told me there was [sic] mental health issues. I wasn't going to just release him to walk out the door on his own."

48 Testimony of Cheryl Byard, page 5296

49 Testimony of Cheryl Byard, page 5349

50 Testimony of Cheryl Byard, page 5297

51 Testimony of Cheryl Byard, page 5330. Ms. Ellet also told Mr. Planetta she did not want to have contact with Mr. Hyde. See, Testimony of Peter Planetta, page 8694

52 Testimony of Cheryl Byard, pages 5281–5282

53 Testimony of Cheryl Byard, page 5332

54 Testimony of Cheryl Byard, page 5283

55 Exhibit 125, page 24

56 Testimony of Cheryl Byard, page 5283

57 Testimony of Cheryl Byard, pages 5332–5333

58 Testimony of Cheryl Byard, page 5283

59 Testimony of Cheryl Byard, pages 5286–5287; 5340

60 Testimony of Cheryl Byard, page 5352

61 Testimony of Cheryl Byard, page 5271

62 Testimony of Cheryl Byard, page 5275

63 Testimony of Cheryl Byard, pages 5347–5348

64 Testimony of Cheryl Byard, page 5286

65 Testimony of Cheryl Byard, page 5334

66 Testimony of Cheryl Byard, page 5352

67 Exhibit 125, page 76

68 Testimony of Cheryl Byard, page 5287

69 Testimony of Cheryl Byard, page 5289

70 Testimony of Cheryl Byard, pages 5336–5337, 5340

71 Testimony of Cheryl Byard, pages 5293; 5298–5299; 5353–4 "I would have called to see if I could get the investigating officer…[or] their court section…"

72 Testimony of Cheryl Byard, page 5298

73 Testimony of Cheryl Byard, page 5354 "That was my interpretation."

74 Testimony of Peter Planetta, pages 8669; 8685 (Mr. Planetta has no memory of Deputy Sheriff Day's mentioning to him that Mr. Hyde was having some mental health issues.)

75 Testimony of Peter Planetta, page 8660

76 Testimony of Peter Planetta, page 8661

77 Testimony of Peter Planetta, pages 8661–8662: Mr. Planetta noted in his testimony that there are disadvantages to court ordered assessments that include the client having to discuss the case with a "psychologist" [actually, it is most likely to be a psychiatrist] with the potential for "a frank discussion and admission of guilt" that then appears in a report to the judge that is not confidential. (Testimony of Peter Planetta, page 8687)

78 Testimony of Peter Planetta, page 8687

79 Testimony of Peter Planetta, page 8688

80 Testimony of Peter Planetta, page 8683

81 Testimony of Peter Planetta, page 8664

82 Testimony of Cheryl Byard, pages 5293–5294: Peter Planetta had the same opinion, see page 8693

83 Exhibit 167

84 Testimony of Cheryl Byard, page 5303

85 Testimony of Cheryl Byard, page 5280

86 Testimony of Peter Planetta, pages 8666, 8692

87 Testimony of Peter Planetta, page 8711

88 Testimony of Cheryl Byard, pages 5343–5344

Admission to the CNSCF

The Central Nova Scotia Correctional Centre was alerted to Mr. Hyde before he arrived in the late afternoon of November 21. Correctional Officer Christopher Dixon was working in Admissions when Deputy Sheriff Crook called around 16:30 with a "heads-up"[1] that Mr. Hyde would be one of their new admissions and was showing "some signs of mental illness."[2] Correctional Officer Dixon recalls being told that Mr. Hyde was off his medication, had been in a significant[3] struggle with police, broken some cuffs[4], and been to hospital but was medically cleared.[5] D/S Crooks also relayed the information that Mr. Hyde had been tasered "four times."[6]

After getting off the telephone with D/S Crook, Correctional Officer Dixon called Health Care to let them know Mr. Hyde was going to be arriving. He passed on the information he had received from D/S Crook.[7]

When Mr. Hyde and two other prisoners arrived, they were accompanied by the required paperwork which included the Warrant of Remand[8] and Mr. Hyde's Health Information Transfer Form.[9] Because the HIT Form goes to Health Care, C/O Dixon did not read it and just checked to make sure it was there.[10]

C/O Dixon also made a point of speaking to Mr. Hyde when he got out of the Sheriffs' van, recognizing that coming into the CNSCF is intimidating especially for new prisoners. He wanted to gauge how Mr. Hyde was feeling and thought he seemed fine.[11] Even so, he had already decided that Mr. Hyde should be placed in one of the Health Segregation cells overnight, in light of what D/S Crook had told him.[12] He wanted to ensure Mr. Hyde was more closely watched than he would have been in a regular cell.[13] He knew that the officers assigned to the Health Segregation cells checked them every thirty minutes, stopping at the door and recording what the prisoner was doing at the time. [14] The Health Segregation cells are also closer to Health Care, a benefit in the event anything were to happen and medical care was required.[15] The cells themselves are really no different than the one used for administrative segregation.[16] They are simply a jail cell.[17]

It was not an option for C/O Dixon to directly send a prisoner over to the Mentally Ill Offender Unit (MIOU) which is located between the East Coast Forensic Hospital and Central Command for the CNSCF.[18] Health Care would have to pursue getting the necessary referral.[19]

C/O Dixon decided to have Mr. Hyde seen first by Health Care before the admitting process, a reversal of the usual sequence, because he wanted him seen by Health Care right away, given the information that D/S Crook had passed along.[20] He wanted that "all sorted out" before he dealt with the admissions process.[21]

The registered nurses on duty in the Offender Health Unit (OHU) are employed by the Capital District Health Authority. As the nursing shift did not end for the day until 19:00, Mr. Hyde did not have to wait until the next morning for a Health Care assessment.

When Sandra McLeod came from the OHU to Admissions she learned that Mr. Hyde had been tasered. C/O Dixon also told her he had mental health issues.[22] She agreed with the plan to lodge Mr. Hyde in a Health Segregation cell.[23]

Sitting with Mr. Hyde for about 5 minutes[24], Ms. McLeod completed the Admission Health Assessment form for the CNSCF.[25] She was not the regular admissions nurse on the Offender Health Unit but was fulfilling roles as both an admissions and charge nurse while the admissions nurse was on a temporary leave.[26] She did have experience rotating through the admissions process.[27]

While completing the assessment process for Mr. Hyde, Ms. McLeod checked his blood pressure, took his temperature and assessed his respiration and pulse.[28] She felt the time she spent with Mr. Hyde was also sufficient to "make a nursing assessment of his mental health…"[29]

Ms. McLeod noted "psychosis/schizophrenia" on the Assessment form, information she got from the HIT Form.[30] Mr. Hyde told Ms. McLeod that he was on olanzapine and she subsequently called his pharmacy for verification.[31] She was informed that Mr. Hyde had not had his prescription refilled: his last thirty day supply had been ordered on June 26, 2007. There was no record of Mr. Hyde having any olanzapine since. Ms. McLeod did not ask Mr. Hyde why he was no longer taking olanzapine.[32]

Ms. McLeod having finished with Mr. Hyde, C/O Dixon undertook his admissions process. It included Mr. Hyde having his picture taken. C/O Dixon managed to lighten the mood, cracking a few jokes and getting Mr. Hyde to smile. He also gave Mr. Hyde a bag lunch[33], a "calming technique…because [the prisoners] are in cells for quite a period of time."[34]

C/O Dixon's interview of Mr. Hyde took twenty minutes[35] and went smoothly. Mr. Hyde was mostly lucid and compliant.[36] There were only a few odd moments: Mr. Hyde losing his focus and spinning around on the stool, and then wandering off into stories about his childhood in New York. His attention would drift as he began engaging in conversations with himself.[37] At one point Mr. Hyde got up and walked away but was responsive when directed to return.[38] C/O Dixon didn't see anything extraordinary[39] about Mr. Hyde's "very bizarre"[40] behaviour and, in any event, Mr. Hyde was going to be in one of the Health Segregation cells.[41]

C/O Dixon did not examine Mr. Hyde's HIT Form or ask him about whether he was taking any medication for a mental illness because health issues were specifically dealt with by Health Care.[42] Had he not had a briefing from D/S Crook the only source of information about Mr. Hyde's health would have been the HIT Form[43] although the transporting sheriffs could have been a source and C/O Dixon would have made his own observations.[44]

Meanwhile, Ms. McLeod was working through what remained to be done in the health care context for Mr. Hyde's admission. She did not know if Mr. Hyde might have been receiving complimentary blister packs of olanzapine from Dr. Singh, information that would have been important for determining whether Mr. Hyde currently required the drug.[45] She did not contact Dr. Singh whose name Mr. Hyde had provided during the Health Admission Assessment. The QEII records indicating that Mr. Hyde had received 10 milligrams of olanzapine in the Emergency Department eventually arrived at the CNSCF but Ms. McLeod did not see them before she went off shift.[46] If she had, she may have contacted the hospital to see if Mr. Hyde should be receiving another dose.[47]

Had Mr. Hyde arrived at the CNSCF with a current prescription, it would have

been for the on-call doctor to re-order the medication upon being contacted by the OHU.[48] The CNSCF has a pharmacy on site and the OHU has a stock cupboard so medications are available and, where prescribed, distributed to prisoners by the paramedic who comes on shift when the OHU nurses finish at 19:00.[49] Where a prisoner does not have a current prescription, the policy and practice of the Offender Health Unit is to refer him for an appointment with the doctor who assesses prisoners during regular clinic hours.[50] A prisoner cannot receive medication without a physician's order.[51]

Mr. Hyde arrived at the CNSCF without any medications.[52] Ms. McLeod noted on the Admission Health Assessment form that Mr. Hyde's medication needs would be re-assessed if he returned to the CNSCF from court.[53]

Ms. McLeod saw and reviewed Mr. Hyde's HIT Form with the direction from Dr. MacIntyre. She had never seen anything like this before on a HIT Form.[54] It prompted her to call the MIOU to see if the Unit was expecting Mr. Hyde for the purposes of a forensic assessment. They weren't.[55] She also learned that Mr. Hyde had been at the hospital and so she had a member of the clerical staff, Maureen Walford, call the QEII Emergency Department to confirm that Mr. Hyde had been medically cleared.[56] Knowing that Mr. Hyde had been tasered, Ms. McLeod was particularly concerned to ensure that he did not need to return to the Emergency Department.[57] Getting Ms. Walford to make this inquiry was routine.[58]

Ms. Walford's mission was to understand why Mr. Hyde wasn't in hospital and to make sure there wasn't supposed to be some follow-up.[59] She knew from an internal Capital Health electronic records system (STAR) that Mr. Hyde had been admitted to the QEII Emergency for "cardiac arrest."[60] When she called, she spoke with the charge nurse, Glenda Keyes, whom she knew from working at the ER.[61] Ms. Walford referred to the HIT Form and read Dr. MacIntyre's direction to Ms. Keyes.[62] Ms. Keyes responded by saying, no, he did not have to come back. I don't have anything here. He doesn't have to return.[63] Ms. Walford stressed that Mr. Hyde was not at the ECFH but was 'in jail."[64] She wanted to be sure Ms. Keyes understood that Mr. Hyde was not receiving any psychiatric services.[65] She was told, "he doesn't have to be returned" and Ms. Keyes confirmed that, yes, he was medically cleared.[66]

Ms. Walford was able to determine from the STAR system that Mr. Hyde had a psychiatric history and had previously been a patient at the Nova Scotia Hospital. She communicated this to Ms. McLeod.[67]

Ms. McLeod did not direct Ms. Walford to find out from the QEII if Mr. Hyde had received any medication while he was there.[68] Ms. Walford would have had Ms. McLeod and Ms. Keyes discuss any medication issues had they come up when she called the ER.[69] There was no indication on Mr. Hyde's HIT Form that he had received the 10 mgs. olanzapine in the Emergency Department. Ms. McLeod would have found it helpful to have known that.[70] She understood olanzapine was a medication used to treat psychosis.[71]

Ms. McLeod had observed no signs of Mr. Hyde's psychosis during the short assessment she conducted of him[72]: he was cooperative and answered her questions appropriately.[73] She saw no reason to contact the on-call doctor.[74] She did not have any concern that Mr. Hyde needed medication.[75] He did not present as "acutely ill"[76] although Ms. McLeod noted that he was "rambling a lot" and repeating himself.[77] He was "a little excited…happy…a little bit elevated…in a great mood."[78] He followed direction and she found him to be calm, pleasant and polite.[79] Ms. McLeod's view of Mr. Hyde's stability was based on his responses to her questions

as she went through the Health Admissions Assessment form – date of birth, how long he had been in police custody etc.[80]

Ms. McLeod saw herself as having no authority to get Mr. Hyde transferred to the Emergency Department in circumstances where she had made an assessment that he was not acutely ill.[81] In her view, it was her assessment that prevailed.[82] The reference in the HIT Form to Mr. Hyde having a "forensic psychiatric assessment" spoke to Ms. McLeod of an assessment that would be done at the ECFH and did not require Mr. Hyde to be returned to the QEII.[83] Ms. McLeod saw Mr. Hyde's circumstances in these terms:

> He didn't require any emergency psychiatric assessment from us. Based on my assessment of him, he didn't appear acutely ill, that if he was to return the next morning, we could contact the on-call physician, who then would contact the on-call psychiatrist and he would be assessed here.[84]

Ms. McLeod understood that Mr. Hyde would be spending the night at the correctional centre. She did not have concerns that he should be in a hospital.[85] In her opinion, Mr. Hyde was not "unfit for detention."[86] The Health Segregation cell seemed to be the best correctional option for a prisoner with an indication of "psychosis" as she had noted on the Assessment Form: providing a less intense environment than a cell in general population.[87]

Mr. Hyde was informed by Ms. McLeod that if he needed to speak to a nurse he could tell the correctional officers and they would get a nurse to come and see him.[88]

Before completing her shift, Ms. McLeod spoke with Kenneth Murray, the physician's assistant and PRAXES[89] employee who was to provide health care coverage in the OHU overnight. She told him that Mr. Hyde was in a Health Segregation cell, that he had been tasered and had a history of schizophrenia. Mr. Murray would have had access at the OHU to Mr. Hyde's HIT Form and the Health Admission Assessment form completed by Ms. McLeod because he needed to prepare a new HIT form to accompany Mr. Hyde back to court the next morning.[90]

Ms. McLeod did not suggest to Mr. Murray that he should look in on Mr. Hyde during the night[91]; the routine was for correctional staff to do the rounds of the Health Segregation cells and bring any concerns to Health Care.[92] In Ms. McLeod's words, Health Care staff are told:

> …they're offenders, so we consider them all offenders.[93]

Accordingly, it is correctional staff who monitor the prisoners in Health Segregation cells. Ms. McLeod, who had been a registered nurse for eighteen years and spent six months working at the ECFH[94], gave no instructions to any of the correctional officers as to what to be on the look-out for in the case of a prisoner with psychosis.[95] In order for the correctional officers to alert Health Care of a problem, they would have to recognize the problem first themselves.[96] Ms. McLeod had some experience, from working at the ECFH, with persons diagnosed with schizophrenia who were not taking their medication. She knew that there could be mood and behavioural changes including increased aggression and violence, confusion and delusions.[97]

Ms. McLeod told the Inquiry she is quite confident that the PRAXES staff who provide Health Care coverage overnight at the CNSCF are "competent."[98] Ms. McLeod went off shift with no concerns about how Mr. Hyde would pass the

night.[99] She was unfazed by the prospect that he wasn't going to sleep because many prisoners don't.[100] She was not concerned that lack of sleep might affect his behaviour, based on her experience of seeing "several people with schizophrenia that don't sleep for days" with no adverse effects.[101]

Hoping that Mr. Hyde was receiving medical treatment, Ms. Ellet called the Nova Scotia Hospital on the afternoon of November 21.[102] When she was told Mr. Hyde was not a patient there, she called the CNSCF. She made that call around 20:00 on November 21 to tell them how sick Mr. Hyde was. She identified herself as Mr. Hyde's common law spouse.[103] She wanted Mr. Hyde to be in hospital and receive proper medical treatment for his psychosis. She tried to communicate this concern.[104] The correctional officer she spoke to would not talk to her, citing prisoner confidentiality rights. [105]

Notes

1 Testimony of C/O Christopher Dixon, page 5433

2 Testimony of C/O Christopher Dixon, page 5433

3 Testimony of C/O Christopher Dixon, page 5498

4 C/O Dixon assumed the reference by D/S Crook to "cuffs" meant metal handcuffs. (Testimony of C/O Dixon, page 5546)

5 Testimony of C/O Christopher Dixon, pages 5433–5434

6 Testimony of C/O Christopher Dixon, page 5461; Exhibit 179, page 8

7 Testimony of C/O Christopher Dixon, page 5436

8 Exhibit 167

9 Testimony of C/O Christopher Dixon, page 5438

10 Testimony of C/O Christopher Dixon, page 5439

11 Testimony of C/O Christopher Dixon, pages 5440–5441

12 Testimony of C/O Christopher Dixon, pages 5444–5559

13 Testimony of C/O Christopher Dixon, page 5444

14 Testimony of C/O Christopher Dixon, page 5463

15 Testimony of C/O Christopher Dixon, pages 5446; 5512; 5554

16 Testimony of C/O Christopher Dixon, page 5554

17 Testimony of Sandra McLeod, R.N., page 5761

18 Testimony of C/O Christopher Dixon, page 5548

19 Testimony of C/O Christopher Dixon, page 5549

20 Testimony of C/O Christopher Dixon, pages 5505–5506; 5507

21 Testimony of C/O Christopher Dixon, page 5507

22 Testimony of C/O Christopher Dixon, page 5447

23 Testimony of C/O Christopher Dixon, pages 5447–5561: Even if Mr. Hyde had been the subject of a court-ordered assessment, in November 2007, he would have spent the night, as he did, in a Health Segregation cell because at that time the ECFH did not accept new admissions after 17:00. (Testimony of C/O Dixon, page 5435)

24 Although Ms. McLeod testified to her belief that the interview with Mr. Hyde lasted 15–20 minutes (Testimony of Sandra McLeod, R.N., page 5626), the video surveillance evidence from the CNSCF shows Mr. Hyde being interviewed for 5 minutes, from 17:02:39 – 17:07:41 on Exhibit 60, Tab 9, 17 clips "medical questions", also Exhibit 170, in a format edited to protect the identity of other individuals.

25 Exhibit 79A, Tab 5

26 Testimony of Sandra McLeod, R.N., page 5690

27 Testimony of Sandra McLeod, R.N., page 5735
28 Testimony of Sandra McLeod, R.N., page 5732
29 Testimony of Sandra McLeod, R.N., page 5742
30 Testimony of Sandra McLeod, R.N., pages 5618–5619
31 Testimony of Sandra McLeod, R.N., page 5597
32 Testimony of Sandra McLeod, R.N., page 5761
33 Exhibit 60, Tab 9, video DVD comprised of 17 clips: Medical Questions, 17:02 – 17:10
34 Testimony of C/O Christopher Dixon, page 5490
35 Testimony of C/O Christopher Dixon, page 5466
36 Testimony of C/O Christopher Dixon, page 5550
37 Testimony of C/O Christopher Dixon, pages 5543–5544
38 Testimony of C/O Christopher Dixon, page 5464
39 Testimony of C/O Christopher Dixon, page 5583
40 Testimony of C/O Christopher Dixon, pages 5544–5545
41 Testimony of C/O Christopher Dixon, page 5465
42 Testimony of C/O Christopher Dixon, pages 5508–5509; 5552–5553; 5586
43 Testimony of C/O Christopher Dixon, page 5567
44 Testimony of C/O Christopher Dixon, page 5568
45 Testimony of Sandra McLeod, R.N., pages 5686–5687
46 Testimony of Sandra McLeod, R.N., page 5685
47 Testimony of Sandra McLeod, R.N., page 5686
48 Testimony of Sandra McLeod, R.N., page 5613
49 Testimony of Sandra McLeod, R.N., pages 5613–5614
50 Testimony of Sandra McLeod, R.N., pages 5608–5609; 5749
51 Testimony of Sandra McLeod, R.N., page 5743
52 Testimony of Sandra McLeod, R.N., pages 5614; 5712
53 Exhibit 79A, Tab 5, page 2; Testimony of Sandra McLeod, R.N., pages 5625
54 Testimony of Sandra McLeod, R.N., pages 5612, 5640
55 Testimony of Sandra McLeod, R.N., pages 5599–5600
56 Testimony of Sandra McLeod, R.N., page 5601
57 Testimony of Sandra McLeod, R.N., page 5644
58 Testimony of Maureen Walford, page 5798
59 Testimony of Maureen Walford, pages 5769–5770
60 Testimony of Maureen Walford, page 5774
61 Testimony of Maureen Walford, page 5770
62 Testimony of Maureen Walford, page 5789
63 Testimony of Maureen Walford, page 5790
64 Testimony of Maureen Walford, page 5770
65 Testimony of Maureen Walford, page 5778
66 Testimony of Maureen Walford, page 5770
67 Testimony of Maureen Walford, pages 5787–5788
68 Testimony of Sandra McLeod, R.N., page 5712
69 Testimony of Maureen Walford, page 5791
70 Testimony of Sandra McLeod, R.N., page 5730

71 Testimony of Sandra McLeod, R.N., page 5760

72 Testimony of Sandra McLeod, R.N., page 5636

73 Testimony of Sandra McLeod, R.N., pages 5607; 5725; 5741

74 Testimony of Sandra McLeod, R.N., page 5608

75 Testimony of Sandra McLeod, R.N., pages 5620–5621

76 Testimony of Sandra McLeod, R.N., page 5656

77 Testimony of Sandra McLeod, R.N., pages 5638–5639, referring to her RCMP statement of November 26, 2007

78 Testimony of Sandra McLeod, R.N., pages 5639–5640

79 Testimony of Sandra McLeod, R.N., page 5736

80 Testimony of Sandra McLeod, R.N., page 5758

81 Testimony of Sandra McLeod, R.N., page 5641

82 Testimony of Sandra McLeod, R.N., page 5642

83 Testimony of Sandra McLeod, R.N.,, page 5644

84 Testimony of Sandra McLeod, R.N., pages 5644–5645

85 Testimony of Sandra McLeod, R.N., pages 5603; 5745–5746

86 Testimony of Sandra McLeod, R.N.,, page 5688

87 Testimony of Sandra McLeod, R.N., page 5603

88 Testimony of Sandra McLeod, R.N., page 5693

89 The company contracted by the CDHA to provide health care coverage overnight at the CNSCF.

90 Testimony of Sandra McLeod, R.N., pages 5650; 5698

91 Testimony of Sandra McLeod, R.N., page 5652

92 Testimony of Sandra McLeod, R.N., pages 5652–5653

93 Testimony of Sandra McLeod, R.N., page 5683

94 Testimony of Sandra McLeod, R.N., pages 5654; 5719–5720

95 Testimony of Sandra McLeod, R.N., pages 5685; 5713

96 Testimony of Sandra McLeod, R.N., page 5688. Ms. McLeod acknowledged to the Inquiry that there could be "a gap" if correctional officers did not recognize they should be contacting Health Care about a prisoner.

97 Testimony of Sandra McLeod, R.N., pages 5709-5710

98 Testimony of Sandra McLeod, R.N., page 5687

99 Testimony of Sandra McLeod, pages 5712–5713

100 Testimony of Sandra McLeod, R.N., page 5752

101 Testimony of Sandra McLeod, R.N., page 5763

102 Testimony of Karen Ellet, page 149

103 Testimony of Karen Ellet, page 154

104 Testimony of Karen Ellet, page 191

105 Testimony of Karen Ellet, pages 129, 139

Overnight in Health Segregation Cell #11

During the time that Mr. Hyde was lodged in Health Segregation Cell #11, he was monitored by four correctional officers –Stephen Kayongo and Bradley Morris who did rounds on the unit through the night, and Michael Oliver and Earnest MacRae who staffed the Main and North Control stations. At 07:00 on November 22, C/O Morris was relieved by C/O Christopher Digout. As of November 21, 2007, Officer Kayongo had been a correctional officer for about a year.[1] Officer Morris had worked as a correctional officer for just under two months.[2] None of the correctional staff had had any training in relation to mental health issues in the corrections context or otherwise.

The correctional officers' role was to provide security. Health Care was responsible for any medical issues the prisoners might have.[3] The only other person to observe Mr. Hyde during the night of November 21/22 was Ken Murray, the PRAXES paramedic.

When Mr. Hyde was placed in cell #11, he was instructed that the camera and the lights were on and had to remain uncovered at all times. He was informed that he could call on his intercom if he needed the correctional officers [4] and that the correctional officers would be checking on him every half hour.[5] C/O Kayongo found Mr. Hyde to be composed and saw no problems with him at that time.[6] He did not know anything about the circumstances that had brought Mr. Hyde to the correctional centre.[7] He knew Mr. Hyde was not at the CNSCF for a court-ordered assessment and passed this information along to C/O Morris at shift-change.[8]

Between 19:30 and 20:00 C/O Kayongo brought Mr. Hyde some juice.[9] Before opening the cell door, he poured the juice into a cup because Mr. Hyde was pacing back and forth. Mr. Hyde responded in an unusual way, asking C/O Kayongo: "Are you coming in to get me?"[10] C/O Kayongo told him, no, he was just offering him some juice if he wanted it.[11] He thought the question was odd; it wasn't the kind of question he was used to prisoners asking.[12] This was the only time in over twelve hours between the late afternoon of November 21 and the early morning of November 22 that Mr. Hyde had any face-to-face contact with anyone.[13]

The video surveillance of Health Segregation cell #11 shows Mr. Hyde at 18:57 hrs apparently pushing a buzzer on the cell wall.[14] If this activated the intercom system for the cell, it would have been picked up by North control. North control would have then have radioed the correctional officers doing rounds in Health Segregation to deal with the matter.[15]

The camera in Health Segregation cell #11 did not project an image on the CNSCF Main Control monitors automatically. If a prisoner activated the intercom buzzer in his cell, it would come up on the DXI box (intercom) at North or Main

Control. The officer working at Control would "acknowledge" the DXI box with the result that the camera image from the cell would be displayed on a monitor and the Control officer could then talk with the prisoner.[16] The DXI box beeps to indicate a call and will keep beeping until the call is acknowledged. An intercom call has to be acknowledged before other intercom calls can be dealt with.[17]

Up until 23:00, North Control handles the intercom calls from Health Segregation cells. At 23:00 that responsibility is assumed by Main Control.[18] Neither of the officers on shift at North Control (18:45 November 21 to 23:00 November 22) or Main Control (20:30 November 21 to 06:45 November 22) recall being "buzzed" by Mr. Hyde or having any dealings with him.[19]

There is the possibility that the intercom had been disabled by a previous prisoner. It was not tested on the overnight shift and cell searches that might have incidentally detected a problem with the system were not conducted every day.[20]

Had the Main Control officer seen Mr. Hyde pacing in the cell it would not have seemed remarkable as pacing is typical for prisoners.[21] All-night pacing would have merited an inquiry to ensure everything was alright.[22]

Mr. Hyde continued to pace through the night. C/O Kayongo was doing rounds to observe him every thirty minutes and noticed he was pacing and yelling, talking to himself at a high volume which could be heard through the cell door. While on his rounds, between his first observations of Mr. Hyde in the cell at 17:41 and his final recorded entry into the incident report system, C/O Kayongo made nine further entries of Mr. Hyde's activities: 17:59, 18:30, 19:02, 20:03, 20:35, 21:05, 21:39, 22:05, and 22:38. All entries recorded Mr. Hyde being awake and active in his cell.[23] C/O Kayongo observed him pacing back and forth in the cell and yelling and talking to himself.[24] None of the other prisoners on C/O Kayongo's watch were pacing back and forth.[25]

Although C/O Kayongo had no training on dealing with prisoners who had mental health issues,[26] he was concerned about Mr. Hyde's continuous pacing. He had seen other prisoners pace but not to the extent he was observing with Mr. Hyde.[27] He saw it as normal that a prisoner would pace around the cell, but not for such an extended period of time.[28] Usually after some pacing, prisoners settle down and may try to sleep.[29] At some point in the night, likely in the hour before the shift change at 23:00[30], C/O Kayongo made a note to alert his relief about Mr. Hyde: "Howard Hyde seems out of his 'marbles'. He keeps talking and shouting to himself and pacing in his cell. Needs to be checked on."[31] He wanted the next shift to keep "an extra eye" on Mr. Hyde given how he was presenting.[32]

C/O Kayongo also made a note in the Segregation Pass On Book, indicating: "Howard Hyde H/seg 11 keeps talking to himself and shouting to himself. He does not seem to be there."[33] The reference to Mr. Hyde being out of his 'marbles' was C/O Kayongo's way of conveying that Mr. Hyde was exhibiting signs of mental illness.[34] He meant no disrespect by the use of this language: he was just trying to convey the worrisome behavior Mr. Hyde was exhibiting.[35]

C/O Kayongo's concerns about Mr. Hyde did not take long to develop.[36] He had already mentioned them to Ken Murray, by 20:00 – 20:15 which is when Mr. Murray did his medication rounds.[37] C/O Kayongo told Mr. Murray about Mr. Hyde's pacing and yelling to himself and asked to have him assessed.[38] C/O Kayongo wanted to get Mr. Hyde settled down before the end of his shift so his relief would not have to worry too much about his mental state.[39] He also made mention of Mr. Hyde's pacing to his captain.[40]

Mr. Murray did speak to Mr. Hyde, through the second of the two doors to the cell. He did not go into the cell.[41] C/O Kayongo did not unlock the second cell door because Mr. Murray was not administering any medication to Mr. Hyde.[42] Had Mr. Murray wanted to go into the cell to speak to Mr. Hyde, the door would have been opened to allow him to do so.[43] C/O Kayongo did not hear the exchange between Mr. Murray and Mr. Hyde and Mr. Murray did not tell C/O Kayongo anything about what had been said.[44] After the visit from Mr. Murray, Mr. Hyde's yelling lessened "a tiny bit" but he kept pacing.[45]

The visit to Mr. Hyde was brief, maybe five minutes.[46] It was Mr. Murray's impression that Mr. Hyde was "very apprehensive and scared".[47] He told Mr. Murray that "they" were going to take him down a tunnel and he wouldn't get out, a statement he was unable to explain.[48]

The "tunnel" comment that Mr. Murray claims to recall Mr. Hyde making could have been a foretelling of the next morning's events. When questioned at the Inquiry, Mr. Murray testified he had not been asked by anyone about his dealings with Mr. Hyde[49], and had no discussion of any significance about Mr. Hyde at the CNSCF on November 22 when he went back to work[50]. He also had not been following the evidence of the Inquiry either in the newspaper or on the webcast before testifying.[51] This all suggests that there was no source for Mr. Murray's description of what Mr. Hyde said to him other than Mr. Hyde himself. That being said, Mr. Murray's recollection of his contact with Mr. Hyde was so flawed it is hard to have confidence in this piece of his narrative. In any event, whether Mr. Hyde was growing fearful overnight or not, the evidence is unambiguous about his state of mind the next morning at the top of the long hallway, as I discuss in Chapter 24. And the evidence is also clear that Mr. Murray made no record of his perfunctory interaction with his patient.[52]

Mr. Murray does not clearly recall if he saw HIT Form that accompanied Mr. Hyde from the QEII [53] but did know, from the report provided by Health Care when he began his shift around 18:30, that he had a diagnosis of schizophrenia.[54] He also recalls being told that Mr. Hyde would be going for an assessment when he returned from court.[55] He determined that Mr. Hyde was not in need of emergency medical assistance, basing this on his own assessment and also the fact that Mr. Hyde had been medically cleared by a doctor for release from hospital and assessed by the Health Care nurse at the time of his admission to the CNSCF.[56] In his view, there was nothing he needed to address on an emergency basis as Mr. Hyde was to be psychiatrically assessed the next day and his mental health issues would be dealt with at that time.[57]

C/O Bradley Morris relieved C/O Kayongo at the 23:00 hour shift change on November 21. C/O Kayongo informed him that Mr. Hyde was pacing, yelling and talking to himself throughout the previous shift.[58] C/O Morris also saw the "out of his marbles" notation in the changeover log.[59] This did not cause him any alarm. He reasoned that as Mr. Hyde was in a cell close to the office, he would be able to keep checking on him by standing up and looking through the window. He did not regard the pacing, talking and yelling he was told about as out of the ordinary, based on his experience.[60]

During C/O Morris' shift there were no meals, juice or medication rounds.[61] He did not find that Mr. Hyde did much yelling during the night.[62] He heard Mr. Hyde shouting at times, and talking loudly to himself but not yelling at anyone or trying to get his attention.[63] He had some minimal interaction with Mr. Hyde, tell-

ing him a couple of times to take a break from his pacing by sitting or lying down and relaxing. Mr. Hyde would sit for a little while, "But then he'd be back up and walking around again."[64] At one point, around 02:20[65] it looked as though Mr. Hyde might be talking into a cell phone although C/O Morris, who knew he had been strip-searched, did not think he had one.[66] At another point he said, "Don't shoot me", which C/O Morris found a little strange.[67] It happened when C/O Morris was on his rounds using the recording wand outside Mr. Hyde's cell.[68] C/O Morris treated the cell phone reference as a security issue, asking the control post to observe Mr. Hyde on the monitor and advising his supervisor.[69] He contrasted Mr. Hyde's behavior to the more violent acting out of some prisoners who kick, scream and try to break the sprinklers and the lights, and concluded that Mr. Hyde's affect was "good".[70] He was looking for signs of Mr. Hyde having physical problems or being in any "medical distress" of a physical nature.[71] He didn't see anything that made him think there was a need to contact the paramedic.[72] Like C/O Kayongo, he had no training in relation to mental health issues.[73]

During his eight hour shift, Mr. Morris "wanded" Mr. Hyde's cell activity fifteen times: 23:16, 23:45, 00:16, 00:33, 01:10, 01:47, 02:22, 02:24, 02:46, 03:21, 04:14, 04:45, 05:15, 05:43, and 06:42.[74] He recorded Mr. Hyde to be active in the cell or talking except for a few short intervals when the downloaded wand recordings indicate he was apparently asleep.[75] A viewing of cell #11's video surveillance shows Mr. Hyde pacing and gesturing for 12 hours and 9 minutes and off his feet for a total of 51 minutes.

Correctional Officers Christopher Digout and Algernon Smith relieved C/O Morris at 07:00. C/O Digout was informed that Mr. Hyde had been up all night, pacing, talking to himself, at times "screaming".[76] He was given a "heads-up" to keep an eye on Mr. Hyde due to the unusual behavior.[77] C/O Digout reviewed the notation C/O Kayongo had made about Mr. Hyde being "out of his marbles." He does not now recall if he saw the note in the Segregation Pass On Book.[78] He interpreted the "marbles" comment as possibly, but not necessarily referring to a mental health issue.[79]

C/O Digout did a "takeover" round and said hello to Mr. Hyde, who was still pacing, to see what response he would get. Mr. Hyde muttered in reply but C/O Digout could not make out what he said.[80] C/O Morris saw no need to contact health care. Mr. Hyde was not presenting any new behaviours nor was he being violent. C/O Digout either assumed Mr. Hyde would have been seen by Health Care the day before at the time of his admission[81], or he was advised by C/O Morris of Mr. Hyde having contact with Health Care[82], although he did not know anything about what health conditions Mr. Hyde might have.[83] He thought Mr. Hyde was much calmer than what had been described to him as his demeanor during the night.[84] Mr. Hyde was still pacing and did seem confused about going to court.[85]

C/O Digout's reliance on Health Care's assessment of prisoners at the admission stage is a shared view. As another correctional officer testified:

> They admitted him and then they would have been around the unit he was in. That night they would have talked to him. They know their job…So if they had no concerns about it, like his mental health issues, then I wouldn't have no concerns because I wouldn't know.[86]

Had C/O Digout known that Mr. Hyde had a diagnosis of schizophrenia and was off his medication, he probably would have contacted Health Care "given the

fact that I knew he was going to court in a short period of time."[87] He also would have contacted Health Care if he had seen Mr. Hyde start to escalate and shout.[88] He did not regard it as necessary to do so, based on the behaviour Mr. Hyde was exhibiting.[89] Like his colleagues, C/O Digout had no training in mental health issues.[90]

When C/O Digout told Mr. Hyde about 10 – 15 minutes later that he was going to bring him some breakfast, he got a response that he took to be an acknowledgement by Mr. Hyde of what was happening.[91] This was around 07:15 and just before the arrival of the correctional officers who were assigned to escort prisoners from Health Segregation to Admitting for the purpose of getting them processed for court.[92] Either C/O Digout [93]or C/O Smith[94] delivered a bagged breakfast to Mr. Hyde in his cell. This was handed to Mr. Hyde at 07:40 through the opened door of his cell.[95] This brief opening of Mr. Hyde's cell appears to be the first time Mr. Hyde had any face-to-face contact with anyone in the twelve hours since C/O Kayongo gave him juice the night before. The short exchanges that C/O Digout recalls having with Mr. Hyde must have been through the closed cell door as the video surveillance does not indicate that Mr. Hyde's cell was opened until Mr. Hyde was given his breakfast.

When handed the bagged breakfast, Mr. Hyde continued to pace. He carried the breakfast very briefly for a few turns in his cell and then put it down and kept pacing. At 07:42 Mr. Hyde left his cell, taking the breakfast with him, untouched.[96]

Notes

1 Testimony of C/O Stephen Kayongo, page 5800

2 Testimony of C/O Bradley Morris, page 5893

3 Testimony of C/O Stephen Kayongo, page 5861

4 Testimony of C/O Stephen Kayongo, page 5845. There were two lights in cell #11, a bright day light and a night light. A prisoner had to request the day light be turned off or it would be left on all night. Some prisoners preferred that. (Kayongo, page 5845)

5 Testimony of C/O Stephen Kayongo, page 5809

6 Testimony of C/O Stephen Kayongo, page 5809

7 Testimony of C/O Stephen Kayongo, pages 5828–5829. This has since changed and correctional officers are told whether a prisoner is being placed in Health Segregation cells for psychiatric or medical reasons. (Kayongo, page 5866)

8 Testimony of Bradley Morris, page 5895

9 Testimony of Stephen Kayongo, page 5810; Exhibit 59B, 19:47 hours

10 Testimony of C/O Stephen Kayongo, page 5810

11 Testimony of C/O Stephen Kayongo, pages 5811; 5825

12 Testimony of C/O Stephen Kayongo, page 5811

13 Testimony of C/O Stephen Kayongo, page 5867

14 Exhibit 59B

15 Testimony of C/O Stephen Kayongo, page 5821. An activated intercom from Health Segregation would go to North control before 23:00 hours and Main control after that. If North/Main control could answer a prisoner's question they would do so but otherwise would radio the officers doing rounds in the unit. (Testimony of C/O Stephen Kayongo, page 5821)

16 Testimony of C/O Michael Oliver, page 8415

17 Testimony of C/O Michael Oliver, page 8423; Testimony of C/O Earnest MacRae, page 8445

18 Testimony of C/O Michael Oliver, page 8424

19 Testimony of C/O Ernest MacRae, page 8442; Testimony of C/O Michael Oliver, page 8416

20 Testimony of C/O Michael Oliver, pages 8425–8426

21 Testimony of C/O Michael Oliver, page 8417. C/O Ernest McRae also viewed pacing as common for prisoners. He would have contacted Health Care if he observed a prisoner harming himself.

22 Testimony of C/O Michael Oliver, page 8417

23 Exhibit 111 (Report of Paul Martell, "In Custody Death of Howard Hyde") pages 68–75 "Activity in cell": See also Exhibits 59B through H which show Mr. Hyde pacing almost continuously. At various points he takes off his shirt for awhile, puts it back on and then later, takes it off again.

24 Testimony of C/O Stephen Kayongo, page 5815

25 Testimony of C/O Stephen Kayongo, page 5816

26 Testimony of C/O Stephen Kayongo, pages 5803, 5819

27 Testimony of C/O Stephen Kayongo, pages 5817, 5864

28 Testimony of C/O Stephen Kayongo, page 5820

29 Testimony of C/O Stephen Kayongo, page 5826

30 Testimony of C/O Stephen Kayongo, page 5838

31 Exhibit 130 (Department of Justice Report from Paul Dorrington, November 22, 2007), page 15; also found in Exhibit 111 (Report of Paul Martell "In Custody Death of Howard Hyde", April 2, 2008) page 62

32 Testimony of C/O Stephen Kayongo, page 5839

33 Exhibit 183

34 Testimony of C/O Stephen Kayongo, page 5830 – "His mind wasn't there."

35 Testimony of C/O Stephen Kayongo, pages 5866–5867

36 Up until the nurse in the Offenders Health Unit went off shift at 19:00, C/O Kayongo did not have concerns about Mr. Hyde. (Testimony of C/O Stephen Kayongo, pages 5856–5857) The evidence indicates that Mr. Hyde just kept pacing, leading to C/O Kayongo developing concerns about its unrelenting character.

37 Testimony of C/O Stephen Kayongo, page 5841

38 Testimony of C/O Stephen Kayongo, page 5840

39 Testimony of C/O Stephen Kayongo, page 5851

40 Testimony of C/O Stephen Kayongo, page 5852

41 Testimony of C/O Stephen Kayongo, pages 5842–5843. In his evidence, Kenneth Murray initially recalled going into Mr. Hyde's cell and meeting with him, even to the point of remembering that he took Mr. Hyde's pulse. (Testimony of Kenneth Murray, page 8580) However, when it was pointed out to him that the video surveillance of the cell did not show him entering it, he acknowledged that he must have spoken to Mr. Hyde through the door. (Testimony of Kenneth Murray, page 8589)

42 Testimony of C/O Stephen Kayongo, page 5843

43 Testimony of C/O Stephen Kayongo, page 5862

44 Testimony of C/O Stephen Kayongo, pages 5842, 5844

45 Testimony of C/O Stephen Kayongo, pages 5864–5865

46 Testimony of Kenneth Murray, page 8577

47 Testimony of Kenneth Murray, pages 8575, 8603, 8629

48 Testimony of Kenneth Murray, page 8575

49 Testimony of Kenneth Murray, page 8593

50 Testimony of Kenneth Murray, pages 8593–8594

51 Testimony of Kenneth Murray, page 8631

52 Testimony of Kenneth Murray, pages 8576, 8603

53 Testimony of Kenneth Murray, pages 8572; 8621–8622 ("I did not see [the HIT Form]") ("I believe that I did see it…but I am not positive. I think there is a possibility.")

54 Testimony of Kenneth Murray, pages 8575, 8590

55 Testimony of Kenneth Murray, page 8623

56 Testimony of Kenneth Murray, page 8613

57 Testimony of Kenneth Murray, pages 8628–8630

58 Testimony of C/O Bradley Morris, page 5874; see also, Testimony of C/O Stephen Kayongo, page 5853

59 Testimony of C/O Bradley Morris, page 5874. Although it was his practice to review this log book at shift changeover, Mr. Morris does not recall if he also saw the Segregation Pass On Book notation by C/O Kayongo

60 Testimony of C/O Bradley Morris, page 5875

61 Testimony of C/O Bradley Morris, page 5872

62 Testimony of C/O Bradley Morris, page 5887

63 Testimony of C/O Bradley Morris, page 5877

64 Testimony of C/O Bradley Morris, pages 5876–5877

65 Testimony of C/O Bradley Morris, page 5896

66 Testimony of C/O Bradley Morris, pages 5890–5891

67 Testimony of C/O Bradley Morris, page 5876

68 Testimony of C/O Bradley Morris, page 5892. The electronic wand system has a different code for the prisoner's cell activities – appears asleep, activity in cell, sitting on the bed, talking – which the correctional officers input when they do their observation rounds. (Testimony of C/O Stephen Kayongo, pages 5806–5807)

69 Testimony of C/O Bradley Morris, pages 5875–5876

70 Testimony of C/O Bradley Morris, page 5876

71 Testimony of C/O Bradley Morris, pages 5879, 5881

72 Testimony of C/O Bradley Morris, page 5879

73 Testimony of C/O Bradley Morris, pages 5870, 5879

74 Exhibit 111 (Report of Paul Martell "In Custody Death of Howard Hyde"), pages 77–88

75 Exhibit 111 (Report of Paul Martell "In Custody Death of Howard Hyde"), pages 80, 81 and 84

76 Testimony of C/O Christopher Digout, page 6045. See also, Exhibit 111, page 30, C/O Digout's incident report.

77 Testimony of C/O Christopher Digout, page 6045

78 Testimony of C/O Christopher Digout, page 6054

79 Testimony of C/O Christopher Digout, page 6058. The other option in C/O Digout's mind was that Mr. Hyde may have been under the influence of a substance. (Testimony of C/O Christopher Digout, page 6059)

80 Testimony of C/O Christopher Digout, page 6046

81 Testimony of C/O Christopher Digout, page 6062

82 Testimony of C/O Christopher Digout, page 6063

83 Testimony of C/O Christopher Digout, page 6047

84 Testimony of C/O Christopher Digout, pages 6064–6065

85 Testimony of C/O Christopher Digout, pages 6049, 6065, 6075. See also, Exhibit 111, page 30, C/O Digout's incident report.

86 Testimony of C/O Ernest MacRae, pages 8442 and 8443

87 Testimony of C/O Christopher Digout, page 6047

88 Testimony of C/O Christopher Digout, page 6069

89 Testimony of C/O Christopher Digout, page 6070

90 Testimony of C/O Christopher Digout, page 6070

91 Testimony of C/O Christopher Digout, page 6048

92 Testimony of C/O Christopher Digout, page 6048

93 Testimony of C/O Christopher Digout, page 6074

94 Testimony of C/O Algernon Smith, page 6234. It was probably C/O Smith; see Exhibit 60, Tab 10:9, C/O Algernon Smith's Information Report dated November 22, 2007, 10:15

95 Exhibit 59I, 07:40:22

96 Exhibit 59I, 07:42

Going to Court – The Morning Escort of Howard Hyde (November 22, 2007)

At 07:35[1] Correctional Officer Peter Lloyd, as the main floater[2], arrived at Health Segregation to escort Mr. Hyde to Admissions and Discharge [Admissions] in preparation for his transport to court. C/O Renee Jones was also on hand for the escort. Usually only one officer goes to Health Segregation to collect a prisoner and she had expected to be doing another escort but her prisoner was not there.[3]

C/O Digout advised C/O Lloyd that Mr. Hyde had been up all night but had presented him with no problems.[4] He did not pass along the information C/O Kayongo had recorded in the log book about Mr. Hyde being "out of his marbles"[5] because Mr. Hyde seemed much calmer to him. He considered that he conveyed similar information.[6]

Although not standard procedure[7], it was not unusual for the escorting officers to be given some information at Health Segregation about a prisoner, such as why the person was there, and whether there were any special issues to be aware of.[8] Whether provided to the escorting officers or inquired about by them, information about a prisoner can be helpful for taking any necessary precautions during the escort.[9]

When C/O Digout opened Mr. Hyde's cell and informed him that an officer had come to take him to court, Mr. Hyde responded by saying he was not sure he wanted to go to court.[10] Once C/O Digout explained that he had a court appointment and was required to go with the officer, Mr. Hyde complied and was calm and cooperative.[11]

C/O's Lloyd and Jones did not speak to Mr. Hyde as he did not initiate any conversation.[12] It was their practice not to make any effort to get their prisoner to talk to them in case he didn't want to.[13] Mr. Hyde was quiet and "normal."[14] He walked along carrying his bag breakfast.[15]

Neither C/O Lloyd nor C/O Jones knew that Mr. Hyde had a diagnosis of schizophrenia and was off his medications.[16] The officers were not told that Mr. Hyde had been tasered during a struggle with Halifax police.[17] C/O Jones assumed that any relevant information would have been passed on to them by the correctional staff working in Health Segregation.[18] Had C/O Lloyd known about the events at HRPS Booking he would have ensured that Mr. Hyde was handcuffed before he left the Health Segregation cell.[19] C/O Jones testified that if she had known before the escort about Mr. Hyde's mental health issues and the tasering she would have made a greater attempt to communicate with him and verbally distract him.[20]

C/O Jones left C/O Lloyd and Mr. Hyde at the doorway at Main Control to col-

lect handcuffs from North Control for the escort of another prisoner.[21]

Mr. Hyde had seemed to C/O Lloyd to be an appropriate candidate to walk unescorted down the long hallway.[22] He was intending to radio Admissions once Mr. Hyde was on his way.[23] It was not a requirement for correctional officers to walk a prisoner right into Admissions. An alternative, in the right circumstances, was to radio Admissions and tell them a prisoner was on his way down.[24]

At the intersection with the long hallway, Mr. Hyde stopped. He indicated to C/O Lloyd he was not going any further.[25] He seemed afraid and said there were "bad things down there."[26] C/O Lloyd tried to explain there was nothing bad down in the hallway, that officers were waiting for him as soon as he went through the door at the end of the hallway, that he had nothing to be afraid of, and would be okay[27].

Mr. Hyde insisted he wasn't going. He became adamant.[28] C/O Lloyd kept talking to him, trying to reassure and persuade him. He testified that he called Mr. Hyde "friend" and lowered his voice[29]. Mr. Hyde's fears about "something bad waiting for him" were not typical prisoner anxieties.[30] C/O Lloyd recognized "some instability" and told Mr. Hyde he would walk down the hallway with him.[31]

It seemed to C/O Lloyd that Mr. Hyde was not hearing him as he tried to direct him to Admissions. He gestured at first to show Mr. Hyde where to go and after that was trying to reassure him.[32] At no time did he order Mr. Hyde to go down the hallway.[33] He did however see it as his responsibility to get Mr. Hyde to the sheriffs for transport to court, notwithstanding his strange behaviour at the top of the long hallway.[34]

The long hallway to Admissions is sterile and gloomy. The doorway at the end was not readily discernible from where Mr. Hyde and C/O Lloyd were standing. Mr. Hyde would only have known there was a doorway at the end if C/O Lloyd had explained that to him.[35]

C/O Lloyd had no training to recognize a medical emergency and did not feel Mr. Hyde was experiencing a mental health crisis at the time.[36] He did not know Mr. Hyde's "history" or whether he had ever been in jail before. He did not know whether to attribute Mr. Hyde's fear to nervousness about encountering another prisoner.[37]

Mr. Hyde wouldn't budge. C/O Lloyd can be seen in the video surveillance gesturing a total of 6 times to Mr. Hyde to go down the long hallway. It was at this point that C/O Lloyd went back along the corridor and yelled for Cst. Jones.[38] He told C/O Jones that they were going to walk Mr. Hyde down the long hallway to Admissions because he was having problems.[39]

After leaving C/O Lloyd and Mr. Hyde, C/O Jones had not gone far when she heard C/O Lloyd call her name. She returned to see Mr. Hyde at the intersection of the hallways, refusing to walk down to Admissions.[40] C/O Lloyd was trying to persuade him to proceed but Mr. Hyde was balking.

C/O Jones viewed her role as assisting C/O Lloyd get Mr. Hyde to court.[41] Returning to where C/O Lloyd and Mr. Hyde were stalled, she told Mr. Hyde he had to go down the hall to Admitting for court and placed her hand on his back to give him some gentle direction. "Howard, we've got to go down to admitting for court."[42] C/O Lloyd was also engaged in urging Mr. Hyde on to Admissions, saying: "Okay, sir, it's time to go. We'll walk down with you and we'll make sure you get down there safely." He placed his hand on Mr. Hyde's shoulder as an expression of reassurance.[43]

Mr. Hyde was emphatic: "No, I am not going down there. I'm not."[44] He reacted to being touched, veering away abruptly and starting to flee.[45] Although C/O Lloyd described Mr. Hyde becoming "aggressive and violent"[46], I find that he was simply trying to get away. C/O Jones could see he was running away from the long hallway.[47] The struggle was on.[48]

Before I describe the evidence of the struggle at the top of the long hallway, I will discuss what the video surveillance evidence reveals about the escort of Mr. Hyde by C/O's Lloyd and Jones. As it is without audio it provides no insight into the content of the statements described by the officers as their efforts to reassure and persuade Mr. Hyde to walk down the hallway. However the visual images do tell a story.

Mr. Hyde walks into view at 07:33:40 according to the time stamp on view 6 of the video surveillance.[49] He can be seen walking slightly ahead of C/O Lloyd, carrying the bag breakfast in his hand. Just before the intersection with the long hallway, C/O Lloyd strides ahead of Mr. Hyde and, at 07:33:47, points to where Mr. Hyde is to go to Admissions. Mr. Hyde walks a few steps and, at 07:33:54, stops and faces C/O Lloyd. He is standing just at the top of the hallway. C/O Lloyd points again with his arm, at 07:33:55 – 07:33:58, in the direction of Admissions. Mr. Hyde fails to oblige and continues to face C/O Lloyd, presumably talking to him. C/O Lloyd points again a couple of times, 07:34:00 – 07:34:02. The stances of Mr. Hyde, still facing C/O Lloyd, and C/O Lloyd sometimes looking at him and sometimes with his head turned away, suggest talking by Mr. Hyde and listening by C/O Lloyd. At 07:34:16, C/O Lloyd points again toward Admissions.

Mr. Hyde does not comply with C/O Lloyd's directions to proceed down the hallway. At 07:34:24, C/O Lloyd turns and walks back in the direction where, according to the testimony, C/O Jones has gone. Just as she is coming into view, C/O Lloyd, at 07:34:28, obviously having seen her, makes a motion that suggests "come here, there's a problem to deal with" and turns back toward Mr. Hyde.

The officers can be seen immediately converging on Mr. Hyde at 07:34:34. They move quickly and appear to be trying to "herd" Mr. Hyde into the long hallway. It is very difficult to see how, at this juncture of the events, there could have been any time for discussion or reassurance. The officers are on the move, and purposeful, placing their hands on Mr. Hyde. He veers away from them. By 07:34:38 they have him on the floor.

C/O Jones probably provided the best description of what happened just before Mr. Hyde tried to escape. She saw that Mr. Hyde was not complying with C/O Lloyd's efforts to direct him down the long hallway. She testified that she told Mr. Hyde: "You've got to go down to Admitting for court", and then "attempted to put my hand on his back, not forceful but to give him some direction in that direction. And that's when he just pulled away completely and abruptly."[50]

The video surveillance indicates that C/O Lloyd spent 37 seconds trying to direct Mr. Hyde down the hallway to Admissions before turning to get C/O Jones.[51] It is 5 seconds from the time that C/O Jones appears in the frame to when the officers attempt to "herd" Mr. Hyde into the hallway [52] and a further 4 seconds before he is on the floor.[53]

Notes

1 Exhibit 130, Department of Justice Report re: death of Howard Hyde prepared by Cpt. Paul Dorrington, November 22, 2007, page 36 – CNSCF Movement/Event/Occurrence/Activity Log

2 Testimony of C/O Peter Lloyd, page 6373

3 Testimony of C/O Peter Lloyd, page 6375; Testimony of C/O Renee Jones, page 6024

4 Testimony of C/O Christopher Digout, pages 6049, 6050

5 Testimony of C/O Christopher Digout, page 6064. C/O Lloyd confirmed in his testimony that he was not made aware of C/O Kayongo's log notation. (Testimony of C/O Peter Lloyd, page 6416)

6 Testimony of C/O Christopher Digout, page 6064

7 Testimony of C/O Renee Jones, page 5904

8 Testimony of C/O Peter Lloyd, page 6376; Testimony of C/O Renee Jones, page 5904

9 Testimony of C/O Peter Lloyd, page 6415; Testimony of C/O Renee Jones, page 5905

10 Testimony of C/O Christopher Digout, pages 6049, 6050; Exhibit 60, Tab 10:9, C/O Digout's Information Report dated November 22, 2007, 09:42

11 Testimony of C/O Christopher Digout, pages 6049, 6076

12 Testimony of C/O Peter Lloyd, page 6455

13 Testimony of C/O Renee Jones, page 5907

14 Testimony of C/O Renee Jones, page 5907

15 Testimony of C/O Renee Jones, page 5983

16 Testimony of C/O Peter Lloyd, page 6394; Testimony of C/O Renee Jones, page 5905

17 Testimony of C/O Peter Lloyd, page 6395; Testimony of C/O Renee Jones, page 5905

18 Testimony of C/O Renee Jones, pages 5946–5947

19 Testimony of C/O Peter Lloyd, page 6396

20 Testimony of C/O Renee Jones, pages 6012–6013

21 Testimony of C/O Renee Jones, page 5966

22 Testimony of C/O Peter Lloyd, page 6465

23 Testimony of C/O Peter Lloyd, page 6466

24 Testimony of C/O Peter Lloyd, page 6412; Testimony of C/O Renee Jones, page 5954

25 Testimony of C/O Peter Lloyd, page 6378

26 Testimony of C/O Peter Lloyd, page 6378

27 Testimony of C/O Peter Lloyd, page 6378; Exhibit 59I, view 6, 07:33:43

28 Testimony of C/O Peter Lloyd, page 6411

29 Testimony of C/O Peter Lloyd, page 6395

30 Testimony of C/O Peter Lloyd, pages 6402, 6420)

31 Testimony of C/O Peter Lloyd, page 6394 referring to his RCMP statement of November 23, 2007; Exhibit 59I, view 6, 07:33:43

32 Testimony of C/O Peter Lloyd, page 6468

33 Testimony of C/O Peter Lloyd, page 6395

34 Testimony of C/O Peter Lloyd, page 6419

35 Testimony of C/O Renee Jones referring to Exhibit 61, Tab 6, Booklet of Photographs in the RCMP Investigations Binder, Photograph 22; Testimony of C/O Peter Lloyd, page 6424: Question: In fact, if we look down that long hallway, we can't even see a door, can we? Answer: No. See also: Testimony of C/O Christopher Dixon, page 5531, "The long hallway certainly appears to have no door at the end".

36 Testimony of C/O Peter Lloyd, page 6459

37 Testimony of C/O Peter Lloyd, page 6394 referring to his RCMP statement of November 23, 2007

38 Testimony of C/O Peter Lloyd, pages 6378–6379 referring to Exhibit 59I, view 6, 07:34:09; Testimony of C/O Renee Jones, page 5978

39 Testimony of C/O Peter Lloyd, page 6403

40 Testimony of C/O Renee Jones, page 5908

41 Testimony of C/O Renee Jones, page 5976

42 Testimony of C/O Renee Jones, pages 5978, 6038

43 Testimony of C/O Peter Lloyd, pages 6379, 6407, 6452

44 Testimony of C/O Peter Lloyd, page 6452

45 Testimony of C/O Renee Jones, page 5975

46 Testimony of C/O Peter Lloyd, page 6379

47 Testimony of C/O Renee Jones, pages 5909, 5980–5981

48 Testimony of C/O Peter Lloyd, page 6404, referring to Exhibit 59I, view 6, 07:34:34; Testimony of C/O Renee Jones, pages 5984–5985, also referring to Exhibit 59I, view 6, 07:34:34

49 Exhibit 59I, view 6, CNSCF video from November 22, 2007

50 Testimony of Correctional Officer Renee Jones, page 5978

51 Exhibit 59I, view 6, CNSCF video from November 22, 2007, 07:33:47 – 07:34:24

52 Exhibit 59I, view 6, CNSCF video from November 22, 2007, 07:34:29 – 07:34:34

53 Exhibit 59I, view 6, CNSCF video from November 22, 2007, 07:34:34 – 07:34:38

The Struggle at the Top of the Long Hallway

As Mr. Hyde twisted away from C/O's Lloyd and Jones, they grappled him to the floor. It took them 4 seconds.[1] The officers were aiming for better control of Mr. Hyde by way of a proned position on the floor and handcuffing.[2] This proved to be a challenge. Mr. Hyde was extraordinarily strong for his size.[3] C/O Lloyd was surprised at the fight Mr. Hyde put up against their efforts to restrain him[4] and thought about grabbing his hair to try and gain control of him.[5]

Mr. Hyde landed on the floor on his right side and turned on to his back.[6] He was grabbing at the officers.[7] They found he was too strong to control as he resisted their efforts to get his arm behind his back so he could be rolled into a prone position for handcuffing.[8]

It felt to C/O Lloyd as though Mr. Hyde was throwing him and C/O Jones around "like ragdolls."[9] Although the video footage[10] does not show as dramatic a struggle as C/O Lloyd's description suggests[11], the few seconds after Mr. Hyde is brought to the floor are a flurry of Mr. Hyde and the officers spinning around and Mr. Hyde flailing and turning.[12] The officers were winded by the exertion.[13]

Mr. Hyde did not flip himself on top of the officers which would have put them at a serious disadvantage.[14] C/O Jones does not recall having any weight on Mr. Hyde; she was trying to gain control of his left arm.[15]

Other officers responded as Mr. Hyde struggled to get up from the floor. Shortly after 07:30, C/O's Cameron Lamond and Herman Mrvelj, working together in Admissions heard shouting and the sounds of a commotion in the Admissions hallway.[16] They ran up the hallway[17] to where C/O's Jones and Lloyd were struggling with Mr. Hyde. They could see that Mr. Hyde, who was on the floor [18], was resisting the officers' efforts to take control of his arms.

C/O Mrvelj grabbed Mr. Hyde's right arm, placing it on his back. Mr. Hyde, who had been on his side, was now prone. C/O Mrvelj estimated that it took 1 – 2 seconds to get Mr. Hyde from his side to his abdomen and a further 2 – 3 seconds for officers to control his other arm so that Mr. Hyde could be handcuffed.[19]

C/O Lamond grabbed Mr. Hyde's legs. He held them down with his hands, using his weight to restrict their movement.[20] He had been involved in many incidents of use of force and noted that Mr. Hyde was "a fairly strong person."[21]

C/O Mrvelj also found Mr. Hyde to be unexpectedly strong although it only took him a second to get Mr. Hyde's arm behind his back.[22] Using a scale of 1 to 10, he put Mr. Hyde's strength at "an 8 or 9" with what he was accustomed to in the usual use of force situation meriting "a 5 to 6."[23] It was however, according to C/O Mrvelj, "A simple use of force."[24] C/O Jones also described the use of force as "standard…very by the book."[25]

C/O Mrvelj had his knee close to Mr. Hyde in order to hold Mr. Hyde's arm, but did not put any weight on him. He knew this could cause breathing problems during restraint.[26] He did not observe anyone put their body weight on Mr. Hyde.[27]

C/O's Lloyd and Lamond got Mr. Hyde to his feet and into a "high profile" position for escort.[28] He continued to shout out statements that seemed out of place[29]. C/O Mrvelj recalls him referring to George Bush.[30]

The officers did not know Mr. Hyde or anything about him. They had no information about his mental health issues. They dealt with the situation that confronted them.[31] Mr. Hyde's efforts to flee the area required them to respond and restrain him.[32] The force they used was sufficient to accomplish their objectives.[33]

Once Mr. Hyde attempted to flee, the officers had no choice but to use physical force to restrain him.[34] There were serious risks associated with him running loose in the institution.[35] The struggle had erupted in an insecure area of the institution and Mr. Hyde had to be brought under control.[36] The officers were also influenced by the fact that Mr. Hyde was subject to a court order requiring him to be delivered to court that morning.[37]

Notes

1 Exhibit 59I, view 6, CNSCF video surveillance from November 22, 2007, 07:34:34 – 07:34:38; Testimony of C/O Renee Jones, pages 5984–5985

2 Testimony of C/O Peter Lloyd, page 6380; Testimony of C/O Renee Jones, page 5909

3 Testimony of C/O Peter Lloyd, pages 6454, 6457; Testimony of C/O Renee Jones, pages 5918–5919

4 Testimony of C/O Peter Lloyd, pages 6380–6381, 6453

5 Testimony of C/O Peter Lloyd, page 6454

6 Testimony of C/O Renee Jones, page 5910

7 Testimony of C/O Renee Jones, page 5910

8 Testimony of C/O Renee Jones, pages 5910–5911

9 C/O Peter Lloyd's RCMP statement of November 23, 2007

10 Exhibit 59I, view 6, CNSCF video surveillance from November 22, 2007, 07:34:34 – 07:34:38

11 Testimony of C/O Peter Lloyd, page 6432

12 Testimony of C/O Peter Lloyd, pages 6459–6460: The flailing and spinning happened after Mr. Hyde was brought to the floor. (Testimony of C/O Peter Lloyd, page 6460, referring to Exhibit 59I, view 6)

13 Testimony of C/O Peter Lloyd, page 6456; Testimony of C/O Renee Jones, pages 6008, 6013–6014

14 Testimony of C/O Peter Lloyd, page 6405; Testimony of C/O Renee Jones, pages 5989–5990

15 Testimony of C/O Renee Jones, page 5988

16 Testimony of C/O Cameron Lamond, pages 6118, 6178;

17 Testimony of C/O Cameron Lamond, pages 6153–6154, referring to Exhibit 59I, view 7, identifies himself as the first officer running toward the struggle at 07:34:45

18 Testimony of C/O Herman Mrvelj, page 6085

19 Mr. Hyde was handcuffed at 07:35:18 by C/O Jones. (Testimony of C/O Jones, pages 5912, 5939, 5987 and 5993, referring to Exhibit 59I, view 6, CNSCF video surveillance from November 22, 2007)

20 Referred to his RCMP statement of November 26, 2007, C/O Lamond testified that his memory was better at that time about taking control of Mr. Hyde's legs while the

other officers gained control of his arms and applied the handcuffs. (Testimony of C/O Cameron Lamond, pages 6166, 6152

21 Testimony of C/O Cameron Lamond, page 6168

22 Testimony of C/O Herman Mrvelj, page 6087

23 Testimony of C/O Herman Mrvelj, page 6108

24 Testimony of C/O Herman Mrvelj, page 6097

25 Testimony of C/O Renee Jones, pages 6003, 6023 referring to her RCMP statement of November 22, 2007

26 Testimony of C/O Herman Mrvelj, page 6099

27 Testimony of C/O Herman Mrvelj, page 6109

28 A "high profile escort" positions the prisoner, his hands cuffed behind him, to be walked backwards by correctional officers with their arms linked through his handcuffed arms on either side. It allows the officers to maintain their balance while keeping the prisoner a little off balance. (Testimony of C/O Peter Lloyd, pages 6382, 6432; Testimony of C/O Renee Jones, referring to Exhibit 59I, view 6, CNSCF video surveillance from November 22, 2007, 07:35:42 and at page 5995)

29 Testimony of C/O Cameron Lamond, pages 6164–6165; Testimony of C/O Renee Jones, page 5996: "[It was] a little bit [strange]…He was just rambling."

30 Testimony of C/O Herman Mrvelj, page 6098

31 Testimony of C/O Cameron Lamond, page 6212

32 Testimony of C/O Renee Jones, pages 6012, 6018–6019

33 Testimony of C/O Renee Jones, page 6038

34 Testimony of C/O Renee Jones, pages 6019, 6027–6028

35 Testimony of C/O Renee Jones, page 6034

36 Testimony of C/O Renee Jones, pages 6018–6019, 6027–6028

37 Testimony of C/O Renee Jones, page 6018

The High-Profile Escort of Mr. Hyde to Search Cell #2

Once Mr. Hyde was brought to his feet, he was placed by the correctional officers into a "high-profile" escort. It took only about a minute from when Mr. Hyde's legs were restrained while he was on the floor to standing him up for the escort.[1] Cpt. Todd Henwood[2] told Mr. Hyde that correctional staff were going to escort him to Admissions and that he would be going to court. He asked for Mr. Hyde's cooperation and that he calm down.[3]

Cpt. Henwood, as the highest ranking officer on the scene, provided direction to the other correctional staff. He wanted Mr. Hyde taken to the first available cell[4] near Admissions where he could be brought under control and readied for court.

The "high profile" escort involved Mr. Hyde being positioned to face in the opposite direction to where he was being taken, with officers on either side of him, walking him backwards down the long hallway.[5] His hands were cuffed behind his back[6] with C/O Cameron Lamond on his right side and C/O Peter Lloyd on his left.[7] C/O Lamond held Mr. Hyde's wrist in a wrist-lock ready position but did not have to apply any pressure as Mr. Hyde was under control.[8] C/O Lloyd's stance was more relaxed and he did not have his hand on Mr. Hyde's wrist.[9] Mr. Hyde walked backwards with his escort and did not have to be dragged or carried.[10] C/O Lloyd recalls "a hint of resistance"[11], but as the video surveillance shows, Mr. Hyde was no longer struggling.[12]

C/O Dixon recalls Mr. Hyde "thrashing around" during the high profile escort [13], however the video surveillance does not support this description.[14] Furthermore, had Mr. Hyde been actively resisting during the escort, C/O Lloyd would presumably have used both his hands to control him, which as I have noted, he did not.

During the escort, Mr. Hyde was very vocal, loudly making "nonsensical" statements.[15] He was "rambling" about being an RCMP officer and requiring a haircut.[16] He appears to have been repeating a theme he had emphasized with the police the previous day, saying: "I'm an innocent man, you can't do this to me."[17] C/O Lamond, who had six years' experience providing security at the East Coast Forensic Hospital,[18] thought Mr. Hyde was delusional and tried to reorient him to time and place, telling him where he was being taken.[19] He had no information about Mr. Hyde and had no idea what his illness may have been.[20] The correctional officers thought Mr. Hyde's statements were odd and out of context and Cpt. Henwood also thought he might have a mental illness.[21] Mr. Hyde was not following his commands or those of staff in a rational manner.[22] He did not know that Mr. Hyde had a diagnosis of schizophrenia and had stopped taking his medication.[23]

C/O Dixon did apparently tell Cpt. Henwood what he knew about the incident in HRPS Booking, that there had been a struggle and Mr. Hyde, showing unusual

strength, had broken cuffs.[24] Cpt. Henwood has no recall of being told this information during the escort and would not have regarded a story about a prisoner acting out to be unusual anyway.[25]

Cpt. Henwood did not consider the scene to be safe[26] and saw no other option, such as taking Mr. Hyde to Health Care, as being feasible.[27] With Cpt. Henwood following them, the escort team and Mr. Hyde reached the doorway of search cell #2. There was a brief struggle[28] and Cpt. Henwood urged Mr. Hyde to follow the direction of the team.[29]

Notes

1 Testimony of C/O Cameron Lamond, pages 6183–6184, referring to Exhibit 59I, video surveillance from the CNSCF

2 Cpt. Todd Henwood's rank in November, 2007 was Sergeant.

3 Testimony of Cpt. Todd Henwood, page 6546

4 Testimony of Cpt. Todd Henwood, page 6557

5 Testimony of C/O Peter Lloyd, pages 6382, 6432

6 Testimony of C/O Cameron Lamond, page 6151

7 Testimony of C/O Cameron Lamond, page 6162

8 Testimony of C/O Cameron Lamond, page 6163

9 Testimony of C/O Cameron Lloyd, page 6435; Exhibit 59I, view 7

10 Testimony of C/O Cameron Lamond, page 6184

11 Testimony of C/O Peter Lloyd, page 6383

12 Exhibit 59I, view 7, 07:35:54 – 07:36:08

13 Testimony of C/O Christopher Dixon, pages 5473, 5532

14 Exhibit 59I, view 7

15 Testimony of C/O Cameron Lamond, pages 6164–6165

16 Testimony of C/O Cameron Lloyd, page 6383: Testimony of C/O John Currie, page 6481

17 Testimony of C/O Cameron Lamond, page 6165

18 Testimony of C/O Cameron Lamond, pages 6173, 6219

19 Testimony of C/O Cameron Lamond, page 6185

20 Testimony of C/O Cameron Lamond, page 6215

21 Testimony of Cpt. Todd Henwood, pages 6551–6552

22 Testimony of Cpt. Todd Henwood, page 6552

23 Testimony of Cpt. Todd Henwood, pages 6553

24 Testimony of C/O Christopher Dixon, pages 5535–5536, referring to his RCMP statement of November 26, 2007

25 Testimony of Cpt. Todd Henwood, page 6588

26 Testimony of Cpt. Todd Henwood, page 6553

27 Testimony of Cpt. Todd Henwood, pages 6552–6553

28 Testimony of Cpt. Todd Henwood, page 6557

29 Testimony of Cpt. Todd Henwood, page 6558

The Struggle and Mr. Hyde's Collapse in Search Cell #2

As the high-profile escort approached Search Cell #2, Mr. Hyde's anxieties erupted again. He resisted at the doorway[1] as the correctional officers in the escort angled themselves sideways to get through with him.[2] It was apparent he did not want to enter the cell[3]and struggled to get free.[4] C/O Peter Lloyd used joint manipulation to no effect which surprised him.[5]

Getting Mr. Hyde to the Floor

The escorting correctional officers[6] forcibly hustled Mr. Hyde through the door and into the cell. It didn't take them long to do so, a matter of seconds.[7] There were now a number of correctional officers in the cell.[8] Cpt. Henwood gave Mr. Hyde directions to lie on the floor.[9] He failed to comply and was bent over at the waist and pushed as close to the ground as possible. He continued to struggle against these attempts to lower him to the floor so his legs were pulled out from under him.[10] It was not a soft landing: this technique for getting a prisoner into a prone position so he can be controlled has "a little bit of roughness to it."[11] It took seconds to get him to the floor.[12]

Mr. Hyde ended up on the cell floor on his side with his hands cuffed behind him.[13] He continued "hollering, shouting" and "bucking" against being restrained.[14] In his frantic struggles with the officers, Mr. Hyde was flexing his hips up and down as he lay on the floor.[15] Cpt. Henwood positioned himself so he was holding Mr. Hyde's handcuffs in his left hand. The pitching of Mr. Hyde's body required him to crouch beside him with both feet on the floor.[16]

Cpt. Henwood recalls that he "brought [Mr. Hyde] to the point where he was… proned out…belly to the floor"[17] but the testimony of other correctional officers indicates their involvement assisted in the process of getting Mr. Hyde into this position.

"Proning" Mr. Hyde Out on the Floor

The correctional officers were instructed to get Mr. Hyde into a prone position.[18] This was standard for gaining control of a prisoner. In a spontaneous use of force, there is no set procedure for achieving this.[19]

Correctional Officer John Currie knelt down beside him and took hold of Mr. Hyde's right wrist and elbow. Applying a wrist lock he tried to subdue Mr. Hyde with pain compliance hoping to get him into a prone position.[20] He abandoned the technique after a couple of attempts[21] as Mr. Hyde gave no indication of even noticing what he was doing.[22] It was having no effect.[23]

Mr. Hyde's right leg was free and to stop him kicking it, C/O Michael Green,

situated on Mr. Hyde's right side[24], tried to get it under control.[25] He found controlling Mr. Hyde's legs a challenge because Mr. Hyde was trying to lift his body off the floor.[26]

Sgt. Prall helped get Mr. Hyde into a fully proned position by straightening out his left leg and then securing it.[27] Mr. Hyde's hips had been raised because his legs were still slightly underneath him.[28]

Sgt. Prall moved Mr. Hyde's left leg onto the back of his right thigh. C/O Green moved Mr. Hyde's right leg to trap the left, controlling both legs.[29] After that, Sgt. Prall applied minimal force to Mr. Hyde whose legs could be controlled solely by C/O Green.[30]

When he was controlling Mr. Hyde's legs, C/O Green recalls Mr. Hyde's knees being on the floor. C/O Green did not force Mr. Hyde's legs up against his torso, "absolutely not."[31] Mr. Hyde pushed against C/O Green with his right leg and C/O Green, using his arms, pushed back using "just enough [force] to maintain the position he was trying to hold.[32] Mr. Hyde's thighs and knees remained on the floor.[33]

Cpt. Paul Whitman was outside Search Cell #2 watching the efforts to restrain Mr. Hyde. He observed Mr. Hyde in a prone position trying to "buck" against the officers restraining him.[34] They were holding Mr. Hyde to prevent him from trying to get away.[35] He monitored the situation as a supervisor and did not see anything being done that was contrary to the policies and procedures of the CNSCF.[36]

Repeated Themes of Apology and Innocence

While the officers were struggling with Mr. Hyde, he was yelling and screaming, reiterating a theme that he'd voiced with the police in Booking, repeatedly crying out: "…sorry, I'm innocent!"[37] He yelled for the officers to get off him[38], that it wasn't right, that he shouldn't be there,[39] that he was not going to court, he was innocent.[40] He also referred to being an RCMP officer[41] as he had during the high-profile escort. Cpt. Paul Whitman heard Mr. Hyde's protests against the attempts to get him to court: "…going on like he was in some place that he shouldn't have been…[He was told] you got to get ready for court."[42]

Surprising But Not Overpowering Strength

The correctional officers were surprised at Mr. Hyde's strength. He was deceptively strong for a man of his size.[43] "I wasn't expecting him to be able to move around that much…I was quite surprised how elevated he was getting and how much he was moving officers around."[44] He seemed "very powerful"[45] and to have a lot of energy.[46] He did not seem to tire.[47]

Mr. Hyde was not able to overpower the officers. Sgt. Prall recounted instances of trying to restrain prisoners and ending up "rolling around on the ground with them because they are that strong. Mr. Hyde was not that strong. He was very capable but he wasn't at a point where we couldn't be in control of him."[48] The techniques used to control Mr. Hyde were standard use of force procedures established through policy.[49]

In the Prone Position

Mr. Hyde's attempts to resist the correctional officers were futile. Notwithstanding his strength, it did not take long to get him into a prone position.[50] There were enough officers to handle him.[51] He continued to struggle, trying to move around.[52]

The control C/O Green and Sgt. Prall had of Mr. Hyde's legs "pretty much en-

sured" he was not going to get up. Meanwhile Cpt. Henwood leaned over Mr. Hyde, talking to him, trying to secure his cooperation.[53] He was leaning over Mr. Hyde telling him to calm down, that the officers wanted to take the handcuffs off and get him to court and that everything was going to be alright.[54] Mr. Hyde's clothes were brought into the cell, and dumped on the floor.[55] The goal was to get Mr. Hyde to agree to get ready for court.[56] If he had complied, the correctional officers would have backed out of the cell and let him dress.[57]

Although Cpt. Henwood testified that Mr. Hyde tried, in the prone position, to push him off[58], Sgt. Prall's evidence was that he was no longer able to "buck" once proned out on the floor.[59] There was "very minimum force" required to keep Mr. Hyde down on the floor once his legs were restrained and he was in a fully proned position.[60]

Cpt. Henwood described his positioning as being "bridged" over Mr. Hyde, controlling the handcuffs with his left hand grasping the link between the manacles.[61] "My right hand went from being on the floor to on his shoulder. And as he would push up into my body, I would lower the handcuffs back down to the floor."[62] "I would push the handcuffs back down on the floor and the ease off the pressure."[63] Sgt. Prall observed Cpt. Henwood controlling the handcuffs and Mr. Hyde's right shoulder with his hands.[64]

In November 2007, Cpt. Henwood weighed about 290 – 300 lbs.[65] He knew the risks associated with applying body weight to a prone prisoner.[66] He also knew that lying on top of a prisoner in a struggle created risks to officer safety.[67]

The purpose of controlling the handcuffs was to control the prisoner's upper torso without putting pressure on it.[68] It is a technique correctional officers are trained in: the prisoner is only pushed down when there is upward resistance from him.[69]

Suddenly, Nothing

C/O Currie asked Mr. Hyde if he was going to calm down. Mr. Hyde, responding for the one and only time in the search cell,[70] said, "yes, yes."[71] Sgt. Prall recalls this as an inquiry about whether Mr. Hyde intended to comply.[72] Whatever the precise words were[73], Mr. Hyde indicated he would settle down and after 1 – 2 seconds he seemed to do so. The officers began to remove his handcuffs.[74] C/O Currie noticed that Mr. Hyde just stopped responding at this point and his ear had become discoloured. Something was wrong, which prompted giving Mr. Hyde "…a couple of shakes…Come on. Come on, let's go. And nothing."[75] It was like a switch turning off.[76] Cpt. Whitman, observing from outside the search cell had just noticed a droplet of blood under Mr. Hyde's face.[77]

Mr. Hyde's left handcuff was too tight, defeating Cpt. Henwood's efforts to remove it.[78] Sgt. Prall got it off,[79] handing the keys over to C/O Renee Jones.[80] A few seconds after removing the handcuff, Sgt. Prall noticed the limpness in Mr. Hyde's hand and the pallor of his skin.[81]

Although Cpt. Henwood testified that he and Sgt. Prall started to remove Mr. Hyde's handcuffs because of his implied readiness to cooperate[82] that is not the reason he gave to the RCMP when he was interviewed on November 22, 2007. He told the RCMP:

> And it was about a couple of minutes into the cell…I wasn't sure if…he held his breath or if he was trying to get us off him by holding his breath and faking something but, obviously, he wasn't faking too much…he held his breath and I

waited a good two-second count and he just went limp…I've seen dead people before in jails and…**I knew he was in trouble. I knew he was in some type of duress at that time, so I removed the handcuffs**…[83] [emphasis added]

When pressed about the differences in his explanations, Cpt. Henwood testified that his memory at the Inquiry[84] was "clearer" than when he gave his RCMP statement. It was his evidence that before he took Mr. Hyde's handcuffs off he did not believe he was "in any type of trouble."[85] Having said that, he also testified that he noticed Mr. Hyde being limp on two occasions, separated by approximately 2 – 3 seconds: first, when he thought Mr. Hyde was holding his breath and then when he felt his arm go limp.[86]

When Cpt. Henwood realized Mr. Hyde had gone limp, he said to his fellow officers: "Boys, we have a problem."[87] He testified that he believed Mr. Hyde to be unconscious[88], adding subsequently that he believed that to be "a possibility."[89]

Sgt. Prall felt Mr. Hyde's left hand go limp when he removed the handcuff.[90] It fell straight to the floor.[91] He was no longer offering any resistance[92] and had started to become greyer.[93] Sgt. Prall smelled urine.[94] He did not conclude that this meant Mr. Hyde was unconscious. At this point, officers thought Mr. Hyde might have been playing "coy" with them[95] and might "lash back out again."[96] It was still a use of force situation.[97] Sgt. Prall thought there was a very strong possibility that Mr. Hyde was faking unconsciousness until the restraints were off him.[98]

Cpt. Whitman, still observing from outside the search cell, saw Mr. Hyde become motionless and directed staff to call Health Care.[99]

Assessing Pulse and Breathing

When Sgt. Prall noticed Mr. Hyde's discoloration, before Health Care arrived, Mr. Hyde appeared to him to still be breathing.[100] It appeared to him that there was movement in Mr. Hyde's chest area.[101] Cpt. Henwood checked for a pulse and said he had found one.[102] He told the Inquiry he was sure he located a pulse in Mr. Hyde.[103] However, he told the RCMP he wasn't confident that he had detected one:

> …I was trying to get a pulse. I wasn't sure if I got a pulse, didn't get a pulse. It was confusing at the time because I am not big on getting pulses. That's probably not my really area of expertise but I thought I had felt something initially but I wasn't sure.[104]

When Health Care arrived, Cpt. Henwood and Sgt. Prall moved Mr. Hyde on to his back.[105] Although Sgt. Henwood had not seen any discoloration previously[106], when he was briefing the nurses, Mr. Hyde was "definitely purple".[107]

Mr. Hyde had been placed on his side after becoming limp.[108] No CPR had been started by the correctional officers because it was thought that Mr. Hyde had a pulse and was still breathing.[109] That appears to be very doubtful, despite Cpt. Henwood's confident assertions.[110] When Nurse Cheryl Champion entered the cell and assessed Mr. Hyde's pulse she told Sgt. Henwood: "No, sweetie, there's no pulse. Call 911."[111]

What the Correctional Officers Knew about Mr. Hyde before the Struggle in Search Cell #2

Sgt. Prall, who had started his shift supervising staff on the North Unit at 06:00 on November 22[112], saw Mr. Hyde on the monitor in North Control. He was pacing which is what Sgt. Prall was told he had been doing all night.[113] It was his experience that pacing was a common response by prisoners nervous about going to court. Pacing for 12 – 13 hours was "unusual" but it was not the first time he had known someone be up all night before court the next day.[114] The correctional officers had not known that Mr. Hyde had a diagnosis of schizophrenia and was not taking his medication.[115] According to Sgt. Prall, it would not have made any difference in the use of force as the officers still had to control Mr. Hyde.[116]

Reflecting on the events, Cpt. Henwood testified that in terms of doing anything differently, he would have established more contact with Mr. Hyde in the long hallway "and possibly defused it."[117]

> …it appeared to be somewhat under control, he wasn't being dragged down the hall. He was walking with the officers in the high-profile position…I guess I could have reassured him going up the hallway a little bit more…knowing, I guess, from what I've heard after the fact, that the hallway seemed to be this contentious issue where it's dark and gloomy and he doesn't know where he's going, obviously. I can understand his fright, I guess, perhaps.[118]

The Video Surveillance of Search Cell #2

The video footage of Mr. Hyde and the correctional officers in Search Cell #2[119] is of limited usefulness as the correctional officers' bodies obscure Mr. Hyde and much of the struggle is not fully captured by the fixed camera position. There is no sound. However the images on the video surveillance reveal a much shorter and less intense confrontation between Mr. Hyde and the correctional officers than the testimony suggested.

The struggle inside the cell lasted approximately two and half minutes.[120] It took the four officers about six seconds to get Mr. Hyde to the floor.[121] They can be seen pulling his legs out, although Mr. Hyde appears to be prostrate by this point.[122] Sgt. Prall recalls trying to control Mr. Hyde's legs in the seconds following[123]: in less than a minute after this Mr. Hyde was being placed in a prone position.[124]

The four officers[125] clustered around Mr. Hyde lying on the floor at this point do not appear to be engaged in a struggle. They can be seen to be restraining Mr. Hyde's limbs but there is no obvious movement involved in them doing so. A decision was made to remove Mr. Hyde's handcuffs.[126] Within seconds after this decision, C/O Currie can be seen to stand up and wipe his brow[127] while his colleagues remain crouched around Mr. Hyde. The search cell may have been quite warm; C/O Peter Lloyd can also be seen wiping his face[128] even though he has been doing nothing other than standing and watching since bringing Mr. Hyde's clothes in.

Mr. Hyde's handcuffs were removed[129], and just over a minute later, the Health Care nurses arrived in the cell.[130] The correctional officers moved back thirteen seconds earlier and Mr. Hyde can be seen to be lifeless.[131] Nurse Champion took Mr. Hyde's pulse with Cpt. Henwood by her side.[132] Chest compressions were started. Mr. Hyde had been in Search Cell #2 for less than six minutes.[133]

Notes

1 Testimony of Sgt. Ian Prall, page 6289

2 Testimony of Cpt. Todd Henwood, page 6557

3 Testimony of C/O John Currie, page 6475

4 Testimony of C/O John Currie, page 6476

5 Testimony of C/O Peter Lloyd, page 6455

6 C/O's Peter Lloyd, and Cameron Lamond with Cpt. Todd Henwood following.

7 Testimony of C/O John Currie, page 6505

8 Cpt. Todd Henwood, Sgt. Ian Prall, C/Os Peter Lloyd, Michael Green, and John Currie. (Testimony of C/O Peter Lloyd, page 6387.) Sgt. Prall and C/Os Green and Currie had responded to a "10-13" call which indicates an emergency for staff. The call was made at 07:36. (Exhibit 185, Time Line of Events prepared by C/O Cameron Lamond on November 22, 2007)

9 Testimony of Cpt. Todd Henwood, page 6557

10 Testimony of Cpt. Todd Henwood, page 6559

11 Testimony of C/O Peter Lloyd, page 6439, referring to his RCMP statement of November 23, 2007

12 Testimony of C/O Cameron Lamond, page 6156; Testimony of Cpt. Todd Henwood, page 6578, "pretty quick"

13 Testimony of C/O John Currie, page 6478; Cpt. Todd Henwood, page 6561

14 Testimony of C/O Peter Lloyd page 6387

15 Testimony of C/O John Currie, pages 6511 and 6529; Sgt. Ian Prall, page 6388

16 Testimony of Cpt. Todd Henwood, page 6563

17 Testimony of Cpt. Todd Henwood, page 6563

18 Testimony of Sgt. Ian Prall, pages 6289–6929, 6326

19 Testimony of Sgt. Ian Prall, page 6326

20 Testimony of C/O John Currie, pages 6478–6479, 6480–6481

21 Testimony of C/O John Currie, page 6481

22 Testimony of C/O John Currie, page 6482

23 Testimony of C/O John Currie, page 6530

24 Testimony of C/O Michael Green, page 6737

25 Testimony of C/O Michael Green, page 4722

26 Testimony of C/O, page 6723

27 Testimony of Sgt. Ian Prall, page 6326

28 Testimony of Sgt. Ian Prall, page 6327

29 Testimony of Sgt. Ian Prall, page 6291; C/O Michael Green, page 6737

30 Testimony of Sgt. Ian Prall, page 6328

31 Testimony of C/O Michael Green, page 6760

32 Testimony of C/O Michael Green, pages 6739, 6740

33 Testimony of C/O, Michael Green, pages 6746–6747

34 Testimony of Cpt. Doug Whitman, page 6676, referring to his RCMP statement of November 22, 2007

35 Testimony of Cpt. Doug Whitman, page 6689

36 Testimony of Cpt. Doug Whitman, pages 6683–6684

37 Testimony of C/O John Currie, page 6515, referring to his RCMP statement of November 22, 2007

38 This referred to the C/O's trying to control him, not to anyone having his body weight on him, according to the testimony of C/O John Currie, page 6527.

39 Testimony of C/O John Currie, page 6516, referring to his RCMP statement of November 22, 2007

40 Testimony of C/O John Currie, page 6517, referring to his RCMP statement of November 22, 2007

41 Testimony of C/O John Currie, page 6516, referring to his RCMP statement of November 22, 2007

42 Testimony of Cpt. Doug Whitman, page 6676, referring to his RCMP statement of November 22, 2007

43 Testimony of Sgt. Ian Prall, page 6300; C/O John Currie, page 6484

44 Testimony of C/O John Currie, pages 6484–6485

45 Testimony of C/O John Currie, page 6519, referring to his RCMP statement of November 22, 2007

46 Testimony of C/O John Currie, page 6519

47 Testimony of C/O John Currie, page 6520, referring to his RCMP statement of November 22, 2007

48 Testimony of Sgt. Ian Prall, page 6333

49 Testimony of Sgt. Ian Prall, pages 6352–6354

50 Testimony of C/O John Currie, page 6529

51 Testimony of Sgt. Ian Prall, page 6301

52 Testimony of Sgt. Ian Prall, page 6335

53 Testimony of Sgt. Ian Prall, pages 6291, 6330–6331, 6332; Cpt. Todd Henwood, page 6564

54 Testimony of Cpt. Todd Henwood, page 6564

55 Cpt. Whitman was asked about Mr. Hyde's clothes and directed they be given to him without a hanger to avoid the risk of introducing a potential weapon into the mix. He thought the officers might have to change Mr. Hyde for court because he was being uncooperative. (Testimony of Cpt. Douglas Whitman, page 6671) At Cpt. Henwood's direction, (Testimony of Cpt. Todd Henwood, page 6570), C/O Peter Lloyd took the bag of clothes and dumped them on the cell floor. (Testimony of Peter Lloyd, page 6388)

56 Testimony of Sgt. Ian Prall, page 6364; Cpt. Todd Henwood, page 6609

57 Testimony of Sgt. Ian Prall, page 6364

58 Testimony of Cpt. Todd Henwood, page 6564

59 Testimony of Sgt. Ian Prall, page 6338

60 Testimony of Sgt. Ian Prall, page 6338

61 Testimony of Cpt. Todd Henwood, pages 6600, 6601

62 Testimony of Cpt. Todd Henwood, page 6600

63 Testimony of Cpt. Todd Henwood, page 6609

64 Testimony of Sgt. Ian Prall, page 6337

65 Testimony of Cpt. Todd Henwood, page 6624

66 Testimony of Cpt. Todd Henwood, page 6564

67 Testimony of Cpt. Todd Henwood, page 6652

68 Testimony of Cpt. Todd Henwood, page 6662

69 Testimony of Cpt. Todd Henwood, pages 6661, 6662–6663

70 Testimony of Sgt. Ian Prall, page 6366

71 Testimony of C/O John Currie, page 6483

72 Testimony of Sgt. Ian Prall, pages 6292, 6365–6366

73 Testimony of C/O John Currie, page 6521

74 Testimony of Sgt. Ian Prall, page 6366

75 Testimony of C/O John Currie, page 6523, referring to his RCMP statement of November 22, 2007. He agreed that his memory at the time of giving his RCMP statement was better than when he testified on October 27, 2009 although he did confirm that it was difficult for him to recall the precise sequence and timing of events when he spoke with the RCMP. (Testimony of C/O John Currie, pages 6524 & 6526) Note: Mr. Currie started his evidence on October 26, 2009.

76 Testimony of C/O Michael Green, page 6727, referring to his RCMP statement of November 22, 2007

77 Testimony of Cpt. Doug Whitman, page 6674

78 Testimony of Cpt. Todd Henwood, page 6566

79 Cpt. Todd Henwood indicated that Sgt. Prall is shown on Exhibit 59I, view 9 at 07:39:23 working on the removal of the left handcuff, the right one having already been taken off.

80 Testimony of Sgt. Ian Prall, page 6292

81 Testimony of Sgt. Ian Prall, page 6367

82 Testimony of Cpt. Todd Henwood, pages 6566, 6594

83 Testimony of Cpt. Todd Henwood, pages 6593–6594

84 Cpt. Henwood testified at the Inquiry on October 27, 2009.

85 Testimony of Cpt. Todd Henwood, page 6598

86 Testimony of Cpt. Todd Henwood, page 6627

87 Testimony of Cpt. Todd Henwood, page 6567

88 Testimony of Cpt. Todd Henwood, page 6615

89 Testimony of Cpt. Todd Henwood, page 6616

90 Testimony of Sgt. Ian Prall, page 6306, referring to his RCMP statement of November 30, 2007

91 Testimony of Sgt. Ian Prall, page 6344

92 Testimony of Sgt. Ian Prall, page 6344

93 Testimony of Sgt. Ian Prall, page 6299

94 Testimony of Sgt. Ian Prall, page 6303

95 Testimony of C/O Michael Green, pages 6741, 6752

96 Testimony of Sgt. Ian Prall, page 6344

97 Testimony of Sgt. Ian Prall, page 6344

98 Testimony of Sgt. Ian Prall, page 6345

99 Testimony of Cpt. Doug Whitman, page 6674

100 Testimony of Sgt. Ian Prall, pages 6293, 6299

101 Testimony of Sgt. Ian Prall, pages 6293, 6346, 6360

102 Testimony of Sgt. Ian Prall, pages 6299, 6361; Testimony of Cpt. Doug Whitman, page 6674

103 Testimony of Cpt. Todd Henwood, page 6574

104 Testimony of Cpt. Todd Henwood, page 6574, referring to his RCMP statement of November 22, 2007. A number of correctional officers testified to having heard Cpt. Henwood say he had a pulse: C/O Peter Lloyd, page 6390; C/O John Currie, page 6484; Sgt. Ian Prall, page 6299; Sgt. Doug Whitman, page 6674. C/O Renee Jones testified that she heard someone say he had a pulse although she cannot now remember who that was. (Testimony of C/O Jones, page 5917) However, notwithstanding what he

may have said to witnesses, Cpt. Henwood's statement to the RCMP indicates he was not certain that he had in fact found a pulse.

105 Testimony of Sgt. Ian Prall, page 6295

106 Testimony of Cpt. Todd Henwood, page 6614

107 Testimony of Cpt. Todd Henwood, page 6633

108 Testimony of Sgt. Ian Prall, page 6345

109 Testimony of Sgt. Ian Prall, page 6362; Testimony of Sgt. Todd Henwood, page 6567

110 Testimony of Cpt. Todd Henwood, pages 6575, 6648

111 Testimony of Cpt. Todd Henwood, pages 6569, 6634

112 Testimony of Sgt. Ian Prall, page 6282

113 Testimony of Sgt. Ian Prall, page 6283

114 Testimony of Sgt. Ian Prall, page 6284

115 Testimony of Sgt. Ian Prall, pages 6301–6302; Testimony of C/O Peter Lloyd, page, 6394; Testimony of Cpt. Todd Henwood, page 6553

116 Testimony of Sgt. Ian Prall, page 6302

117 Testimony of Cpt. Todd Henwood, page 6585

118 Testimony of Cpt. Todd Henwood, pages 6585–6586

119 Exhibit 59I, view 9

120 Exhibit 59I, view 9 shows Mr. Hyde being grappled into the search cell at 07:36:21. The decision to remove Mr. Hyde's handcuffs (because he was either compliant or lifeless) was made at 07:38:56. (Testimony of Cpt. Todd Henwood, page 6626)

121 Exhibit 59I, view 9, 07:36:27

122 Exhibit 59I, view 9, 07:36:33

123 Exhibit 59I, view 9, 07:36:40 (Testimony of Sgt. Ian Prall, pages 6297–6298)

124 Testimony of Cpt. Todd Henwood, pages 6606–6607 referring to Exhibit 59I, view 9, 07:37:34 as the time that Mr. Hyde started to be put "proned" out. The video footage shows that the garment bag with Mr. Hyde's clothes was brought in at 07:37:32, the hanger removed (07:37:44) and the clothes dumped out on the floor (07:37:53).

125 Cpt. Todd Henwood, C/O's John Currie and Michael Green, and Sgt. Ian Prall

126 Testimony of Cpt. Todd Henwood, page 6626, referring to Exhibit 59I, view 9 at 07:38:56.

127 Exhibit 59I, view 9, 07:30:01, 07:39:32, 07:39:40

128 Exhibit 59I, view 9, 07:39:49

129 Testimony of Sgt. Ian Prall, page 6299, referring to Exhibit 59I, view 9, 07:39:34

130 Exhibit 59I, view 9, 07:40:51

131 Exhibit 59I, view 9, 07:40:38

132 Exhibit 59I, view 9, 07:41:25

133 Exhibit 59I, view 9, 07:36:21 – 07:42:03

The Arrival of Nursing Staff in Search Cell #2

On November 22, Nurses Cheryl Champion and Karen Daigle were in Health Care when, at 07:35 they heard a 10:13 call. They knew to stand by in case they were needed to assess someone who had been in an altercation. About five minutes later an officer called for Health Care to go to Admitting.[1] When Ms. Champion queried whether the "gear" was needed she was told it was. The "gear" consisted of an oxygen tank, face mask, ambu bag, oral airway, intravenous equipment, and oxygen saturation monitor.[2] The nurses knew then that the situation was 'fairly serious."[3]

A minute later Ms. Champion and Ms. Daigle arrived at the top of the long hallway to Admitting. Correctional officers motioned them to come down to search cell #2.[4] Ms. Champion can be seen on Exhibit 59-I, view 9, with a time stamp of 07:40:30 arriving at the doorway of the search cell.[5]

The correctional officers were quite upset. The nurses saw from the doorway that Mr. Hyde was "quite mottled"[6] and blue, indicating that he was cyanotic. They could tell Mr. Hyde was in serious trouble. They told the officers to call 911 immediately.[7] They knew time was of the essence.[8] C/O Cameron Lamond made the call.[9] There was a short briefing by correctional officers on the struggle with Mr. Hyde before he went limp.[10] The officers cautioned the nurses that if Mr. Hyde got up, they should get out of the way because he had been extremely strong.[11]

After getting the officers to move Mr. Hyde away from the wall and turn him over from the prone position onto his back, Ms. Champion checked his pupil response and tried to find a carotid pulse. Mr. Hyde's pupils were fixed, he did not appear to be breathing and had no pulse.[12] He was incontinent of urine.[13] There was a saliva stain of blood on the side of his mouth.[14]

Within a minute of arriving on the scene, Ms. Champion began chest compressions.[15] Ms. Daigle started work on establishing an airway. One of the correctional officers was dispatched to get a bigger airway from Health Care. With this in place the nurses started to get air into Mr. Hyde with the ambu bag. An oxygen saturation monitor indicated that Mr. Hyde's oxygen saturation was 68 percent. This was very low, with the normal range being 97 – 100 percent.[16] It indicated that Mr. Hyde had been without oxygen for some time.[17]

For a brief period Mr. Hyde's abdomen seemed to be expanding, an indication of the air not making it into Mr. Hyde's lungs, which can happen with bagging where the airway is not secured by an endotracheal tube.[18] The nurses' observation that Mr. Hyde's abdomen was not getting any larger satisfied the nurses that Mr. Hyde's lungs were receiving the air being pumped into him.[19]

Ms. Champion and Ms. Daigle continued to perform CPR on Mr. Hyde for about 10 minutes until EHS arrived.[20] The protocol was to then turn the resuscita-

tion efforts over to the paramedics. Mr. Hyde did not regain consciousness or take a breath.[21] The slight decrease in his cyanotic appearance indicated only that some oxygen was getting into his bloodstream through the bagging and the chest compressions.[22] But he never "pinked up."[23] The nurses had a defibrillator, a LifePak 12, however Mr. Hyde had no shock-able heart rhythm so it was not used.[24]

Notes

1 Testimony of Cheryl Champion, R.N., pages 6766–6767: According to C/O Christopher Dixon, he made this call to the OHU. (Testimony of C/O Dixon, page 5564)

2 Testimony of Cheryl Champion, R.N., page 6767

3 Testimony of Cheryl Champion, R.N., page 6767

4 Testimony of Cheryl Champion, R.N., page 6768

5 Testimony of Cheryl Champion, R.N., page 6820

6 Testimony of Karen Daigle, R.N., page 6948

7 Testimony of Cheryl Champion, R.N., page 6768

8 Testimony of Karen Daigle, R.N., page 6948

9 Testimony of C/O Cameron Lamond, pages 6124, 6218

10 Testimony of Cheryl Champion, R.N., page 6780

11 Testimony of Cheryl Champion, R.N., page 6780

12 Testimony of Cheryl Champion, R.N., pages 6768–6769

13 Testimony of Karen Daigle, R.N., page 6965

14 Testimony of Karen Daigle, R.N., page 6949

15 Testimony of Cheryl Champion, R.N., page 6769

16 Testimony of Karen Daigle, R.N., page 6951

17 Testimony of Karen Daigle, R.N., page 6961

18 Testimony of Karen Daigle, R.N., page 6956

19 Testimony of Cheryl Champion, R.N., page 6829; Testimony of Karen Daigle, R.N., page 6957

20 Testimony of Cheryl Champion, R.N., page 6770

21 Testimony of Cheryl Champion, R.N., page 6771

22 Testimony of Karen Daigle, R.N., page 6966

23 Testimony of Karen Daigle, R.N., pages 6952, 6966

24 Testimony of Karen Daigle, R.N., page 6953 ("He was asystole.")

The Attendance of Paramedics to the CNSCF and the Transport to the Dartmouth General Hospital

It was approximately quarter to eight on the morning of November 22, 2007 when Emergency Health Services at the Main and Major EHS station in Dartmouth received a dispatch to the Central Nova Scotia Correctional Centre for a "witnessed cardiac arrest." It took paramedics Glenn Beck, Shawn Welsh and Kyle Meyer about 8 – 10 minutes to reach the facility.

The paramedics found two nurses working on Mr. Hyde. Mr. Hyde was observed to be cyanotic. Defibrillator pads had already been placed on his chest. When EHS connected Mr. Hyde to a cardiac monitor he was asystole, no cardiac rhythm. They inserted an endotracheal tube and began to "bag" him, forcing air in and out of his lungs. One intravenous line and then another were started.

Within minutes, firefighters from the Highfield Park Fire Station, Andrew Bednarz, Sherry Thibault and David Carmichael, also arrived as a result of 07:49 hours dispatch call for a "witnessed cardiac arrest" at the CNSCF.

Mr. Carmichael took over CPR chest compressions and Ms. Thibault assisted by holding intravenous bags over Mr. Hyde while EHS continued their care of him. In light of the nature of the incident and having been provided with information that Mr. Hyde had been in police custody the previous day, Mr. Bednarz radioed dispatch to contact Halifax Regional Police. He was surprised no one at the CNSCF had done so.[1]

The medications being "pushed" through the IV line were Epinephrine and Atropine. Checking the cardiac monitor, EHS noted a viable rhythm. A very weak, irregular femoral pulse was detected. Mr. Hyde's blood pressure was "really low." Then the pulse was gone. Paramedic Glenn Beck knew the medications were likely responsible for Mr. Hyde gaining a discernible pulse.

After a further IV infusion of Epinephrine, EHS noted that Mr. Hyde appeared to have gone into ventricular fibrillation (VF). Although this indicated that Mr. Hyde's heart was not actually working effectively to circulate blood, EHS regarded it as a "shockable" rhythm and proceeded to "shock" Mr. Hyde's heart. Checking the monitor, EHS saw that Mr. Hyde was asystole. They continued to work on Mr. Hyde, "pushing" the IV Epinephrine, "bagging" him and continuing the chest compressions. A pulse was detected and the decision made the get Mr. Hyde to hospital. It was now about 30 minutes since EHS and the firefighters had arrived. David Carmichael was sent with EHS to assist with chest compressions. Mr. Hyde's heart stopped again before EHS and Mr. Carmichael had left the CNSCF.[2]

En route Mr. Hyde was given further infusions of the IV Epinephrine and At-

ropine, with no results. A rhythm seen on the cardiac monitor in the ambulance dissipated within 5 to 6 seconds once chest compressions were stopped. There was nothing to shock as EHS had hoped and Mr. Hyde was observed to be once again asystole.

By the time the ambulance arrived at the Dartmouth General Emergency, efforts to resuscitate Mr. Hyde had been underway for about 40 minutes. Although Shawn Welsh had found a femoral pulse, one he described as "a good strong pulse", it did not have "enough pressure to really circulate anything."[3] CPR was continued by EHS at the Dartmouth General. Mr. Hyde was transferred to a stretcher in the Emergency and placed in a cardiac monitor. He was asystole.[4] The Emergency Department doctor, Dr. Wurster did an ultrasound of Mr. Hyde's heart that showed no movement at all. Resuscitation efforts were stopped.[5] Mr. Hyde was pronounced dead by Dr. Wurster at 08:42 on November 22, 2007.[6] EHS did not "call the arrest" because they transported Mr. Hyde to the Dartmouth General so that the Emergency Department doctor could do so.[7]

Notes

1 Exhibit 256, Statement of Andrew Bednarz, November 24, 2007, page 7

2 Exhibit 258, Statement of Kyle Meyer, November 22, 2007, page 11

3 Exhibit 263, Statement of Shawn Welsh, November 22, 2007, page 21

4 Exhibit 259, Statement of Lee Mailman, clinical leader, Dartmouth General ER, December 6, 2007, page 3

5 Exhibit 60, Tab 10:10, Dartmouth General Hospital Records

6 Exhibit 259, Statement of Lee Mailman, page 4; Exhibit 60, Tab 10:10, Dartmouth General Hospital Records

7 Exhibit 263, Statement of Shawn Welsh, page 23

Part III

Cause and Manner of Death

Date, Time and Place of Death

Howard Hyde died on November 22, 2007 at the Central Nova Scotia Correctional Facility in Dartmouth, Nova Scotia when his heart stopped sometime between 07:38:56[1] and 07:39:34[2] according to the time stamp for the surveillance camera in Search Cell #2. Although he was not pronounced dead until it was confirmed at the Dartmouth General Hospital by an ultrasound that he was asystole, there is no evidence that his heart restarted at any time during the resuscitation efforts by EHS. Dr. Wurster pronounced Mr. Hyde dead at 08:42 on November 22, 2007.[3]

In fixing the time when Mr. Hyde's heart likely stopped, according to the only record for time available – that of the video surveillance camera – I have relied on what Captain Todd Henwood[4] told the RCMP in his interview on November 22, 2007 when he was explaining the decision to remove Mr. Hyde's handcuffs:

> …I've seen dead people before in jails and…**I knew he was in trouble. I knew he was in some type of duress at that time, so I removed the handcuffs**…[5] [emphasis added]

It is this recollection by Captain Henwood of having decided to remove Mr. Hyde's handcuffs because he was limp and unresponsive that I accept as accurate and reliable.[6]

Notes

1 The time, according to the time stamp for search cell #2's video surveillance camera when the decision was made to remove Mr. Hyde's handcuffs.

2 The time, according to the time stamp for search cell #2's video surveillance camera when the handcuffs were removed.

3 Exhibit 259, Statement of Lee Mailman, page 4; Exhibit 60, Tab 10:10, Dartmouth General Hospital Records

4 Then, Sgt. Henwood.

5 Testimony of Cpt. Todd Henwood, pages 6593–6594

6 See further, Part II, Chapters 27 and 28 for descriptions of Mr. Hyde's condition at the time of and after his collapse in search cell #2.

Cause of Death: The Autopsy

An autopsy was performed on Mr. Hyde's body on November 23, 2007 by Dr. Martin Bullock, a fully trained forensic pathologist[1]. Dr. Bullock was selected to do the autopsy by Dr. Bowes because of his expertise. Dr. Bowes felt that as it was a "high-profile…in-custody death…[that had] to be managed with very specialized techniques", Dr. Bullock was the most appropriate choice.[2]

Dr. Bullock was qualified by the Inquiry as "a forensic pathologist able to give opinion evidence in respect of the cause and type of injuries to the human body."[3] Dr. Bullock was not asked to provide an opinion on what caused Mr. Hyde's death.[4]

An autopsy is an examination for evidence of injury and disease.[5] Dr. Bullock conducted Mr. Hyde's autopsy from approximately 08:45 to mid-afternoon on November 23,[6] preparing a Report of Postmortem Examination[7] and some additional notes[8] that documented his external and internal examination of Mr. Hyde's body. A series of photographs were also taken of the autopsy.[9]

Dr. Bullock was mindful of the fact that Mr. Hyde's death was an in-custody death[10] and did a comprehensive examination of the structures of Mr. Hyde's neck, chest and buttocks and those in his back[11], looking for evidence of deep soft tissue injury such as bruising to muscles. He carefully examined Mr. Hyde's neck structures for evidence of pressure or damage [12] but found none.[13] Mr. Hyde's body did indicate multiple blunt force injuries in the form of bruises and abrasions on his face, ears and scalp.[14] His skull was not fractured and there was no evidence of subdural or subarachnoid bleeding.[15] Dr. Bullock also located bruises on Mr. Hyde's neck and jaw and a superficial laceration of the lining of his right upper lip.[16]

Dr. Bullock saw rare[17] petechial hemorrhages – pinpoint hemorrhages – on the inner aspect of Mr. Hyde's conjunctiva[18] which can be an indication of pressure having been placed on the neck[19] although these hemorrhages are found "in many people who die under all sorts of circumstances, including natural circumstances."[20] It is numerous petechiae that raise the possibility of an asphyxial death, specifically, a death associated with pressure on the neck.[21] In Dr. Bullock's autopsy on Mr. Hyde's body, he did not find evidence of asphyxia, positional or otherwise.[22]

The autopsy also revealed bruising and abrasions on Mr. Hyde's torso and abdomen and the presence of multiple rib fractures.[23] Dr. Bullock attributed the rib fractures to CPR[24] which he felt was the most plausible explanation.[25] Rib fractures from vigorous CPR efforts are quite common.[26] Dr. Bullock identified bruising and abrasions on Mr. Hyde's back[27] and his hands, wrists, arms and legs.[28] These injuries were consistent with the physical events Mr. Hyde had experienced on November 21 and 22, including struggling while restrained.[29]

Dr. Bullock located "three pattern wounds" on Mr. Hyde's upper back consistent with Mr. Hyde having been shocked by CEW probes.[30] The injuries noted by Dr. Bullock were "burn-like", causing necrosis[31] of the "superficial portions of the

skin associated with bruising and blistering that I felt would be consistent with Taser injury."[32]

Dr. Bullock's examination of Mr. Hyde's internal organs did not identify any notable findings.[33] He noticed blood cells in the air sacs of Mr. Hyde's lungs, another "non-specific finding that is found in many autopsies."[34] He also did not consider the "little bit" of inflammation in Mr. Hyde's lungs to be of great significance.[35] In his report he noted "extensive intra-alveolar hemorrhage in both lungs, associated with moderate interstitial chronic inflammation."[36] Although Dr. Bullock could not provide a "clear-cut explanation" for why this occurred, it is seen in many autopsies.[37] The microscopic examination suggested it had happened around the time of Mr. Hyde's death[38] and could be related to CPR and the dying process.[39] The "ischemic necrosis" of Mr. Hyde's liver was consistent with low blood pressure and a lack of oxygen supply associated with Mr. Hyde's collapse in Booking on November 21.[40]

Dr. Bullock sent Mr. Hyde's heart to Dr. Avi Ostry, a cardiovascular pathologist, for examination, and his brain and spinal cord to Dr. Robert Macaulay, a neuropathologist.[41] Dr. Ostry indicated that the left circumflex artery of Mr. Hyde's heart showed narrowing that measured 60 – 70 percent at its greatest degree.[42] Dr. Ostry commented that the stenosis "…raises the possibility of a possible ischemic dysrhythmia although under 70% stenosis, these vessels are usually associated with thrombus."[43] The stenosis seen in Mr. Hyde's heart is not "typically consider[ed] a critical narrowing…"[44]

Dr. Macaulay noted that Mr. Hyde's brain was heavy, beyond what was considered normal for a brain weight, with some enlargement of the ventricles.[45] He described this in his consultation report as "mildly enlarged lateral ventricles" with the volume of the brain being "modestly more than average despite the expansion in ventricular volume."[46] Dr. Macaulay noted that the enlargement of the brain and the enlargement of the ventricles as "likely related" and commented that: "Enlargement of lateral ventricles is a regular observation in patients suffering from schizophrenia, although its precise relationship to the mental disorder is unknown." He found "no structural change which could account for death…"[47]

Dr. Bullock concluded his autopsy report with the following comment[48]:

> No anatomical findings are present to definitively explain this man's death. The injuries, while numerous, are generally superficial and not considered life-threatening. There is evidence of liver injury that would be consistent with an episode of hypotension[49] and ischemia[50] during his hospitalization 30 hours prior to his death. Extensive lung hemorrhage was present the explanation for which is not clear, but which appears fresh[51] and likely occurred around the time of his death (possibly associated with CPR).

Dr. Bullock signed off on his autopsy report on June 16, 2008, the cardiovascular and neuro-pathology consultation reports having been completed in January and February. On May 28, 2008, Dr. Bullock emailed[52] the Chief Medical Examiner, Dr. Matthew Bowes:

> I am just in the process of finalizing this [his postmortem report], but I really don't think there will be any earth-shattering findings that will explain his death. The best I will be able to do is issue a list of autopsy findings, and leave it to the ME concerned to give a COD/MOD[53].

Notes

1 Dr. Bullock has done work for the Medical Examiner's Office in Nova Scotia for many years. He has been qualified as an expert forensic pathologist in the courts in Ontario (1998–2008) and also Nova Scotia and Maryland. His curriculum vitae was entered as Exhibit 231.

2 Testimony of Dr. Matthew Bowes, pages 8140–8141

3 Transcript pages 7608 and 7614

4 Testimony of Dr. Martin Bullock, pages 7609–7610: "I was asked by Dr. Bowes [the Medical Examiner for Nova Scotia] if I would do this particular autopsy, because Dr. Bowes was unavailable to do it. And so I agreed to do the autopsy, for which I prepared a report documenting my findings at the autopsy. Subsequently, Dr. Bowes and I discussed the case, and as was normal practice at that time, Dr. Bowes wrote a report… stating the cause of death and the manner of death through examination of all the circumstances around this death."

5 Testimony of Dr. Martin Bullock, page 7626

6 Testimony of Dr. Martin Bullock, page 7624

7 Exhibit 113, pages 14–25 [Exhibit 113 is a binder of the file materials from the Halifax Medical Examiner's Office re: Howard Hyde]

8 Exhibit 233 (2 pages)

9 Exhibit 61, Tab 100, Photographs 48–182 taken by D/Cst. Andre Habib, HRPS Forensic Identification Section

10 Testimony of Dr. Martin Bullock, pages 7689–7690

11 Testimony of Dr. Martin Bullock, page 7630

12 Testimony of Dr. Martin Bullock, page 7631

13 Testimony of Dr. Martin Bullock, pages 7641, 7653. See also: Testimony of Dr. Martin Bullock, page 7652 referring to Exhibit 61, Tab 100, Photographs 144–150

14 Testimony of Dr. Martin Bullock, pages 7631–7633

15 Testimony of Dr. Martin Bullock, page 7633. See also: Testimony of Dr. Martin Bullock, pages 7654–7655 referring to Exhibit 61, Tab 100, Photographs 128–135

16 Testimony of Dr. Martin Bullock, page 7634

17 i.e., three or less. (Testimony of Dr. Martin Bullock, page 7658); "…I would use the term rare meaning one or two." (Testimony of Dr. Martin Bullock, page 7687)

18 i.e., eyelids. (Testimony of Dr. Martin Bullock, page 7628)

19 Testimony of Dr. Martin Bullock, page 7628

20 Testimony of Dr. Martin Bullock, page 7629

21 Testimony of Dr. Martin Bullock, page 7658

22 Testimony of Dr. Martin Bullock, page 7692

23 Testimony of Dr. Martin Bullock, page 7634

24 Testimony of Dr. Martin Bullock, pages 7646, 7677

25 Testimony of Dr. Martin Bullock, page 7679

26 Testimony of Dr. Martin Bullock, page 7661

27 Testimony of Dr. Martin Bullock, pages 7635–7636

28 Testimony of Dr. Martin Bullock, pages 7637–7641

29 Testimony of Dr. Martin Bullock, pages 7664–7667

30 Testimony of Dr. Martin Bullock, page 7646

31 i.e., death; Testimony of Dr. Martin Bullock, page 7651

32 Testimony of Dr. Martin Bullock, page 7651, referring to Exhibit 61, Tab 100, Photograph 155

33 Testimony of Dr. Martin Bullock, pages 7641–7643

34 Testimony of Dr. Martin Bullock, page 7644

35 Testimony of Dr. Martin Bullock, page 7644

36 Exhibit 113, page 24

37 Testimony of Dr. Martin Bullock, page 7660

38 Testimony of Dr. Martin Bullock, page 7661

39 Testimony of Dr. Martin Bullock, pages 7662, 7710

40 Testimony of Dr. Martin Bullock, pages 7647, 7663, 7737–7738

41 Testimony of Dr. Martin Bullock, page 7643.

42 Testimony of Dr. Martin Bullock, page 7646 referring to Exhibit 113, page 38, Dr. Ostry's Pathology Consultation Report. The left circumflex artery supplies the left side and sometimes the back of the heart.

43 Exhibit 113, page 38, Dr. Ostry's Pathology Consultation Report

44 Testimony of Dr. Martin Bullock, page 7664

45 Testimony of Dr. Martin Bullock, page 7647. The ventricles are the spaces inside the brain that are filled with cerebral spinal fluid.

46 Exhibit 113, page 27, Dr. Macaulay's Pathology Consultation Report

47 Exhibit 113, page 27, Dr. Macaulay's Pathology Consultation Report

48 Exhibit 113, page 25, Dr. Martin Bullock's Report of Postmortem Examination

49 i.e., low blood pressure. (Testimony of Dr. Martin Bullock, page 7647)

50 i.e., lack of oxygen supply. (Testimony of Dr. Martin Bullock, page 7647)

51 i.e., quite recent. (Testimony of Dr. Martin Bullock, page 7648)

52 Exhibit 239, page 5, Emails from the Medical Examiner's Office provided by Dr. Matthew Bowes

53 i.e, cause of death/manner of death. (Testimony of Dr. Matthew Bowes, page 8234)

Cause of Death: The Opinion of the Chief Medical Examiner

Dr. Matthew Bowes is the Chief Medical Examiner for the Province of Nova Scotia[1] a position he has held since 2006.[2] He was qualified by the Inquiry as a forensic pathologist and medical examiner able to give opinion evidence in respect to the type and cause of injuries to the human body and to the cause of death.[3] Since becoming the Chief Medical Examiner Dr. Bowes has certified all the causes of death for the cases that have been examined by the ME's office.[4]

What Dr. Bowes Reviewed

As the Chief Medical Examiner, Dr. Bowes prepared a report[5] after reviewing material relating to the case that included: police reports, can-say statements from correctional officers in relation to Mr. Hyde's collapse and death, Cpt. Paul Dorrington's Report[6], David Wojcik's Report[7], the autopsy reports, toxicology reports, and Mr. Hyde's previous medical records accessible through the Horizon Patient Folder (HPF) database,[8] Dr. Bowes also reviewed video footage of Mr. Hyde's struggle with correctional officers at the CNSCF.[9]

Dr. Bowes' Findings in His Examination of Mr. Hyde's Death

Dr. Bowes enumerated the "salient points" of the ME examination[10]:

- The autopsy did not demonstrate the presence of blunt force injuries that could explain Mr. Hyde's death;
- The autopsy demonstrated the presence of atherosclerotic coronary artery disease;
- The autopsy documented [Mr. Hyde's] weight of 87 kgs. and a height of 165 cms., giving a calculated body-mass index [BMA] of 32;
- Toxicological analysis performed on fluid and tissue taken from Mr. Hyde did not demonstrate the presence of a poison that could have caused his death. This analysis also failed to demonstrate the presence of Mr. Hyde's medication;
- Examination of the video evidence, the witness statements and other documents suggest that Mr. Hyde was in a state of excited delirium at the time of his collapse and death.
- Examination of the video evidence, the witness statements and other documents do not suggest that Mr. Hyde died directly of asphyxiation due to the restraint employed by the correctional officers;
- The investigation did not uncover credible evidence that the CED [CEW] caused Mr. Hyde's death.

Eliminating the CEW As a Cause of Death

In his examination of Mr. Hyde's death, Dr. Bowes eliminated the CEW as a cause although he did not discount the possibility of "electrical capture of the heart" under special circumstances.[11] However, three factors persuaded Dr. Bowes that the CEW was not the culprit in this case: (1) Of very significant weight in Dr. Bowes' opinion[12], the time course between the application of the CEW and the final collapse in death was approximately 30 hours, too long to account for Mr. Hyde's death[13]. Dr. Bowes referred to the exclusionary criterion of twenty-four hours between discharge of the CEW and death.[14] (2) The fact that Mr. Hyde was shot in the back, with the CEW probes, not the chest area around his heart.[15] (3) The events at the CNSCF superseded the use of the CEW and posed an intervening cause of death.[16]

Dr. Bowes also saw as relevant the fact that Mr. Hyde had been medically monitored in hospital after collapsing in Booking and that his blood chemistry and EKG indicated a "normal, if agitated man."[17]

Dr. Bowes' Conclusions on Cause and Manner of Death

Determining the cause of death in Mr. Hyde's case was not straightforward as it can be in some cases.[18] His case fell into the subset of cases where the chain of events causing death to occur "has been initiated by something that leaves no anatomic sequella" that can be detected in a postmortem examination.[19] Dr. Bowes indicated that such deaths require a very careful examination of the circumstances surrounding the death.[20] In Mr. Hyde's case, Dr. Bowes knew that Mr. Hyde had a diagnosis of schizophrenia, and based on the CNSCF videos and can-say statements of the correctional officers, concluded that Mr. Hyde was in a state of excited delirium when he died.[21] He stated this as:

> …excited delirium due to paranoid schizophrenia. Atherosclerotic coronary artery disease, obesity and restraint during a struggle are contributing factors.[22]

It is only the second or third time that Dr. Bowes has concluded that the cause of death was Excited Delirium.[23]

For the purposes of formulating his opinion on the cause of Mr. Hyde's death, it was the "last moments of Mr. Hyde's life" that were critical to Dr. Bowes.[24] For him, the most relevant information were the correctional officers' can-say statements and the CNSCF video of the struggle in Search Cell #2.[25]

Dr. Bowes found the manner of death[26] to have been "accidental."[27]

Excited Delirium

Dr. Bowes' focus for Mr. Hyde's cause of death became excited delirium, a controversial medical condition that has not been universally accepted as even existing.[28] The nomenclature alone is controversial with there being no consensus as to what the condition should be called.[29]

Dr. Bowes accepts excited delirium as "a distinct clinical entity" characterized by "some or all of the following symptoms: extreme agitation, violent and bizarre behaviour, insensitivity to pain, elevated body temperature and super human strength.[30] It is said to occur primarily in persons who are chronic cocaine users or as an acute complication of a pre-existing mental illness, typically schizophrenia.[31] Dr. Bowes concluded in his Report that: "Mr. Hyde has (sic) a long-standing history

of schizophrenia, and is thus at risk for the development of excited delirium. His symptoms at the time of his death (agitation, remarkable strength, bizarre statements) are typical of this condition."[32] Dr. Bowes based his opinion on the file material he reviewed in the case and "a largely negative autopsy."[33]

The Role of Restraint in Mr. Hyde's Death

In Dr. Bowes' opinion, the restraint of Mr. Hyde following the struggle in Search Cell #2 was a "reasonable contributor" to his death[34] He observed that it "only makes sense from a geometric point of view" that if an obese male – Mr. Hyde, with a BMI of 32, was obese – is placed face down on "their obese belly", the viscera "will put pressure on the diaphragm and cause…a hypoventilatory state."[35] However, in Dr. Bowes' view, the medical evidence for the restraint being causal "is not strong enough."[36]

In his Summary of the Investigation – Addendum to Post Mortem Report[37], Dr. Bowes considered various research studies (which he cited) and Mr. Hyde's case and reached the following conclusion about the factors that contributed to Mr. Hyde's death:

> …I conclude that it is reasonable to consider restraint as a contributing factor in this death, but I cannot quantify the role that this may have played. I also conclude that it is reasonable to consider artherosclerotic coronary artery disease and obesity as having contributed to this death.[38]

Cause of Death – Dr. Bowes' Practical Analysis

Dr. Bowes saw it as vital, in his determination of what caused Mr. Hyde's death, to be explicit about what was not a cause. Based primarily on the autopsy findings he was able to rule out blunt trauma, penetrating trauma, blunt abdominal trauma and strangulation through neck restraint.[39] He then dealt with the role of the CEW and the role of restraint, "and then the potential role of excited delirium."[40] It is his opinion that:

> …there are a number of different correct ways to classify this death, or perhaps one should say, not incorrect ways to classify this death. I would certainly not put my own opinion as being sacrosanct or absolute in any way...many reasonable people could come up with slightly different formulations. But I think the formulation I have put together is certainly a reasonable one, considering the data.[41]

Notes

1 Testimony of Dr. Matthew Bowes, page 8098

2 Testimony of Dr. Matthew Bowes, page 8102

3 Transcript, page 8101. Dr. Bowes' curriculum vitae was entered as Exhibit 232.

4 Testimony of Dr. Matthew Bowes, page 8199

5 Exhibit 113, pages 29–34, Summary of the Investigation – Addendum to Post Mortem Report ("Dr. Bowes' Report")

6 Exhibit 130

7 Exhibit 110

8 Testimony of Dr. Matthew Bowes, pages 8114–8116

9 Testimony of Dr. Matthew Bowes, pages 8120, 8211

10 Exhibit 113, page 29

11 Testimony of Dr. Matthew Bowes, page 8121

12 Testimony of Dr. Bowes, page 8278

13 Testimony of Dr. Matthew Bowes, page 8122, referring to a study by Nanthakumar K, Masse S, Umapathy K, Dorian P, Sevaptsidis E and Waxman M. "Cardiac stimulation with high voltage discharge from stun guns. CMAJ 2008; 178: 1451–1457 "There is no conclusive evidence to show whether stun gun stimulation (under certain electrophysiologic conditions) can result in cardiac arrhythmias, late after stun gun discharge." (Exhibit 113, page 32) The article also notes: *In our view, it is inappropriate to conclude that stun gun discharges cannot lead to adverse cardiac consequences in all real world settings.*

14 Testimony of Dr. Matthew Bowes, page 8122 referring to a study by Strote J and Hutson HR. "Taser use in restraint-related deaths." Prehosp. Emerg. Care 2006; 10: 447–450

15 Testimony of Dr. Matthew Bowes, pages 8123–8124

16 Testimony of Dr. Matthew Bowes, page 8124

17 Testimony of Dr. Matthew Bowes, page 8281, referring to his interview with Inquiry Counsel on November 30, 2009

18 Testimony of Dr. Matthew Bowes, page 8117

19 Testimony of Dr. Matthew Bowes, page 8118

20 Testimony of Dr. Matthew Bowes, page 8118

21 Testimony of Dr. Matthew Bowes, pages 8119, 8120

22 Exhibit 113, page 29

23 Testimony of Dr. Matthew Bowes, page 8289

24 Testimony of Dr. Matthew Bowes, page 8276

25 Testimony of Dr. Matthew Bowes, page 8289

26 *Fatality Investigations Act, 2001, c. 31,* section 2(i) defines manner of death as meaning "the mode or method of death whether natural, homicidal, suicidal, accidental or undeterminable."

27 Exhibit 113, page 29

28 Testimony of Dr. Matthew Bowes, page 8126

29 Testimony of Dr. Matthew Bowes, page 8126

30 Testimony of Dr. Matthew Bowes, page 8125; see also, Exhibit 113, page 30, Dr. Bowes' Report

31 Testimony of Dr. Matthew Bowes, page 8125, referring to his Report in Exhibit 113, page 30

32 Testimony of Dr. Matthew Bowes, page 8128

33 Testimony of Dr. Matthew Bowes, page 8128

34 Testimony of Dr. Matthew Bowes, page 8130

35 Testimony of Dr. Matthew Bowes, pages 8130, 8263–8266

36 Testimony of Dr. Matthew Bowes, pages 8130, 8266

37 Exhibit 113, pages 29–34

38 Exhibit 113, page 34

39 Testimony of Dr. Matthew Bowes, page 8291

40 Testimony of Dr. Matthew Bowes, page 8292

41 Testimony of Dr. Matthew Bowes, page 8292

Cause of Death: The Opinion of Dr. John Butt

Dr. John Butt, a forensic pathologist and formerly the Chief Medical Examiner for Nova Scotia[1], was also qualified[2] by the Inquiry to give opinion evidence in respect to the type and cause of injuries to the human body and the cause of death.[3] He reviewed a large amount of materials[4]: the RCMP investigation into Mr. Hyde's death (that included can-say statements from police and correctional officers); the Wojcik Report[5], the Martel Report[6], the Medical Examiner's file[7], files from the Public Prosecution Service[8], excerpted records for Mr. Hyde from the QEII[9] and videotape footage from HRPS (Booking) and the CNSCF (including the struggle in Search Cell #2). He submitted a 15 page report referencing 34 books and articles.[10]

The Autopsy

Dr. Butt was impressed with Dr. Bullock's autopsy, emphasizing that it was "done with great skill and attention to detail…everything that could and should have been done in this type of an autopsy…was done."[11] He agreed that Mr. Hyde's fractured ribs were likely due to resuscitation efforts on November 22[12], and while he acknowledged they could have been caused when Mr. Hyde was, on several occasions, taken to the floor,[13] he noted that broken ribs are excruciatingly painful and would have been detected at least in the ER on November 21 had Mr. Hyde been injured in HRPS Booking.[14] The deep bruising in Mr. Hyde's scalp and back could have been sustained in the various "take downs"[15] but could not be reliably dated.[16] Deep bruising of Mr. Hyde's back could have been caused by the pressure of a knee[17] although there was no evidence that anyone knelt on Mr. Hyde in the course of the struggles with him.[18] Dr. Butt found no evidence of injury to Mr. Hyde's brain, lungs or heart, just as Dr. Bullock had not.[19] He did not regard the hemorrhages in Mr. Hyde's lungs as an indication of trauma or an asphyxial death.[20] He saw the same burned tissue in the photographs that Dr. Bullock attributed to the application of the CEW.[21]

Clinical Chemistry at the QEII Emergency Department

Dr. Butt noted that there were some abnormal results in Mr. Hyde's blood chemistry after his collapse in Booking. He had not very significantly elevated levels of creatinine (used to gauge kidney function) which Dr. Butt thought was probably due to dehydration, as well as higher than normal creatine kinase (signaling muscle damage) which was unsurprising given Mr. Hyde's level of activity.[22] His elevated white blood cell count could be attributed to stress.[23] Dr. Butt was unable to determine the explanation for Mr. Hyde's abnormal EKG.[24]

Mr. Hyde's History and Circumstances

Like Dr. Bowes, Dr. Butt looked beyond the negative autopsy findings to Mr. Hyde's history and the circumstances of his death.[25] Three significant issues emerged from his analysis of Mr. Hyde's history: the schizophrenia diagnosis, non-compliance with medication, and agitation.[26] Dr. Butt observed that Mr. Hyde had experienced a previous occasion of agitation that led to the involvement of the police[27].

Dr. Butt's Opinion on Cause of Death

Dr. Butt attributed Mr. Hyde's death to "an agitated state related to chronic schizophrenia…associated with [the] restraint issue."[28] The "agitated part" of Dr. Butt's assessment of the cause of death was "the struggle".[29] He explained it by saying:

> …[the] physical activity is so proximate to the actual drop dead, which is literally what you see here, [that] I don't think you can remove the descriptor of the physical activity [from the cause of death.][30]

In his Report, Dr. Butt indicated that in his opinion the cause of Mr. Hyde's death was: "restraint related to agitated behaviour and due to chronic schizophrenia, the underlying cause."[31] He stated this in his testimony as the immediate cause of Mr. Hyde's death being "agitated behaviour associated with restraint" with the underlying cause being chronic schizophrenia.[32] He was not partial to Dr. Bowes' description of the cause of death as "excited delirium due to paranoid schizophrenia" because it left out the "immediate external factor" of struggle against restraint.[33] He saw the issue in these terms:

> Question: So…there has to be both a struggle and restraint? Restraint in and of itself, unless of course, it's of a very invasive nature, won't cause the problem?
>
> Answer: No, I don't agree with that statement. I think that…when you have a restraint system you can bank on there being a struggle involved… it's basically about a struggle of some form or another.[34]

In Dr. Butt's opinion, the failure to indicate the role of restraint in Mr. Hyde's death opened up the potential for the manner of Mr. Hyde's death to be classified as "natural" rather than "accidental" which he did not accept.[35] Dr. Butt concluded that restraint was a contributing factor to Mr. Hyde's death but was unable to say to what degree.[36]

And although "sudden deaths do occur with schizophrenia"[37], Dr. Butt was clear: he knows of no cases where someone with schizophrenia has just dropped dead because they were agitated.[38]

Dr. Butt thought it likely Mr. Hyde developed a cardiac arrhythmia at the CNSCF while being restrained and died "very quickly from that." With no anatomical findings to assist him, he was unable to say "whether [the cardiac arrhythmia he suspected had occurred at the CNSCF] was of the same genesis as the cardiac arrhythmia that developed and knocked him down once he was tasered…"[39]

Notes

1 January 1996 – September 1999

2 Dr. John Butt's curriculum vitae was entered as Exhibit 237. Dr. Butt has been qualified as an expert in forensic pathology in courts in the United Kingdom, most provinces in Canada, several state courts in the U.S. and on two occasions in the U.S. federal courts.

3 Transcript, page 8299

4 Testimony of Dr. John Butt, pages 8299–8302

5 Exhibit 110

6 Exhibit 111

7 Exhibit 113

8 Exhibits 122, 123, and 125

9 Exhibit 236

10 Exhibit 238

11 Testimony of Dr. John Butt, page 8308

12 Testimony of Dr. John Butt, pages 8310, 8353

13 Testimony of Dr. John Butt, page 8310

14 Testimony of Dr. John Butt, pages 8390–8391

15 Testimony of Dr. John Butt, page 8310

16 Testimony of Dr. John Butt, pages 8353–8354

17 Testimony of Dr. John Butt, pages 8310, 8354

18 Testimony of Dr. John Butt, page 8354

19 Testimony of Dr. John Butt, page 8311

20 Testimony of Dr. John Butt, pages 8355, 8371, 8388

21 Testimony of Dr. John Butt, pages 8313, 8326–8327, 8328

22 Testimony of Dr. John Butt, pages 8325–8329

23 Testimony of Dr. John Butt, page 8329

24 Testimony of Dr. John Butt, page 8329

25 Testimony of Dr. John Butt, page 8324

26 Testimony of Dr. John Butt, page 8342

27 Testimony of Dr. John Butt, pages 8340, 8352. Dr. Butt was plainly referencing the May 2007 episode when Mr. Hyde was apprehended and taken to the Nova Scotia Hospital after hanging from his balcony and threatening to stab his superintendent.

28 Testimony of Dr. John Butt, pages 8333–8334

29 Testimony of Dr. John Butt, page 8334

30 Testimony of Dr. John Butt, page 8334

31 Exhibit 238, Dr. Butt's Report, page 15

32 Testimony of Dr. John Butt, page 8337

33 Testimony of Dr. John Butt, pages 8337–8338

34 Testimony of Dr. John Butt, page 8346

35 Exhibit 238, Dr. Butt's Report, page 15. See also, Testimony of Dr. Butt, page 8338

36 Testimony of Dr. John Butt, page 8335

37 Testimony of Dr. John Butt, page 8336

38 Testimony of Dr. John Butt, page 8345

39 Testimony of Dr. John Butt, page 8349

Mr. Hyde's Heart

Dr. Charles Kerr, a cardiac electrophysiologist,[1] was qualified by the Inquiry to give expert opinion evidence in cardiology and electrophysiology, the cause of death and the administration of CPR.[2] His particular specialty in cardiac electrophysiology is "the study of abnormal heart rhythms."[3] Dr. Kerr reviewed a significant amount of material in preparing his opinions.[4]

Notwithstanding the complexity of the subject-matter, Dr. Kerr provided the Inquiry with an appreciation of the workings of the human heart, including abnormal heart rhythms[5].

Dr. Kerr also discussed the role in heart function of the sympathetic and parasympathetic nervous systems,[6] explaining that the sympathetic nervous system – the fight and flight reflex – is charged by adrenalin-type products – catecholamines – circulating from the adrenal gland.[7] It also is activated by direct stimulation of the nerves coming from the autonomic nervous system.[8] The activation of the sympathetic nervous system may trigger in a person exercising or receiving a painful stimuli an abnormal heart rhythm that would not develop when the person was at rest.[9] "…hearts that are under stimulation of the sympathetic nervous system are… more prone to developing abnormal heart rhythms."[10]

Anxiety, fear and pain will all "charge up the sympathetic nervous system so that it causes an outpouring of adrenalin products from the adrenal gland."[11] The heart then accelerates and the force of the heart's contractions increases "very dramatically." This requires more oxygen to maintain the heart's function because it is working harder. Blood pressure usually rises and the volume of blood pumped out of the heart increases.[12] This, in Dr. Kerr's view, is likely what was happening to Mr. Hyde in HRPS Booking before his collapse.[13] He attributed what happened to Mr. Hyde as probably the result of metabolic acidosis.[14]

A struggle against immoveable objects, especially if oxygen is depleted, will force skeletal muscles to go into anaerobic metabolism, a type of metabolism that does not use oxygen and produces byproducts that include lactic acid.[15] The acidity of the blood, otherwise delicately balanced, is increased (metabolic acidosis) and an inhibition in breathing will result in carbon dioxide accumulating in the blood and being converted to acid (respiratory acidosis).[16] Dr. Kerr used the term "metabolic derangements" to describe these phenomena.[17] Low oxygen levels in the blood (hypoxia[18]) and acidosis can disrupt the potassium levels in heart cells making the heart susceptible to developing abnormal rhythms, if the potassium levels are too low, or asystole, if the potassium levels climb too high.[19] Dr. Kerr referred to "this whole combination" as a hyperadrenergic state.[20]

Metabolic derangements are not part of the fight or flight sympathetic nervous system response.[21]

Pain, such as experienced from the application of a CEW, can amplify the hy-

peradrenergic state. "We know that pain causes blood pressure to go up. We know that pain causes the heart rate to go up. And that's because of the release of adrenalin and sympathetic stimulation of the heart."[22] It was Dr. Kerr's opinion that the application of the CEW to Mr. Hyde "could have been a contributing factor in further enhancing the already elevated catecholamine state."[23]

Mr. Hyde's Collapse at HRPS Booking on November 21

From his review of material related to the case, Dr. Kerr concluded that Mr. Hyde's heart rhythm after the collapse at HRPS Booking was sinus tachycardia "due to the intense sympathetic drive (release of adrenalin-like chemicals and sympathetic nerve stimulation) caused by the anxiety, pain, struggle and restraint."[24] His recorded heart rate of 170 was very fast, but "not out of the realm of what one can see under very intense stimulation of the sympathetic nervous system."[25] Mr. Hyde's systolic blood pressure was 140.

Dr. Kerr noted that Mr. Hyde's potassium, tested at the ER, was normal. Potassium is critical to the electrical function of the heart.[26] Mr. Hyde's creatinine kinase (CK) was elevated which was consistent with an "intense…struggle, and particularly "isometric exercise, straining against immovable objects."[27] The EKG taken at 3:23 showed sinus tachycardia and a much slower heart rate. The sinus tachycardia indicated that Mr. Hyde was still under "some degree of [cardiac] stress and sympathetic stimulation."[28]

Dr. Kerr commented on Mr. Hyde's cyanotic appearance at HRPS Booking on November 21. This suggested "an impairment of oxygenation" of a very large amount of blood.[29] The placement of Mr. Hyde in a prone position could have contributed to impairing his ability to breath with the attendant result of hypoxia.[30] Any metabolic derangement that occurred on November 21 would likely have been, in Dr. Kerr's opinion, completely resolved before the events of November 22.[31]

The sudden flushing that was observed, with colour visibly returning to Mr. Hyde's skin, indicated that he had a "quite abrupt resumption of his circulation and an ability to oxygenate the blood."[32] As for Mr. Hyde's apparent lack of pulse, Dr. Kerr noted that it can be difficult to take a carotid pulse, particularly in an emergency situation. In any event, being pulseless indicates the heart is not pumping effectively to circulate blood.[33]

Mr. Hyde's Death on November 22

In Dr. Kerr's opinion, Mr. Hyde died because his heart stopped.[34] He referred to this as the mechanism, not cause, of death,[35] stating: "…cause of death is sort of a difficult one…"[36] When EHS monitored Mr. Hyde's heart on November 22 at the CNSCF, it showed "electrical asystole", in other words, no electricity of the heart.[37] There was no recordable rhythm. Dr. Kerr noted that this was the condition of Mr. Hyde's heart when he was admitted to the Dartmouth General Hospital.[38]

According to Dr. Kerr, the factors that led to Mr. Hyde's heart stopping were the "extreme hyperadrenergic state, probably acidosis, probably hypoxia, have all led to asystole."[39] He didn't rule out ventricular fibrillation "burning out" into asystole.[40] Mr. Hyde was "severely distressed…under a lot of anxiety…intense physical activity."[41] In Dr. Kerr's view, Mr. Hyde's heart stoppage was related to the metabolic abnormalities that likely occurred during the events leading up to his death.[42]

The sympathetic nervous system response and the metabolic derangement effect can be increased by the restriction of breathing.[43]

In describing what he believed to be the processes that led to Mr. Hyde's heart stopping, Dr. Kerr indicated he was trying to provide "a mechanistic transition" from the state Mr. Hyde was in just before his heart stopped to the point when it was no longer beating.[44]

Dr. Kerr acknowledged that the mechanisms that led to Mr. Hyde's collapse on November 21 from which he recovered and his collapse on November 22 from which he did not were not identical but "…there clearly had to be something going on both days…"[45] Commenting on the struggles Mr. Hyde underwent at the CNSCF, Dr. Kerr observed:

> It is certainly not good for his heart to be in those recurrent episodes where there is clearly going to be a metabolic impact on the way the heart functions…the more times those occur, the more likely…it's going to cause short term sequella to a heart that is borderline normal.[46]

Dr. Kerr considered the fact that Mr. Hyde's heart was in the upper range of weight[47], for a man of his size. However he did not think it was likely this played a major role in Mr. Hyde's death.[48] Nor did he think the possibility that Mr. Hyde may have had fairly mild left ventricular hypertrophy (LVH), a condition related to hypertension, was significant.[49] As for the 60 – 70 percent[50] stenosis, Dr. Kerr noted this as artherosclerosis but not severe and not significant. "…we don't consider narrowings less than about 70 percent to be significant. They don't seem to interfere with blood flow."[51] He thought it unlikely to have been a factor in what happened to Mr. Hyde.[52]

It was Dr. Kerr's opinion that it was Mr. Hyde's underlying metabolic state that was the cause of his death, the "intense metabolic abnormalities and hyperadrenergic state" that he was experiencing.[53]

Notes

1 Dr. Kerr's curriculum vitae was entered as Exhibit 252.

2 Transcript, page 9406

3 Exhibit 255, Dr. Kerr's Report, page 1. Exhibit 255 is a redacted version of Dr. Kerr's original report which was entered as Exhibit 253. Certain opinions expressed by Dr. Kerr were objected to by counsel for various parties as being outside the scope of his expertise. Examination of Dr. Kerr, submissions, and my ruling on what Dr. Kerr was qualified to provide opinion evidence about is contained in Transcript pages 9350–9408. A redacted copy of Exhibit 253 was prepared subsequent to my ruling that certain portions of Dr. Kerr's original report were not admissible. Counsel for the NSGEU indicated his belief that the comments made by Dr. Kerr that were later determined by me to be inadmissible were made with the best of intentions in an effort to be helpful. (Transcript, page 9372) This was not disputed by anyone.

4 Exhibit 255, Dr. Kerr's Report, page 2: Timeline of the events of November 21 and 22, 2007, leading to Mr. Hyde's death; Postmortem examination; Report of the Medical Examiner; Witness reports; EHS Reports for November 21 and 22, 2007; Rhythm strips from the EHS for November 22, 2007; Medical report from the ER; DVD's of surveillance footage from HRPS Booking and the CNSCF; Dr. John Butt's Report; Extensive review of literature on conducted electronic weapons. See also, Testimony of Dr. Charles Kerr, page 9457

5 Testimony of Dr. Charles Kerr, pages 9425–9430. See also, Exhibit 255, Dr. Kerr's Report, pages 6–8

6 Testimony of Dr. Charles Kerr, page 9434

7 Exhibit 255, Dr. Kerr's Report, page 9

8 Testimony of Dr. Charles Kerr, page 9434

9 Testimony of Dr. Charles Kerr, page 9435

10 Exhibit 255, Dr. Kerr's Report, page 8

11 Testimony of Dr. Charles Kerr, pages 9436–9437

12 Testimony of Dr. Charles Kerr, page 9437

13 Testimony of Dr. Charles Kerr, page 9437

14 Testimony of Dr. Charles Kerr, pages 9447–9448

15 Testimony of Dr. Charles Kerr, page 9438

16 Testimony of Dr. Charles Kerr, page 9439

17 Testimony of Dr. Charles Kerr, page 9449

18 Low oxygen content in the arterial circulation. Testimony of Dr. Charles Kerr, page 9467

19 Testimony of Dr. Charles Kerr, pages 9349–9440

20 Testimony of Dr. Charles Kerr, page 9440

21 Testimony of Dr. Charles Kerr, page 9522

22 Testimony of Dr. Charles Kerr, page 9441

23 Exhibit 255, Dr. Kerr's Report, page 15

24 Exhibit 255, Dr. Kerr's Report, page 3. See also, Testimony of Dr. Kerr, page 9413

25 Testimony of Dr. Charles Kerr, page 9413

26 Testimony of Dr. Charles Kerr, page 9413

27 Testimony of Dr. Charles Kerr, pages 9413–9414

28 Testimony of Dr. Charles Kerr, pages 9460–9461

29 Testimony of Dr. Charles Kerr, page 9418

30 Testimony of Dr. Charles Kerr, page 9506

31 Testimony of Dr. Charles Kerr, page 9518

32 Testimony of Dr. Charles Kerr, pages 9418–9419

33 Testimony of Dr. Charles Kerr, page 9418

34 Testimony of Dr. Charles Kerr, page 9467

35 Testimony of Dr. Charles Kerr, pages 9455, 9466

36 Testimony of Dr. Charles Kerr, page 9466

37 Testimony of Dr. Charles Kerr, page 9417

38 Testimony of Dr. Charles Kerr, page 9418

39 Testimony of Dr. Charles Kerr, page 9448

40 Testimony of Dr. Charles Kerr, page 9448

41 Testimony of Dr. Charles Kerr, page 9455

42 Testimony of Dr. Charles Kerr, pages 9467, 9475

43 Testimony of Dr. Charles Kerr, page 9471

44 Testimony of Dr. Charles Kerr, page 9455

45 Testimony of Dr. Charles Kerr, page 9481

46 Testimony of Dr. Charles Kerr, page 9490

47 470 grams

48 Testimony of Dr. Charles Kerr, page 9421

49 Testimony of Dr. Charles Kerr, pages 9463–9464

50 Dr. Kerr commented that because blood vessels tend to collapse post-mortem, the 60 -70 percent is an approximation. (Testimony of Dr. Charles Kerr, page 9422)

51 Testimony of Dr. Charles Kerr, pages 9423, 9425

52 Testimony of Dr. Charles Kerr, pages 9492, 9493–9494

53 Exhibit 255, Dr. Kerr's Report, page 16

The Cause of Death Was Not Excited Delirium

Excited Delirium – An Introduction to the Controversy

There is significant controversy in the medical community as to whether excited delirium exists as a real medical entity.[1] It is not recognized in the reliable psychiatric literature[2] or the DSM IV.[3] However, the American College of Emergency Physicians' Excited Delirium Task Force reports a consensus "based on available evidence…that Excited Delirium is a real syndrome of uncertain etiology."[4] Excited delirium has assumed a very significant profile in the context of this Inquiry because it has been identified by the Province's Medical Examiner, Dr. Matthew Bowes, as the cause of Mr. Hyde's death.[5]

Cause of Death, Excited Delirium and the International Statistical Classification of Diseases

The *Fatality Investigations Act* provides that "cause of death" means "the medical cause of death according to the International Statistical Classification of Diseases and Related Health Problems as last revised by the International Conference for that purpose and published by the World Health Organization."[6] Excited delirium is not listed as a cause of death in the International Statistical Classification of Diseases (ICD).[7] In Nova Scotia, it is the Vital Statistics Department that "codes" deaths according to the ICD: "…all this death data does go into a process whereby it's coded according to international classification of disease."[8]

Dr. Christine Hall[9] identified nine codes in the ICD "that can be assigned to coders to describe the delirious states of patients as recorded in hospital notes by a variety of practitioners…Abnormal excitement, Manic excitement, psychomotor excitement, agitation, psychomotor agitation, Delirium, Delirium of mixed origin, Delirium, drug induced, and Delirium, induced by drug."[10] She went on to explain the ICD coding system and its compatibility with what was observed about Mr. Hyde:

> …Each of these [9] codes reflects potential language medical practitioners have used in the description of the individual who is delirious from a wide variety of potential medical problems. The ICD 9/10 coding system recognizes that there are many ways to describe a delirious person with agitation and/or physiologic excitement and does not subscribe to the notion that only exact language indicates whether or not a medical condition exists. It is important to note that the coding to determine when a condition existed during the hospitalization is based on medical practitioners' descriptions of the behaviour of the patient in the hospital and is not dependent on the

> determination of a final diagnosis since descriptions are noted in the chart irrespective of final diagnosis. Mr. Hyde's behaviours in the corrections facility on the night before his death would clearly have been captured by ICD coding, had those behaviours occurred in a hospital. It is hard to imagine that his not being within hospital walls at the time somehow makes those features irrelevant to his subsequent health.

Dr. Bowes applauded Dr. Hall's coding explanation as "really very nicely described…"[11]

Excited Delirium – The Nomenclature

Excited delirium is said to be characterized by "some or all of…extreme agitation, violent and bizarre behaviour, insensitivity to pain, elevated body temperature and super human strength."[12] Dr. Bowes, a member of the panel of Nova Scotia experts that produced the Report of the Panel of Mental Health and Medical Experts Review of Excited Delirium[13] agrees that he might now classify Mr. Hyde's death as caused by an "autonomic hyper-arousal state" (AHS).[14]

It does not seem to me to make a difference whether the description for Mr. Hyde's cause of death is couched in the language of "excited delirium" or "autonomic hyper-arousal state." Nomenclature has been a focus of debate in the controversy that surrounds the phenomenon of sudden, otherwise unexplained deaths where there have been recognizable pre-mortem clinical and behavioural characteristics.[15] Dr. Christine Hall indicated that she, and the American College of Emergency Physicians' Task Force on Excited Delirium decided to retain usage of the term "excited delirium" primarily because the existing body of research uses that terminology.[16] She took no issue with the use by the Nova Scotia Experts' Panel of "autonomic hyper-arousal state" to describe what she calls excited delirium, commenting that: "You can call it whatever you like, as long as the descriptions are the same."[17] She explained what the terminology accomplishes: "It is just a descriptor. It's a way for me to say to you, this is what I think is going on, without doing the whole summary of the event."[18]

Although not asked to provide an opinion on the cause of Mr. Hyde's death, it is clear that Dr. Hall's saw Mr. Hyde's death in the same terms as Dr. Bowes: "… we really need to think about excited delirium as an umbrella term under which many underlying diagnoses [in Mr. Hyde's case – the diagnosis of chronic schizophrenia] can generate a person being in that undifferentiated state."[19] She too was familiar with the "negative autopsy" referred to by Dr. Bowes, acknowledging that in sudden-in custody deaths the medical examiner usually cannot determine an anatomic cause of death.[20]

The Features of Excited Delirium

The terminology "excited delirium" emerges from a description of the mental ("delirium") and physical and physiologic state.[21] The term "excited" refers to individual's motor agitation plus their physiologic condition. Signs of physiologic excitation are elevated vital signs, such as heart rate, blood pressure and temperature.[22] The American College of Emergency Physicians' Task Force White Paper Report on Excited Delirium Syndrome ("the ACEP's White Paper")[23] describes that clinical picture of excited delirium as being "…one of an agitated and delirious state with autonomic dysregulation. It manifests through sympathetic hyper-arousal

with frequent hyperthermia, vital signs abnormalities, and metabolic acidosis…"[24] Dr. Hall explained that autonomic dysregulation is a failure of normal autonomic control of the body's vital signs with the result in a person with excited delirium of elevated temperature, blood pressure and heart rate.

Dr. Bowes also referred the Inquiry to the ACEP's White Paper for a "…comprehensive list of symptoms in this case."[25] Dr. Bowes approved the following "well known features of this disorder" from the White Paper as "a nice capsule summary of [excited delirium]"[26]:

> When death occurs, it occurs suddenly, typically following physical control measures (physical, noxious chemical, or electrical), and there is no clear anatomic cause of death at autopsy. In cases in which a subject dies following the application of control measures, many or most of the following features are found:
>
> - Male subjects, average age 36
> - Destructive or bizarre behaviour generating calls to police
> - Suspected or known psychostimulant drug or alcohol intoxication
> - Nudity or inappropriate clothing for the environment
> - Failure to recognize or respond to police presence at the scene (reflecting delirium)
> - Erratic or violent behaviour
> - Unusual physical strength and stamina
> - Ongoing struggle despite futility
> - Cardiopulmonary collapse immediately following a struggle or very shortly after quiescence
> - Inability to be resuscitated at the scene, and
> - Inability for a pathologist to determine a specific organic cause of death
> - Attraction to glass or reflective surfaces (less frequent than all others per the Canadian data)

Dr. Bowes acknowledged that the fewer the criteria present, the weaker the case for excited delirium as an explanation for the cause of death.[27]

Dr. Hall described the manifestations of excited delirium as including: agitation, incoherence, resistance and struggle, sweating, sometimes being hot to touch, failure to recognize police presence or the presence of care givers, imperviousness to pain and superhuman strength.[28]

There are no diagnostic tests for excited delirium[29] and the diagnosis depends on "an appropriate history…physical exam, investigation and clinical course."[30] Dr. Hall agreed when it was put to her that excited delirium is an attempt to "corral" a group of undifferentiated symptoms under a label to guide the response of various members of the criminal justice and medical systems.[31]

"Excited delirium" cases are "all very different" and the symptoms associated with them are "very subjective."[32] The determination of an excited delirium death is "based more on the circumstances [of the death] rather than any hard and fast test."[33] "It's the overall picture…the overall feeling, that this is a bad situation…"[34]

Dr. Hall described excited delirium as "compelling in its abnormality…It is a person who implodes and becomes violent and profoundly resistant to intervention and is not someone that can be reasoned with or talked to. It's staggering."[35]

Delirium

Delirium is the most important facet of excited delirium.[36] Delirium is "an abnormal reaction [by the individual] with [their] environment."[37] Delirium combined with,

> …psychomotor agitation, and physiologic excitation differentiates [excited delirium] from other processes that induce delirium only. Similarly, subjects who are agitated or violent but who do not also demonstrate features of delirium simply do not meet the definition of [excited delirium.][38]

The person experiencing excited delirium "is not a goal-oriented person who is bargaining, making a deal, trying to negotiate…"[39] There may be "startling moments of clarity" which Dr. Hall illustrated with the following example:

> …a person… running rampant in a neighbourhood, diving under cars, had just run through a wood fence, and stopped in the backyard, and was described by everyone as being completely nonsensical, crashed through this fence and stopped and there as a dog in the backyard and he stopped and looked at the homeowner, who was startled to find him in his backyard and said, I love dogs, and then carried on, completely delirious, and subsequently died a short time later.[40]

Asked about the evidence that Mr. Hyde had been compliant at various times on November 21 and 22, Dr. Hall cautioned against taking "moments of clarity" out of context and "chopping these cases up into isolated moments of time" when what is required is an understanding of "the whole event."[41]

Dr. Christine Hall's Assessment of Mr. Hyde as a Case of Excited Delirium

It was from a review of the events[42] leading up to Mr. Hyde's death that Dr. Hall concluded he was experiencing excited delirium in HRPS Booking on November 21, and again, on November 22 at the CNSCF.[43] Referring to Mr. Hyde's struggle with police in Booking, Dr. Hall viewed excited delirium as the explanation for "the agitated, incoherent, screaming, violently struggling person…[who is] not goal directed…[44] She stated Mr. Hyde's condition on admission to the QEII Emergency Department as: "screaming, incoherent, agitated and [requiring] chemical sedation to control him."[45] That, she said, is excited delirium.[46] Dr. Hall agreed that Mr. Hyde was neither delirious nor in a state of "mental, physical or physiologic excitation" when, on the morning of November 21, he was talking to the nurses and police officers in the ER and eating breakfast.[47]

Dr. Hall identified the features of excited delirium in what she reviewed about Mr. Hyde at HRPS Booking:

> …Mr. Hyde was agitated, violent, struggling and, by the notations of persons around him at the time, that he was incoherent, agitated, paranoid… and that the combination of those things combined with intense physical struggle requiring multiple people to restrain and then having a fatal cardiopulmonary arrest on the second event is in keeping with what we know about sudden in-custody death and excited delirium.[48]

She added: "…I believe on the first event in the booking area that many people would describe that event, myself included, as a person who is seemingly paranoid, maybe, and having a schizophrenic break, as it were, and then it becomes something else."[49] The "something else" evolved over time in Dr. Hall's assessment: she took into account Ms. Ellet's description of Mr. Hyde decompensating in the days leading up to November 21 and Mr. Hyde's behaviour in Booking and the CNSCF – "nonsensical speech and superhuman strength" [in Booking] and "pacing and incoherence" [at the CNSCF] in concluding that it was "…the totality of the whole event…that makes one appreciate that this is an event that's dynamic and evolving and going badly."[50]

The Expert Evidence that Mr. Hyde Was Not in a State of Excited Delirium

Expert witnesses to the Inquiry were sharply divided about excited delirium. As I have noted, Dr. Hall accepts it as a valid medical entity that can explain sudden in-custody death. It was however also described as "an ideology", an "unhelpful concept" that has more disadvantages associated with it than advantages.[51]

The Inquiry heard from two forensic psychiatrists on the issue of Mr. Hyde's mental state during November 21 and 22, 2007. Dr. Joseph Noone was qualified by the Inquiry[52] to give expert opinion evidence concerning forensic and emergency psychiatry and the clinical aspects of violent behaviour.[53] He reviewed the compendious materials related to the case[54]: RCMP investigation binders (2 volumes), Department of Justice materials, Public Prosecution Service files concerning Mr. Hyde, medical records from the Capital District Health Authority, and the Medical Examiners' Report. The materials he reviewed included the surveillance videotapes from the HRPS and the CNSCF.[55]

After preparing his report[56], Dr. Noone received six volumes of medical records relating to Mr. Hyde from the CDHA.[57] This material did not change Dr. Noone's opinions as expressed in his report although they did give him a better understanding of "the context and…systems issues…"[58]

Dr. Stephen Hucker was qualified by the Inquiry[59] as an expert in forensic psychiatry, able to give opinion evidence in forensic psychiatry as it relates to hospitals, courts, clinical criminology and the law. He reviewed the same full range of materials provided to other experts: the RCMP investigation binders (2 volumes), materials received from the Department of Justice, Public Prosecution Service files relating to Mr. Hyde, medical records from CDHA, the Medical Examiner's Report, the video surveillance DVD's, full disclosure from the Halifax Regional Police Service.[60] Dr. Hucker viewed the video footage from both HRPS Booking and the CNSCF.[61]

Dr. Noone concluded that Mr. Hyde had "a major, persistent and severe" mental illness – schizophrenia – since his 20's.[62] It was his opinion that Mr. Hyde had "a chronic major mental illness of psychotic proportions and in the period leading up to the incident commencing 21 Nov 2007, was suffering a relapse of his mental disorder."[63] Dr. Noone recognized it as a relapse very similar to what Mr. Hyde had experienced in the past.[64] The fact that Mr. Hyde was "psychotic and suffering from delusions presumably of a persecutory nature…helps…explain to a great extent his behaviour."[65] His belief that the long hallway contained demons was a delusional belief and symptomatic of his illness.[66]

A delirious state is manifested by impaired perception (impaired visual cues, hearing, touch, taste, smell) coupled with impaired cognition.[67] It is different from

a delusional state: a delusion is a firmly held fixed belief.[68] A delirious person experiences an abnormal interaction with their environment because they cannot interpret their perceptual abnormalities and think their way through them.[69] Delusions do not make a person delirious.

The "fundamental manifestation" of excited delirium is delirium.[70] Significantly, on this crucial issue in Mr. Hyde's case, Dr. Noone, viewing the video surveillance footage, saw no evidence that Mr. Hyde was experiencing delirium either in HRPS Booking or the CNSCF.[71] Dr. Noone is highly qualified to recognize delirium: he sees delirious patients in his hospital practice "once a week, usually." According to Dr. Butt, the issue of whether Mr. Hyde was experiencing delirium is "best left to a clinical expert in psychiatry."[72]

Dr. Noone described how acutely psychotic people with a specific delusional fear will sometimes disregard direct orders due to being in a different reality.[73] He also noted that pain compliance generally does not work, and, in fact, usually worsens the situation because the acutely psychotic person subjected to pain becomes more fearful and aggressive. "They get more of "a kick-in from fear."[74] He explored the issue of what triggered Mr. Hyde to flee from the officers in HRPS Booking:

> …it was probably the production of the lace-cutter, which he perceived, in a psychotic sense, to be possibly an attack on him, and also in his conversations with [Cst. Edwards in Booking] he was trying to be nice and say "you're a nice guy, but some of the guys are not so nice." So he was doing his best to kind of negotiate around a very fearful state, and one thing we know about fear is it's a potent trigger for adrenaline release. So, again, you get a kind of a vicious circle where the adrenaline increases. The cognitive functioning deteriorates and then you have behaviour that's understandable in the context. He wasn't combative in his behaviour…he was actively resistant, and he was probably actively resistant[75] because he was trying to get away because of his fear.[76]
>
> …
>
> [In HRPS Booking]…he went into that room…and then he came flying out, from my point of view…like a bat out of hell…he obviously was extremely fearful, and he was trying to "get away"…probably, most likely, for psychotic reasons because of his belief…he got basically grabbed by the officers that were there. And…he was so goal-directed, they had a hard time…trying to control him. In fact, he "got away" from them once he was Tasered.[77]

In Dr. Noone's opinion Mr. Hyde was experiencing a psychiatric emergency, certainly by the time of the altercation with Ms. Ellet at Albro Lake Road, an emergency that at no point came to an end.[78] At HRPS Booking Mr. Hyde was in a hyperarousal state due to fear that he is going to be hurt by the police. "…That's his reality. And he's pumped…"[79] His primitive "fight or flight" reflex had kicked in[80] with the high adrenaline rate producing "very powerful" changes to his gross motor strength and his cognition.[81]

Like Dr. Noone, Dr. Hucker recognized that Mr. Hyde was experiencing a psychiatric emergency. It was developing when he was at Albro Lake Road in an agitated state with Ms. Ellet.[82] Dr. Hucker noted the assault on Ms. Ellet and commented that: "…it is not uncommon for mentally ill persons to become involved in minor acts of aggression when they are agitated, suspicious or frankly delusional as it ap-

pears that Mr. Hyde was on this occasion."[83] He understood Mr. Hyde to be,

> A man with a chronic mental illness with no fundamentally antisocial orientation or substance abuse problem who [repeatedly] decided he was well enough to do without his medication and deteriorated and the process relapsed and remitted according to that cycle.[84]

In his experience, Mr. Hyde's history disclosed a "very typical…commonplace problem."[85]

Dr. Hucker characterized Mr. Hyde as being in "an acutely disturbed mental state", or, in other words, acutely psychotic.[86] He described his view of Mr. Hyde's condition at HRPS Booking and the CNSCF:

> …I think he was in a decompensated state, largely because he had come off his medication. So his illness was gathering momentum. And I was asked the question whether a person could have a fluctuating state. That's right. Because he was looking quiescent one minute, agitated the next, raving and shouting the next. It's all part of the same disorganization and decompensation. So it remains an emergency until that's contained.[87]

Even when apparently calm and lucid, Mr. Hyde's psychotic symptoms would have been affecting his perceptions and judgments.[88] The psychosis may not be obvious all the time. It doesn't mean that the problem is any less severe. It just means that at that time it is not being manifest in the same way.[89]

Dr. Hucker recognized that Mr. Hyde was "obviously terrified" at HRPS Booking:

> I mean he said as much. And people who have paranoid delusions often are. I mean if we had a similar situation that was real, then we would be terrified too. And because that's their reality, that's how they respond…"[90]

What Dr. Hucker did not identify was delirium. He saw the situation in HRPS Booking as "an aggressive incident building up." Mr. Hyde's agitation was "revving up" and there was no "scaling back."[91] Dr. Hucker saw the same process of acceleration and deterioration repeat itself at the CNSCF.[92]

From a psychiatric perspective, Dr. Hucker took issue with the linkage of excited delirium in Mr. Hyde's case to his schizophrenia, criticizing it as "unsatisfactory"[93] and stating: "The vast majority of schizophrenics never develop anything remotely like an excited delirium."[94] Dr. Hucker identified excited delirium as "something that's being created to try and explain certain circumstances where sometimes mentally ill people are involved, but not always..."[95] Referring to the fact that "excited delirium" is a term "nowhere to be found as such in current official psychiatric or medical nomenclature", Dr. Hucker took the view that: "If it is a genuine entity, it is surely the result of a combination of factors of which schizophrenia may not be the essential component."[96]

My View of the Issue: Was Mr. Hyde in a State of Excited Delirium?

The Testimonial and Videotape Evidence

Having carefully examined the circumstances surrounding Mr. Hyde's struggles with police and correctional officers on November 21 and 22, and the expert opinion evidence, I find that Mr. Hyde was not in a state of excited delirium at any time during the approximately 30 hours leading up to his death. Neither the testimonial evidence nor the videotaped surveillance footage satisfies me that Mr. Hyde exhibited what has been described as the features of the disorder, reviewed by me earlier in this chapter. Unlike Dr. Hall[97], the overwhelming feeling I have is that this was not a case of excited delirium.

Mr. Hyde had a diagnosis of schizophrenia and a history of decompensation following periods of non-compliance with his medication. On November 21, he was at Albro Lake Road with Ms. Ellet wearing only a pair of boxer shorts because he minded the temperature of the apartment. He was found by police in this condition of undress after he had clambered down the balconies of the apartment building to evade the police. He had wasted no time getting out of the apartment once Csts. Gillis and Jardine arrived. His flight from the apartment was consistent with the reason for his assault of Ms. Ellet when she was on the telephone to the Mobile Mental Health Crisis Team: he did not want to face the intervention of mental health or police authorities. He did not want to go back to hospital. It is to be remembered that Mr. Hyde was "most prone to act impulsively and /or aggressively when acutely psychotic and feels his liberty is about to be curtailed."[98]

There was no time when Mr. Hyde failed to recognize or respond to the police presence. He was cooperative with police right up to the point when he perceived a threat – the cutting of "one of those balls off" – and tried to escape. He can be plainly heard on the video surveillance telling the police officers struggling to restrain him that he is sorry and that he is innocent, asking them what they are doing when the CEW is deployed, and referring to his lawyer. None of this indicates incoherence.

Mr. Hyde was also plainly not impervious to pain. He reacted very strongly, screaming in pain when the CEW was applied and leaping over the Booking counter to escape. And it did not involve extraordinary strength for him to get away from the officers; they stood back and Mr. Hyde can be seen on the video surveillance immediately taking advantage of the opportunity to climb over the counter and dart away.

S/Cst. MacCormick referred to feeling as though they (the police) were losing the fight[99] so the encounter can hardly be described as a futile struggle by Mr. Hyde.[100] And in terms of achieving his objective, Mr. Hyde did successfully escape from the officers, if only for a very brief time.

The officers did report Mr. Hyde being very difficult to restrain and extremely strong. Notwithstanding his strength, they were actually able to bring him down to the ground very rapidly both behind the Booking counter[101] and also out in the hallway[102]. Mr. Hyde continued to resist and much was made of the fact that he snapped a zip tie[103] secured briefly around his ankles. This does indicate that Mr. Hyde was able to exert considerable strength in his struggle with the officers: in S/Cst. MacCormick's prior experience, "…no one had strength like that."[104] This was an unusual event for the police officers: in all likelihood none of their previous prisoners had been as terrified as Mr. Hyde.

Painfully jolted by the CEW and fired up with fear, Mr. Hyde, a man who was physically active and had been able to scale down a four story building, was surging with strength that enabled him to put up a stiff resistance to the officers, including snapping the plastic zip tie.

Mr. Hyde's actions completely undermine any suggestion that he was not "goal oriented." He was very much goal oriented and how he responded to the police officers was intelligible in the context of his paranoia and anxiety. He was solely focused on getting away from the officers whom he believed were going to hurt him. And those fears were only reinforced when the officers did indeed hurt him by deploying the CEW.

Dr. Hall remembered, inaccurately, that Mr. Hyde was brought into the ER "screaming, incoherent, agitated"[105] Although Mr. Hyde was experiencing a psychotic episode recognized by Dr. Curry and treated with olanzapine, on admission he was not exhibiting the signs that have been identified as characterizing excited delirium. For example, when Mr. Hyde's temperature was taken, it was 36.8[106] which is a normal temperature.[107] This indicates that on admission to the ER, Mr. Hyde was not hyperthermic.[108]

Excessive sweating is also said to be a feature of excited delirium[109], and yet, only one police officer described Mr. Hyde "sweating"[110] and none of the officers, including the correctional officers who struggled with Mr. Hyde on November 22, made any mention of him being hot to the touch.[111]

At the CNSCF, Mr. Hyde's struggle with the correctional officers was once again the result of delusional fears[112] this time related to going down the long, gloomy hallway (with no readily visible door) to Admissions and shortly afterwards, entering Search Cell #2. Any incoherence emerged from Mr. Hyde's delusional state, a function of his having an acute psychotic episode. The struggle that started again when Mr. Hyde balked just outside the cell, continued for another six minutes before he collapsed. It would be a mistake in my opinion to view Mr. Hyde as having been engaged in a futile struggle: struggling can be "a natural response to the subjective sensation of being unable to breathe…"[113]

Medical Diagnosis and Treatment on November 21

Not only do I reject the suggestion that the evidence of Mr. Hyde struggling with the police and correctional officers shows him in the throes of excited delirium, delirium was not a condition identified at the ER. Neither of the Emergency Department doctors – Drs. Curry and MacIntyre – diagnosed Mr. Hyde as experiencing delirium or treated him for it. The nurses who attended to Mr. Hyde viewed him as delusional[114], and charted this.[115]

Other Factors that Contributed to Mr. Hyde's Condition

In addition to Mr. Hyde's serious mental illness and the fear and anxiety that sprang from that, I find there were other factors also in play that likely contributed to him deteriorating in custody at HRPS Booking and the CNSCF. Dehydration and lack of sleep and food are psychological stressors that "will tend to accumulate in persons like Mr. Hyde" with negative effects.[116] They can aggravate an acute psychotic episode by metabolically destabilizing the person.[117]

These factors are relevant in Mr. Hyde's case, even if the extent to which they may have affected him is unknowable.[118] We do know that in Mr. Hyde's case, lack of sleep at least exacerbated Mr. Hyde's psychosis.[119]

The evidence indicates that Mr. Hyde was awake throughout the early morning hours of November 21 in police custody, sleeping only for a brief period while sedated at the ER. He was then awake throughout the day on November 21, into that night and went without any or much sleep in the Health Segregation cell where he was known to have been relentlessly pacing. In the 13 hours that Mr. Hyde spent in the cell, he paced for 12 hours and 9 minutes and was off his feet for a total of 51 minutes, not necessarily sleeping.[120] There is no evidence as to when Mr. Hyde may have last had a proper night's sleep – sometimes persons with serious psychiatric issues have sleep disturbances for "months on end"[121] – but it is clear that he had almost no sleep in the 30 hours of his life that has been examined by this Inquiry.

The evidence also indicates that Mr. Hyde had not had much to eat or drink over those 30 hours. Around 07:00 on November 21, he requested and received juice in the ER and did have some breakfast. There is no evidence that he asked for or was provided with any lunch either at HRPS Booking before he went to court or at the courthouse. He can be seen eating and drinking during the admissions process at the CNSCF.[122] Between 19:30 and 20:00 when Mr. Hyde was in the Health Segragation cell, C/O Kayongo brought him some juice. The "bag" breakfast that Mr. Hyde was provided in the early morning of November 22 just prior to his escort from the cell for court, was uneaten. Mr. Hyde can be seen carrying it along as he walks behind C/O's Lloyd and Jones, just before the whole situation unravels for the final time.

Throughout the approximately 30 hours between Mr. Hyde's arrest on November 21 and his death on November 22, he had hardly any sleep, not much nutrition and very little to drink. The same 30 hours were punctuated by bursts of intense activity and heightened psychological stress and anxiety. The effects of being without adequate food, hydration and sleep when Mr. Hyde's body and mind were undergoing such significant stress must be recognized as having contributed to his decompensation in custody.

Excited Delirium – Concluding Remarks

It is unnecessary for me to decide whether excited delirium is an actual medical entity or not. Considering the totality of the evidence at this Inquiry, I find myself in the camp of the skeptics. The concerns raised by Drs. Butt and Noone in particular resonated with me. However what is crucial for the purposes of the mandate of this Inquiry is whether I accept that Mr. Hyde's cause of death was "excited delirium due to paranoid schizophrenia" as determined by Dr. Matthew Bowes. With due respect to Dr. Bowes, I do not find this to have been the cause of death.

This Inquiry heard from Dr. Bowes that the determination of an excited delirium death is "based more on the circumstances [of the death] rather than any hard and fast test."[123] Dr. Hall referred to the focus being on "the overall feeling, that this is a bad situation."[124] While I am of course not medically trained, I have had the benefit of hearing, and reviewing in careful detail, all the evidence relating to Mr. Hyde's death and the circumstances leading up to it. I am satisfied that what I see is not what has been described to the Inquiry as "excited delirium".

Notes

1 Testimony of Dr. Christine Hall, pages 8975, 9014. See, also, Testimony of Dr. Joseph Noone, page 9157: "It's very unsatisfactory from a psychiatry point of view." And from Dr. Noone's Report (Exhibit 251) at page 6: "The term excited delirium is not an accepted medical or psychiatric diagnosis." Dr. Hall was qualified to give expert opinion evidence concerning excited delirium and sudden in-custody death. (Transcript, page 8780) Dr. Noone was qualified by the Inquiry to give expert opinion evidence concerning forensic and emergency psychiatry and the clinical aspects of violent behaviour. (Transcript, page 9118)

2 Testimony of Dr. John Butt, page 8307. Dr. Butt tends to avoid using the term "… notably [because it] does not appear in the reliable psychiatric literature." Dr. Stephen Hucker, qualified by the Inquiry as an expert in forensic psychiatry also observed that "excited delirium" is not in the "psychiatric nomenclature." (Testimony of Dr. Stephen Hucker, page 10033)

3 Testimony of Dr. John Butt, page 8321.

4 The American College of Emergency Physicians' White Paper Report on Excited Delirium Syndrome, September 10, 2009, Summary. The ACEP's White Paper is not paginated so I am unable to provide the reader with the convenience of page references.

5 Exhibit 113, page 29, Summary of the Investigation – Addendum to Post Mortem Report ("Dr. Bowes' Report")

6 *Fatality Investigations Act, 2001, c. 31*, section 2(c)

7 Testimony of Dr. Matthew Bowes, page 8182; Testimony of Dr. Christine Hall, page 8801

8 Testimony of Dr. Matthew Bowes, page 8182

9 As noted earlier, Dr. Hall was qualified to give expert opinion evidence concerning excited delirium and sudden in-custody death. (Transcript, page 8780) Dr. Hall's curriculum vitae was entered as Exhibit 248.

10 Exhibit 247, page 10, Expert Report of Dr. Christine Hall dated June 25, 2009

11 Testimony of Dr. Matthew Bowes, page 8182

12 Testimony of Dr. Matthew Bowes, page 8125; see also, Exhibit 113, page 30, Dr. Bowes' Report

13 June 30, 2009

14 Testimony of Dr. Matthew Bowes, pages 8166–8167

15 Testimony of Dr. Christine Hall, page 8796. See also, the American College of Emergency Physicians' White Paper Report on Excited Delirium Syndrome, Introduction. The ACEP's White Paper is not paginated so I am unable to provide the reader with the convenience of page references.

16 Testimony of Dr. Christine Hall, pages 8796–8797. The American College of Emergency Physicians states in the introduction to its Report: "The Task Force debated the merits of renaming the syndrome in a medically more descriptive way. However, it was decided that the literature and general understanding in the health and law enforcement fields of the term "Excited Delirium" favoured retention of the traditionally understood word for research and clinical purposes."

17 Testimony of Dr. Christine Hall, page 8797

18 Testimony of Dr. Christine Hall, page 8797

19 Testimony of Dr. Christine Hall, page 8867. Dr. Hall also stated: "Excited delirium is a general term…to describe a person who is in an acute agitated, violent, incoherent, combative state. Acute psychosis might be an underlying diagnosis for the existence of that state…so…both terms are correct." (Testimony of Dr. Christine Hall, pages 8901–8902)

20 Testimony of Dr. Christine Hall, page 8852

21 Testimony of Dr. Christine Hall, page 8798

22 Testimony of Dr. Christine Hall, page 8798

23 The ACEP's White Paper was produced by the American College of Emergency Physicians Excited Delirium Task Force of which Dr. Christine Hall was a member.

24 The American College of Emergency Physicians' White Paper Report on Excited Delirium Syndrome, Clinical Characteristics. The ACEP's White Paper is not paginated so I am unable to provide the reader with the convenience of page references.

25 Testimony of Dr. Matthew Bowes, page 8244

26 Testimony of Dr. Matthew Bowes. page 8246. The ACEP's White Paper is dated September 10, 2009, after Dr. Bowes prepared his expert's report.

27 Testimony of Dr. Matthew Bowes, page 8255

28 Testimony of Dr. Christine Hall, page 8806

29 Testimony of Dr. Christine Hall, pages 8812–8813

30 Testimony of Dr. Christine Hall, page 8813

31 Testimony of Dr. Christine Hall, page 9014

32 Testimony of Dr. Matthew Bowes, pages 8254, 8255

33 Testimony of Dr. Matthew Bowes, page 8271

34 Testimony of Dr. Christine Hall, page 8862

35 Testimony of Dr. Christine Hall, pages 9064–9065

36 Testimony of Dr. Christine Hall, page 8802. See, also the ACEP's White Paper: "The fundamental manifestation is delirium."

37 Testimony of Dr. Christine Hall, page 8803

38 The American College of Emergency Physicians' White Paper Report on Excited Delirium Syndrome, Clinical Characteristics

39 Testimony of Dr. Christine Hall, page 8807

40 Testimony of Dr. Christine Hall, page 8809

41 Testimony of Dr. Christine Hall, pages 8928–8929. See also, page 8862

42 Dr. Hall reviewed the same materials reviewed by the other experts, including hospital records, the RCMP investigation which contained statements from HRPS officers and correctional officers, and videotapes from HRPS Booking and the CNSCF. (Testimony of Dr. Christine Hall, pages 8780, 8793, 8887, 8990)

43 Testimony of Dr. Christine Hall, pages 8814, 8815–8816, 8867, 8991, 9029–9030

44 Testimony of Dr. Christine Hall, page 8866

45 Testimony of Dr. Christine Hall, page 8814

46 Testimony of Dr. Christine Hall, page 8814

47 Testimony of Dr. Christine Hall, pages 9031, 9032

48 Testimony of Dr. Christine Hall, page 8900

49 Testimony of Dr. Christine Hall, page 8900

50 Testimony of Dr. Christine Hall, pages 8928. See also, page 9003

51 Testimony of Dr. Joseph Noone, pages 9198, 9200, 9236

52 Transcript, page 9118

53 Dr. Noone's curriculum vita was entered as Exhibit 249. Dr. Noone prepared two documents for the Inquiry: an 18 page summary document prepared from the materials he was asked to review. (Exhibit 250) and a Report dated May 31, 2009. ("Dr. Noone's Report")

54 Exhibit 251, Dr. Noone's Report, page 1

55 Testimony of Dr. Joseph Noone, page 9214

56 Exhibit 251, Dr. Noone's Report

57 Exhibits 79A – F. Testimony of Dr. Joseph Noone, page 9127

58 Testimony of Dr. Joseph Noone, page 9128

59 Transcript, page 9997. Dr. Hucker's curriculum vitae was entered as Exhibit 264.

60 Exhibit 265, Dr. Stephen Hucker's Report dated May 28, 2009, page 1

61 Testimony of Dr. Stephen Hucker, page 10078

62 Testimony of Dr. Joseph Noone, pages 9128, 9129

63 Exhibit 251, Dr. Noone's Report, page 5

64 Testimony of Dr. Joseph Noone, page 9132

65 Testimony of Dr. Joseph Noone, page 9132

66 Testimony of Dr. Joseph Noone, page 9135

67 Testimony of Dr. Christine Hall, pages 8803, 8890

68 Testimony of Dr. Christine Hall, page 8803

69 Testimony of Dr. Christine Hall, page 8804

70 The American College of Emergency Physicians' White Paper Report on Excited Delirium Syndrome, September 10, 2009, Summary. The ACEP's White Paper is not paginated so I am unable to provide the reader with the convenience of page references.

71 Testimony of Dr. Joseph Noone, page 9227

72 Exhibit 238, Dr. Butt's Report, page 14

73 Testimony of Dr. Joseph Noone, page 9175

74 Testimony of Dr. Joseph Noone, page 9220

75 "He wasn't combative, but he was actively resistant." (Testimony of Dr. Joseph Noone, page 9219)

76 Testimony of Dr. Joseph Noone, page 9176

77 Testimony of Dr. Joseph Noone, page 9218

78 Testimony of Dr. Joseph Noone, page 9181

79 Testimony of Dr. Joseph Noone, page 9231

80 Testimony of Dr. Joseph Noone, pages 9230, 9232

81 Testimony of Dr. Joseph Noone, pages 9230, 9233. Dr. Christine Hall acknowledged the "fight or flight" response but did not describe it as a mechanism in excited delirium. (Testimony of Dr. Christine Hall, page 9043)

82 Testimony of Dr. Stephen Hucker, page 10078

83 Exhibit 265, Dr. Stephen Hucker's Report, page 9

84 Testimony of Dr. Stephen Hucker, page 10055

85 Testimony of Dr. Stephen Hucker, page 10056

86 Testimony of Dr. Stephen Hucker, page 10083

87 Testimony of Dr. Stephen Hucker, page 10122

88 Testimony of Dr. Stephen Hucker, page 10124

89 Testimony of Dr. Stephen Hucker, page 10125

90 Testimony of Dr. Stephen Hucker, page 10068

91 Testimony of Dr. Stephen Hucker, page 10068

92 Testimony of Dr. Stephen Hucker, pages 10083, 10122, 10126

93 Exhibit 265, Dr. Hucker's Report, page 11

94 Testimony of Dr. Stephen Hucker, page 10034

95 Testimony of Dr. Stephen Hucker, page 10034

96 Exhibit 265, Dr. Hucker's Report, page 11

97 Testimony of Dr. Christine Hall, page 8997: "You have an overwhelming feeling that this is a person who is not a normal struggling goal-oriented individual."

98 Exhibit 124, page 113, Report to the Criminal Code Review Board prepared by Dr. Ursula Wawer and Louise Bradley, June 17, 2003 and cited in Part II, Chapter 2, note 45

99 Testimony of S/Cst. Gregory MacCormick, page 2036 referring to his RCMP statement of November 25, 2007

100 Dr. Matthew Bowes testified: "It is thought that the usual situation would be that a person in a normal state of mind [i.e., not a person experiencing excited delirium] would recognize the futility of the ongoing struggle and then stop…that the person in a state of excited delirium [is] missing those crucial feedback mechanisms that would tell them to stop. (Testimony of Dr. Matthew Bowes, page 8260)

101 Testimony of Cst. Benjamin Mitchell, page 2224

102 Testimony of Cst. Benjamin Mitchell, page 2267 referring to Exhibit 121A, view 4: Halifax Regional Police Service (HRPS) Booking Video from November 21, 2007, 02:10:18 – 02:10:22

103 Joanna Blair and Dr. Hunter Blair have indicated through the final written submissions of counsel that they "are not convinced that a zap strap was used on Mr. Hyde. They point to the fact that the zip tie is not visible in Exhibit 121, view 5: Halifax Regional Police Service (HRPS) Booking video from November 21, 2007. They note that a supplemental occurrence report of November 22, 2007, 16:42, filed by Cst. G.R. Bonvie of the RCMP, does not refer to a broken zip tie being part of the physical evidence handed over by Sgt. Dean Stienberg. Cst. Bonvie's notes also do not refer to the broken zip tie. ." (Final written submissions of the Blairs, paragraphs 86–88) However, there is plenty of evidence to support the existence of a broken zip tie in the aftermath of the HRPS Booking hallway struggle with Mr. Hyde: S/Cst. Doreen Coombs testified to seeing it on the floor. (Testimony of S/Cst. Doreen Coombs, page 1584) She did not bring it to anyone's attention at the time because "there was quite a bit of debris" and she was "still absorbing the event [and]…didn't want to touch anything…I didn't know why it was there or if it had been used." (Testimony of S/Cst. Doreen Coombs, page 1586) She testified to seeing S/Cst. Gregory MacCormick collect items from the floor, including the spent CEW probes and cartridges and the broken zip tie. (Testimony of S/Cst. Doreen Coombs, page 1590) Cst. Benjamin Mitchell also saw the broken zip tie on the hallway floor when someone pointed it out to him, sometime after Mr. Hyde had been removed by EHS. (Testimony of Cst Benjamin Mitchell, page 2142) Staff Sgt. Sean Auld testified that S/Cst. MacCormick brought various items, including a broken zip tie, to the office when he briefed him. S/Sgt. Auld told S/Cst. MacCormick to lock the items in a locker in Booking. (Testimony of S/Sgt. Sean Auld, page 3173) Sgt. Dean Stienberg retrieved the items secured in an exhibit bag, from Booking on the morning of November 21 when he reported for work and went to take possession of the CEW. He testified that he is "quite certain the flex cuff was there." (Sgt. Dean Stienberg, pages 7126–7131) Exhibit 26 contains CEW probes and cartridges and a broken zip tie. Why the zip tie is not mentioned in Cst. Bonvie's supplemental occurrence report and notes has not been explained. I do not accept that a massive police conspiracy produced the zip tie in Exhibit 26: I expect the fact that it was not referred to by Cst. Bonvie was a simple matter of oversight.

104 Testimony of S/Cst. Gregory MacCormick, page 1852

105 Testimony of Dr. Christine Hall, page 8814

106 Exhibit 79A, Tab 1, page 5

107 Testimony of Dr. John Butt, page 8367. Dr. Christine Hall testified that a temperature of 37 C is normal and that 38C or higher is elevated, however she indicated that "some people use 38.5C" as the standard for a normal temperature. (Testimony of Dr. Christine Hall, page 8982)

108 Testimony of Dr. John Butt, page 8367

109 Testimony of Dr. Christine Hall, page 8806. In her review of Mr. Hyde's case, Dr. Hall made no note of Mr. Hyde sweating. She probably would have included this in her report if she had found it. (Testimony of Dr. Christine Hall, page 8993)

110 Cst. Benjamin Mitchell, page 2130

111 Dr. Christine Hall discussed research that identified, out of 698 uses of force, 24 individuals who were subject to use of force and had features of excited delirium. 19 of the 24 were reported to be hot to the touch. To Dr. Hall, that meant they were very, noticeably hot.

112 Testimony of Dr. Christine Hall, page 8915

113 Morrison, Audrey and Sadler, David: "Death of a Psychiatric Patient During Physical Restraint. Excited Delirium – A Case Report. Medicine, Science and Law (2001) Vol. 41, No. : 46–50, page 48. Article #12 from the Bibliography attached to Dr. John Butt's Report.

114 Testimony of Susan Hedley, RN, pages 3501–3502; Testimony of Laura Morgan, RN, page 3589

115 Exhibit 79A, Tab 1, page 9, "Oriented to place. Remained confused, delusional and flighty" charted by Laura Morgan, RN at 06:15 on November 21, 2007

116 Testimony of Dr. Joseph Noone, page 9177; Testimony of Dr. John Butt, page 8392

117 Testimony of Dr. Stephen Hucker, page 10185

118 Testimony of Dr. Stephen Hucker, page 10185

119 Testimony of Karen Ellet, page 147

120 Exhibit 172, page 6 of a 6 page document – Letter from Cst. Kellock to Crown Attorney dated August 6, 2009 describing the editing process of the video from the Central Nova Scotia Correctional Facility with attachments of the notes of Cst. Terry Kellock describing events on the video clips from the Central Nova Scotia Correctional Facility.

121 Testimony of Dr. Joseph Noone, page 9177

122 Exhibit 60, Tab 9 Video DVD comprised of 17 clips: Medical questions CH05, 17:02 – 17:10

123 Testimony of Dr. Matthew Bowes, page 8271

124 Testimony of Dr. Christine Hall, page 8862

The Cause of Death Was Not the CEW

It was unanimous amongst the experts who were qualified to give opinion evidence about Mr. Hyde's cause of death[1] that the CEW did not play a role.

Like Dr. Bowes, Dr. Butt eliminated the CEW as a cause of Mr. Hyde's death[2] and did not view it has having likely played a role in Mr. Hyde's November 21 collapse in Booking.[3] While he could not exonerate the CEW as "…not directly or indirectly associated with [Mr. Hyde's] collapse [in Booking]", he felt that the electric shock should have immediately sent Mr. Hyde into ventricular fibrillation if it had affected his heart.[4]

Dr. Charles Kerr, qualified by the Inquiry as an expert in cardiology and electrophysiology[5], also formed the opinion that the CEW was not a direct cause of Mr. Hyde's death.[6] He noted that there was "no immediate loss of consciousness, suggesting there was no immediate induction of malignant ventricular arrhythmia."[7] As for the question of whether the CEW played a role in Mr. Hyde's collapse at HRPS Booking on November 21, Dr. Kerr concluded that it was not the singular cause[8] although it may have indirectly contributed.[9]

As Drs. Bowes and Butt had, Dr. Kerr identified as relevant the fact that Mr. Hyde died some considerable time after being shocked by the CEW, more than the threshold 24 hours.[10] I note that Dr. Christine Hall, qualified by the Inquiry as an expert in excited delirium and sudden in-custody deaths[11] came to essentially the same conclusion about the CEW not factoring in to Mr. Hyde's death: that since Mr. Hyde died,

> …after a night of reported near constant pacing and talking, following[12] an apparently short but intense physical struggle in a clearly separate altercation during which no Taser was used, it is difficult to consider there could be a causal relationship between Taser deployments on November 21, 2007 and Mr. Hyde's death on November 22, 2007.[13]

Mr. Hyde's heart showed no signs of damage when examined pathologically[14] although Dr. Butt acknowledged the limitations of postmortem anatomical examination even at the microscopic level.[15] Autopsy cannot determine if the heart has experienced arrhythmia[16] although the condition of the heart would disclose if a heart attack had occurred.[17] There was no such indication in Mr. Hyde's case.[18]

Although not a factor in Mr. Hyde's case, at least in terms of causing death, Dr. Kerr advised the Inquiry of his opinion that there is a possibility that a CEW discharge "could directly induce ventricular fibrillation in [a person]:

I think it's a small possibility due to the combination of [having] to get it

> close to the heart and…land it on the vulnerable period [the T-wave]…I definitely think it could occur…multiple shocks just increase the probability of an impulse falling on the T-wave.[19]

Ventricular fibrillation "effectively stops the pumping of the heart and leads to very rapid loss of consciousness and…death."[20]

Even though the CEW can be eliminated as a cause of Mr. Hyde's death, it should be recognized that in all likelihood it added to the stress his body experienced at the time even though his fatal collapse was a significant number of hours later. This was the opinion of both Dr. Butt[21] and Dr. Kerr.[22] The intense pain and distress experienced by Mr. Hyde when he was shocked in HRPS Booking is obvious from the video surveillance and very disturbing to witness. Nothing done to Mr. Hyde by the police officers leading up to his collapse in Booking affected him like the deployment of the CEW. Just because it cannot be regarded as contributing to Mr. Hyde's death does not mean its application should be seen as benign.

Notes

1 Drs. Matthew Bowes, John Butt and Charles Kerr

2 Testimony of Dr. John Butt, pages 8324, 8325, 8336. "I don't think that the Taser is relevant in Mr. Hyde's death." Dr. Butt concluded in his Report at page 15 that "I believe the conducted energy weapon (Taser) was irrelevant with no bearing on the collapse and dying events the morning of November 22, 2007 when Howard Hyde died."

3 Testimony of Dr. John Butt, page 8323. He discussed this in his Report at pages 12 and 13 under "What role did the conducted energy weapon (CEW/Taser) play in the collapse of Hyde early November 21?"

4 Testimony of Dr. John Butt, page 8323

5 Transcript, page 9406

6 Exhibit 255, Dr. Kerr's Report, page 15

7 Testimony of Dr. Charles Kerr, page 9447

8 Testimony of Dr. Charles Kerr, page 9447

9 Exhibit 255, Dr. Kerr's Report, page 15 "The CEW discharges could have been a contributing factor in further enhancing his already elevated catecholamine state."

10 Testimony of Dr. Charles Kerr, page 9447.

11 Transcript, page 8780

12 I believe this should read "followed by." Dr. Hall is obviously referring to the struggle Mr. Hyde was engaged in after his night in the Health Segregation cell.

13 Exhibit 247, pages 6–7, Expert Report of Dr. Christine Hall dated June 25, 2009

14 Testimony of Dr. John Butt, pages 8324–8325

15 Testimony of Dr. John Butt, page 8348

16 Testimony of Dr. John Butt, page 8324

17 Testimony of Dr. John Butt, page 8325

18 Testimony of Dr. John Butt, page 8325

19 Testimony of Dr. Charles Kerr, page 9445

20 Testimony of Dr. Charles Kerr, page 9429

21 Testimony of Dr. John Butt, page 8323

22 Exhibit 255, Dr. Kerr's Report, page 15

Restraint and the Issue of Positional Asphyxia

The Inquiry was urged by Joanna Blair and Dr. Hunter Blair to accept that Mr. Hyde's death was caused by the restraint method used in Search Cell #2.[1] The Blairs submitted that Mr. Hyde hypoventilated in the prone position on the floor of the cell and died because the restraint position made it impossible for him to breathe. In the words of counsel for the Blairs, "But for the restraint, Mr. Hyde would not be dead."[2]

The scenario envisioned by the Blairs is a genuine risk associated with prone position restraint.

Dr. Bowes notes there is medical literature that indicates a person with an abdominal obesity, as Mr. Hyde had, can have difficulty breathing in a prone position.[3]

The mechanism by which the prone position can contribute to respiratory collapse relates to the effect on the internal organs which in turn compromises the diaphragm and restricts its function in respiration. As explained by Dr. Bowes:

> …the theory is, and one that I think makes very much sense from an anatomic and certainly simple geometry point of view, is that if you place someone with…a relatively marked degree of abdominal obesity on their belly, the weight of the viscera pushing up and out will put the diaphragm[4] at a mechanical disadvantage…[5]

If the diaphragm is compromised, respiration is compromised.[6] Dr. Bowes was of the opinion that it was "very credible" that someone could asphyxiate in a prone position. "…simple geometry and physics…" would account for why the application of weight to a prone body could accelerate the fatal consequences.[7] But Dr. Bowes concluded that while "restraint following a struggle is a reasonable contributor to death" the medical evidence was not strong enough to support restraint being the cause of death.[8]

During the course of the Inquiry's hearings, a number of witnesses were asked questions by counsel for the Blairs about positional asphyxia. Postmortem examination of Mr. Hyde's body provided no evidence of an asphyxial death.[9] The only reference to asphyxia playing a role in Mr. Hyde's death came from Dr. Kerr's Report[10] where he stated:

> I think that the cause of death was related to metabolic derangement and probable cardiac arrhythmia, either ventricular fibrillation or asystole. This was the result of the hyper-adrenergic state and probable acidosis from muscle strain and anaerobic metabolism; and hypoxia related to restraint and partial asphyxia. [11]

During his testimony, Dr. Kerr conceded that "asphyxia" was not the correct term for what he thought had happened to Mr. Hyde.[12] He corrected this error and indicated he should have described Mr. Hyde's condition as one of "hypoventilation."[13] He testified that he was trying to explain a restriction in breathing that led to a decrease in the amount of oxygen Mr. Hyde needed, contributing to the metabolic derangement effect.[14] Dr. Kerr deferred to opinions of the expert pathologists who concluded that Mr. Hyde's death was not an asphyxial death.[15]

None of the experts[16] who rendered opinions on Mr. Hyde's cause of death attributed his death to positional asphyxia. Dr. Bowes regarded it as "very credible" that Mr. Hyde could have been respiratorily compromised but pointed to evidence that indicated this did not lead to asphyxia. In Dr. Bowes' opinion, the time frame between the prone restraint and Mr. Hyde's death was too short for death to have been caused by asphyxia. "…the length of time over which the asphyxia mediates its effects would probably be longer."[17] As well, Mr. Hyde reportedly spoke during the struggle in the search cell, just before he went limp. The fact that he could speak so close to the time when he became unconscious and died contributed to Dr. Bowes' conclusion that it was very unlikely Mr. Hyde's death was due to asphyxiation.

> …if he was truly asphyxiating, and I accept that that is possible even if he is talking…the time line would be longer…But this time line is very, very short and that's why I only contributed restraint [to cause of death]…I do not [think] that it is the direct result of the restraint that caused his death.[18]

Dr. Bowes noted that death from an extreme struggle against restraint is not the same as asphyxia.[19]

Notes

1 Final written submissions of Joanna Blair and Dr. Hunter Blair, paragraph 218; Final oral submissions on behalf of Joanna Blair and Dr. Hunter Blair, page 11313

2 Final oral submissions of Kevin MacDonald, counsel for Joanna Blair and Dr. Hunter Blair, page 11313

3 Testimony of Dr. Matthew Bowes, page 8262

4 The muscular sheath that lies between the abdominal viscera and the thorax. (Testimony of Dr. Matthew Bowes, page 8264)

5 "…the normal thorax consists of many structures …[including]…the rib cage with its muscle and [nerves] and its ability to expand. But also the diaphragm is very important for the expansion of the lungs…[which]…don't have any muscle at all. They are incapable of movement whatsoever. They are entirely dependent upon the thorax to expand and to be deflated…When [the diaphragm] contracts…it pulls down…creating a negative pressure inside the thorax which will inflate the lungs. (Testimony of Dr. Matthew Bowes, pages 8263–8264)

6 Testimony of Dr. Matthew Bowes, page 8264

7 Testimony of Dr. Matthew Bowes, page 8267

8 Testimony of Dr. Matthew Bowes, page 8130

9 Testimony of Dr. Martin Bullock, page 7692. Dr. Bullock found no evidence of asphyxia, positional or otherwise. See also, Exhibit 113, Dr. Matthew Bowes' Report, page 29; Testimony of Dr. John Butt, pages 8355, 8371, 8388; Testimony of Dr. Charles Kerr, page 9478

10 Exhibit 253 (Dr. Kerr's original report); Exhibit 255 (redacted report after rulings on admissibility issues – see Transcript pages 9405–9408

11 Exhibit 255, Dr. Kerr's Report, page 16

12 Testimony of Dr. Charles Kerr, page 9469
13 Testimony of Dr. Charles Kerr, page 9469
14 Testimony of Dr. Charles Kerr, page 9471
15 Testimony of Dr. Charles Kerr, pages 9478–9479
16 Drs. Bowes, Butt and Kerr
17 Testimony of Dr. Matthew Bowes, page 8150
18 Testimony of Dr. Matthew Bowes, page 8151
19 Testimony of Dr. Matthew Bowes, page 8143

My Findings on Cause and Manner of Death

Cause of Death

As indicated in Chapter 35, I have concluded that Mr. Hyde's cause of death was not "excited delirium due to paranoid schizophrenia." I find that Mr. Hyde's death was caused by the struggle with correctional officers, a struggle that resulted from intense fear. I believe that restraint played a role: that restraining Mr. Hyde on the floor of Search Cell #2 may well have compromised his ability to breathe but I accept that it is not possible to quantify the extent to which restraint brought about the fatal collapse. As identified by Drs. Bowes and Butt, it was a contributory factor.

I find that neither blunt force injuries[1] nor coronary artherosclerosis nor the Conducted Energy Weapon nor positional asphyxia caused Mr. Hyde's death.

I know from the evidence that significant physiological changes occur in the human body during a struggle. Dr. Bowes indicated that the body experiences[2]:

- very intense exercise
- metabolic acidosis (not evident from autopsy)[3]
- metabolic derangements (not evident from autopsy)[4]
- increased need for oxygen resulting in more rapid breathing
- possible tachycardia
- possible hypoxia (not evident from autopsy)[5]
- anaerobic metabolism (not evident from autopsy)

Dr. Kerr testified that intense, physical activity, such as that engaged in by Mr. Hyde, would create metabolic disturbances quite apart from any restriction of breathing.[6] According to Dr. Kerr, the most critical element in the metabolic derangement would be an increase in the level of potassium in the blood that could cause the heart to stop beating.[7]

I do not find it possible to determine if Mr. Hyde's heart actually stopped on November 21 in the HRPS Booking hallway or whether a pulse was undetectable because his heart was not pumping effectively or undetected because it can be difficult to take a carotid pulse, especially in stressful circumstances. We cannot conclude from the fact Mr. Hyde returned to consciousness that his heart was still beating. He received the benefit of prompt and properly administered CPR and furthermore, as Dr. Kerr testified: "A transient stoppage of the heart will often restart itself."[8]

As I find that Mr. Hyde was not in a state of excited delirium either when he collapsed in HRPS Booking or when he died, excited delirium, if it exists at all, is irrelevant in this case, a red herring. Furthermore I believe it is inappropriate to say

that Mr. Hyde's death was "due to schizophrenia" or that the "underlying cause of death was schizophrenia." Schizophrenia would not have killed him. It did make him fearful, anxious and delusional but it is completely unhelpful to link his death to his diagnosis of schizophrenia. In my view, describing the underlying cause of Mr. Hyde's death as schizophrenia is stigmatizing of Mr. Hyde as a person who had a mental illness. Such a characterization suggests, even where this would be unintended, that Mr. Hyde's death was somehow inevitable, that he died because he was "a schizophrenic"; that "normal" people would not die in the same circumstances. It stigmatizes in a similar manner that alleging excited delirium as a cause of death does: to employ Dr. Noone's words, "…the deceased is identified as the culprit…"[9]

The only useful approach is to understand that Mr. Hyde died because of physiological changes in his body brought on by an intense struggle involving restraint. He did not die because he was mentally ill. As Dr. Butt stated, the "actual drop dead"[10] was most probably caused by the metabolic effects of the struggle.

It is important to understand that while the physiology that is referenced to explain "excited delirium" deaths and the physiology that has been described by certain experts before the Inquiry to explain Mr. Hyde's death use the same terminology of "metabolic acidosis" and "metabolic derangements", this does not make Mr. Hyde's death an excited delirium death. Even if the "final mechanism of death"[11] in Mr. Hyde's case was metabolic acidosis (which we cannot confirm as there is never any anatomic evidence to establish this), as I explained earlier, I find "the approximate cause" is not excited delirium. And therefore with due respect to Dr. Bowes, I do not accept his statement that "…irrespective of the final metabolic derangement and its nature, the approximate cause [of Mr. Hyde's death] is still the same…excited delirium."[12] As I have explained, it is my considered opinion that Mr. Hyde's condition, presentation and behaviour did not conform to what has been described as "excited delirium."

It was suggested in final submissions that the absence of "…anatomical findings pointing to a particular cause of death, [makes] identifying a cause…somewhat speculative."[13] There is truth to that observation although not in my opinion when it comes to ruling out excited delirium. I have excluded excited delirium on the basis of the evidence even in the absence of anatomic findings which would not be available in any event.

Manner of Death

Manner of death means the mode or method of death whether it is natural, homicidal, suicidal, accidental or undeterminable.[14]

I find that the manner of Mr. Hyde's death was accidental, and in so doing, accept the conclusions of Dr. Bowes and Dr. Butt in this regard.[15]

An accidental death is an unintentional death, according to the World Health Organization statistical classification reflected in the International Statistical Classification of Disease and Injury.[16]

Notes

1 The blunt force injuries had a number of possible causes. (Testimony of Dr. John Butt, page 8354) I find that the rib fractures identified at autopsy were caused by the chest compressions applied in the effort to try and revive Mr. Hyde. (see, Testimony of Dr. Martin Bullock, pages 7675–7677, 7679; Testimony of Dr. John Butt, pages 8310, 8353)

2 Testimony of Dr. Matthew Bowes, page 8259

3 Testimony of Dr. Matthew Bowes, pages 8269–8270, 8289

4 Testimony of Dr. Matthew Bowes, pages 8269–8270, 8289

5 Testimony of Dr. Matthew Bowes, pages 8269–8270, 8289

6 Testimony of Dr. Charles Kerr, page 9473

7 Testimony of Dr. Charles Kerr, pages 9439–9440

8 Testimony of Dr. Charles Kerr, page 9520

9 Testimony of Dr. Joseph Noone, page 9158 referring to his report, Exhibit 251, pages 6–7, where he discussed the use of "excited delirium" as a cause of in-custody death.

10 Testimony of Dr. John Butt, page 8334

11 Testimony of Dr. Matthew Bowes, page 8145

12 Testimony of Dr. Matthew Bowes, page 8145

13 Final written submissions of the Nova Scotia Government and General Employees Union, paragraph 366

14 *Fatality Investigations Act, 2001, chapter 31,* section 2(1)(i)

15 Exhibit 113, Dr. Bowes' Report, page 29; Exhibit 238, Dr. Butt's Report, page 15

16 Testimony of Dr. John Butt, page 8338

Part IV

Matters Arising from the Inquiry

Language

Persons Living With a Mental Illness

The issues of language and stigma in the context of persons living with mental illness are intimately connected: language is informed by stigma and stigma is sustained by language that labels and marginalizes. This cross-pollination has been recognized in the Mental Health Commission of Canada's seminal document: A Framework for A Mental Health Strategy for Canada: Toward Recovery and Well-Being:

> There are many ways in which people can begin to immediately tackle stigma and discrimination and to foster inclusion – and many of these are not difficult to do. For example, each of us can refrain from using language that labels and demeans people living with a mental health problem or illness…[1]

Early on in the Inquiry's proceedings, the CMHA provided the Inquiry and the parties with a handout about the use of language when discussing mental illness. Inappropriate language contributes to the stigma experienced by persons living with a mental illness. Although never marked as an exhibit or referenced to by the witnesses, the CMHA material is instructive. The following are some excerpts:

> Language matters. The right kind of language when discussing mental illness can help communicate acceptance and understanding. The wrong kind of language, however, can add to the stigma and rejection that persons with mental illness so often encounter.
>
> What is the right kind of language to use about mental illness? When speaking or writing about any disability, you need to use what is called "People First Language." This consists of words that refer to the person first, rather than that person's condition. Avoid such terms as "the mentally ill." Instead, say: "People with mental illness", "a man or woman who has a mental illness", "individuals with mental illness."

Also included in the CMHA material was "Mental Illness Language Guide"[2], providing, in part, as follows:

> **Why is language important?**
>
> …The way that language is used in both written and verbal communication can be very important in influencing public opinion and attitudes. The language used in communication about mental illness can play a major role in creating and perpetuating stereotypes, myths and stigma. In

communicating about mental illness it is important to be mindful of the following points:

- Avoid outdated language;
- Do not use medical terminology out of context;
- Avoid labeling people by their illness;
- Avoid any language that perpetuates inaccurate stereotypes.

Tips for using appropriate language

To ensure you are not labeling people by their illness,

> **Say** – "a person is living with" or "has a diagnosis" of schizophrenia
> **Rather than** – "she is a schizophrenic"

To avoid using derogatory terms which can lead to stigma and discrimination; and to also avoid language that implies mental illness is a life sentence,

> **Say** – "a person is living with" or "has a diagnosis" of a mental illness
> **Rather than** – a person is "suffering from"; a "lunatic" or "mad"

To ensure that you are describing the person's behaviour, rather than implying something about their mental health status,

> **Say** – the person's behaviour was "unusual" or "erratic"
> **Rather than** – they were "crazy", "deranged" or "psycho"

To ensure you are not using outdated terminology,

> **Say** – the person is being treated for a mental illness
> **Rather than** – they are a "mental patient".

Language such as "suffers from", "afflicted by", "stricken with" is also inappropriate when describing a person "with a mental illness."

Language may be very specific to the context. In a report recently prepared for the Mental Health and the Law Advisory Committee of the Mental Health Commission of Canada (May 2010), the authors explained their use of PMI (persons with mental illness):

> There are a variety of different terms used by researchers, police, consumers and others to describe people who are living with mental illness or people with lived experience of mental illness. In this paper, the term "person with a mental illness" or PMI has been employed as it is familiar to the target audience, and most accurately describes the situation in which police interact with this population – that is, at times when signs and symptoms of mental illness are readily apparent – as opposed to people who may have a history or past experience of mental illness but whose symptoms are not evident at the moment.[3]

Steven Lurie, the Executive Director since 1979 of the CMHA, Toronto branch and chair of the Service Systems Advisory Committee, Mental Health Commission of Canada[4] made the following observations about language in his testimony before the Inquiry:

> …I don't think we're ever going to get agreement on the terms but I think it's what is underneath that. How do we use our language to show respect? How do we use our language to show hope and belief in people's recovery? How do we show them that we're actually there to provide them with the help and support that they define and they need? I think if we can use our language to address those issues, it will change the mind set.[5]

Persons Detained in Custody

Appropriate language is also important when describing the status of persons in custody. I favour and use the term "prisoner" rather than "inmate" with reference to the language of the United Nation's Standard Minimum Rules for the Treatment of Prisoners. In this document, the term used is "prisoner" to describe persons detained in pre-trial custody and those who have been sentenced. This is the word that most appropriately describes these persons' loss of liberty and detention by the state.

Throughout the testimony and in the relevant policies tendered in evidence before the Inquiry, the term "offender" was, and is used to describe prisoners like Mr. Hyde who have been charged but have not pleaded or been found guilty. Of course, such prisoners are presumed to be innocent until their guilt is established beyond a reasonable doubt. They are not offenders.[6] This is a wholly incorrect term and should not have been applied to Mr. Hyde. Witnesses used it because it is the terminology that appears in the policies they are tasked to follow.[7]

The Conducted Energy Weapon

There is one additional language issue I will address, the terminology employed to describe the M26 Taser[8] that was used to shock Mr. Hyde at HRPS Booking on November 21. In Part II, I have used the words "taser" and "tasering" because that is the terminology that Mr. Hyde would have known and in fact, used when talking in hospital and with Dr. Singh about his experiences with the police in 2005. The correct term in my opinion is Conducted Energy Weapon (CEW). The M26 Taser is categorized by police use of force guidelines as an "intermediate weapon".[9] It is not simply a "device" and the alternative term, "Conducted Energy Device", is not an accurate descriptor. It is designed and employed as a weapon. Referring to CEW's as "tasers" also obscures this fact. Furthermore, use of the term "taser" generically functions as a form of proprietary branding by Taser International.

Notes

1 Mental Health Commission of Canada, "A Framework for a Mental Health Strategy for Canada: Toward Recovery and Well-Being", page 97

2 The "Mental Illness Language Guide" is a fact sheet from the public relations website of Response Ability, an initiative of the Australian Government, Department of Health and Ageing, implemented by the Hunter Institute of Mental Health in partnership with universities and tertiary educators.

3 "Police Interactions with Persons with a Mental Illness: Police Learning in the Environment of Contemporary Policing" prepared for the Mental Health and the Law Advisory Committee of the Mental Health Commission of Canada by Terry G. Coleman, PhD(C) and Dr. Dorothy Cotton, May 2010

4 Exhibit 278, curriculum vitae of Steven Lurie

5 Testimony of Steven Lurie, page 10699

6 Counsel for the Attorney General of Nova Scotia recognized this in the course of put-

ting questions to a Deputy Sheriff. (Transcript, page 5233)

7 Testimony of Correctional Officer Renee Jones, page 5955

8 Exhibit 24

9 Testimony of John McKay, page 7791. Mr. McKay was qualified by the Inquiry as "an expert in use of force by peace officers, capable of giving opinion evidence on the development and practical application of use of force models and theory of the use of force by police officers and by correctional officers in a jail or a correctional facility, in training use of force theory and tactics." (Transcript, page 7772)

Stigma

The Mental Health Commission of Canada defines stigma as "a negative and unfavourable attitude [that] causes those living with a mental illness to be labeled, stereotyped and feared."[1] Stigma emerges from

> …beliefs and attitudes about mental health problems and illnesses that lead to negative stereotyping of people living with mental health problems and illnesses and to prejudice against them and their families. These are often based on ignorance, misunderstanding and misinformation.
>
> The labeling of people that occurs as a result of this prejudice can become all-encompassing to the point that it leads some to no longer view people living with mental health problems or illnesses as people, but rather as nothing more than their mental health problems or illnesses. As a result, people with mental health problems are defined by label, rather than by who they really are.[2]

The Commission makes the point that people "should not be defined by the challenges they face as a result of the symptoms of an illness or disability."[3] Acknowledged by the Supreme Court of Canada as "very damaging"[4], stigma has played a pernicious role in the historic marginalization of persons with mental illness.

Both of the community organizations with standing at the Inquiry, the Schizophrenia Society of Nova Scotia (SSNS)[5] and the Canadian Mental Health Association (CMHA)[6] made submissions to the Inquiry on the role of stigma in the experience of persons living with mental illness. As the CMHA have noted, the Mental Health Commission of Canada[7] (and the Canadian Alliance for Mental Illness and Mental Health and the CMHA) have targeted stigma against persons living with mental illness as "one of the pressing priorities for improving the mental health of Canadians."[8] Dispelling stigmatizing attitudes and beliefs requires improved public education around the issue of mental health and illness, with the need for an enhanced role for such organizations as the SSNS and the CMHA. Public inquiries can also have a positive influence on the public's understanding of the issues.[9] Strategies need to be developed "to address the stigma of mental illness in our community[10]…and how it impacts people even being able to access services."[11]

The Mental Health Commission of Canada has identified beliefs that persons living with a mental illness are generally violent or dangerous or unpredictable as among the most common stereotypes.[12] The Supreme Court of Canada has also commented on this fear of persons with mental illness, characterizing it as "irrational".[13]

The Commission has recognized that persons living with a mental illness are

affected by stigma and discrimination in all aspects of their lives, including their dealings with the criminal justice and health care systems.[14]

Evidence before the Inquiry revealed that Mr. Hyde was painfully aware of the stigma that attached to him as a person with a major mental illness. He denied having schizophrenia and expressed the belief that it could be "cured." He wanted schizophrenia to be seen as a condition not a "disease, illness or disorder."[15] He resisted being defined by his illness: "I am a very intelligent person. I don't have anything wrong."[16]

The Inquiry also heard expert opinion evidence about stigma. Dr. Noone noted that psychiatric patients "still suffer a tremendous amount of stigma" that doubles in its effect when the person is also identified as being in the "forensic" system.[17] "People are kind of afraid of them just because of their history…"[18] Steven Lurie also identified the operation of a double stigma "when you add to it a justice system involvement…"[19], as did Dr. Hucker.[20]

And it is not only the general public who stigmatize persons living with a mental illness; according to Dr. Noone, they are even stigmatized by health care providers.[21] He described what can happen in general emergency departments:

> In the emergency, they usually don't want mental patients (sic) to stay there very long. They would like you to…either discharge them or move them on. And so you're always negotiating. It's what I've called before an uneasy relationship between…what they like to think as true emergencies and the mental illness emergencies. And that's why, to some extent, some psychiatric units have developed other resources to try and get the person out of the [ER] pretty quickly into appropriate treatment.[22]

Sometimes even the physical health needs of the person with a mental illness are not adequately addressed.[23]

Stigma also influences how a person with a mental illness manages their condition. Dr. Hucker described how stigma makes a person living with a mental illness "want to normalize themselves."[24]

> I don't think anybody wants to be regarded as "crazy"…They don't want to be taking medications, seeing the clinic, those kinds of things which reinforce your [mental] patienthood.

This description captures Mr. Hyde's resistance to the stigmatizing effects of his diagnosis. Dr. Hunter Blair, a psychiatrist himself, commented on his brother-in-law's awareness of and fears about being stigmatized by his illness: "He was his own worst enemy because he didn't like to take pills…this is not unusual, this is a very common phenomena in the mentally ill; they don't want to be mentally ill and taking medication is a symbol of being mentally ill, so they don't want to do it."[25]

Understanding stigma and its effects is relevant to issues such as training of police[26] and correctional officers and informs our understanding of Mr. Hyde's reactions to his illness, including his non-compliance with medications. As Dr. Hucker observed, no one wants to be seen as "sick" or "crazy"[27].

Notes

1 The Mental Health Commission of Canada, "Stigma: the facts"

2 The Mental Health Commission of Canada, "A Framework for A Mental Health Strategy For Canada: Toward Recovery and Well-Being", page 91

3 The Mental Health Commission of Canada, "A Framework for A Mental Health Strategy For Canada: Toward Recovery and Well-Being", page 15

4 *R. v. Swain, [1991] S.C.J. No. 32, paragraph 39*

5 Final written submissions of the Schizophrenia Society of Nova Scotia, pages 31- 32

6 Final written submissions of the Canadian Mental Health Association, pages 15–19

7 Mental Health Commission of Canada anti-stigma initiative: Opening Minds: Changing How We See Mental Illness

8 Final written submissions of the Canadian Mental Health Association, page 15; see also, the Mental Health Commission of Canada, "A Framework for A Mental Health Strategy For Canada: Toward Recovery and Well-Being", page 90: "…reducing stigma, eliminating discrimination, and fostering full inclusion of people living with mental health problems and illnesses must become central to the transformation of the mental health system."

9 Testimony of Susan Hare, page 3947

10 Testimony of Susan Hare, page 3942

11 Testimony of Susan Hare, page 3946

12 The Mental Health Commission of Canada, "A Framework for A Mental Health Strategy For Canada: Toward Recovery and Well-Being", page 91

13 *R. v. Swain, supra, paragraph 29*

14 The Mental Health Commission of Canada, "A Framework for A Mental Health Strategy For Canada: Toward Recovery and Well-Being", page 90

15 Exhibit 79-F, Tab K, Yarmouth Regional Hospital Mental Health Centre Assessment, page 30, interview with Dr. Appavoo, a psychiatrist at the Yarmouth Regional Hospital, June 14, 2000

16 Exhibit 79-A, Tab B, page 21, Nova Scotia Hospital Comprehensive Assessment, April 23, 2002

17 Testimony of Dr. Joseph Noone, page 9172

18 Testimony of Dr. Joseph Noone, page 9172

19 Testimony of Steven Lurie, page 10689

20 Testimony of Dr. Stephen Hucker, page 10187; Dr. Hucker also noted that the term "forensic" is often used "inappropriately to refer to someone with a past history of criminal behaviour or incarceration." (Exhibit 265, Dr. Hucker's Report dated May 28, 2009, page 10)

21 Testimony of Dr. Joseph Noone, page 9223. Steven Lurie also identified this phenomenon: "…one of the things [that people who live with mental illness] impressed on Senator Kirby when he was doing his Senate Committee hearings [that produced the report – Out of the Shadows at last: Transforming mental health, mental illness and addictions services in Canada – that led to the establishment of the Mental Health Commission of Canada] was that there is a lot of stigma not only out there in society but within health care itself. And that's one of the reasons the Mental Health Commission has launched its Opening Minds anti-stigma campaign that is targeted at mental health professionals. Because we have work to do to make sure that people do get…recovery-based, individualized, respectful care. That's not to say that people who work very long and hard in the mental health service system…don't try and do a good job and don't try to be respectful. But people who use the services say their experience is that there is stigma, that they aren't treated with respect. So I think, overall, our mental health systems have to do a better job at that." (Testimony of Steven Lurie, pages 10688–10689)

22 Testimony of Dr. Joseph Noone, pages 9223–9224; Dr. Michael Howlett, an expert in emergency medicine, agreed, saying: "I've seen it happen, so that's the reality. Mental health issues have been stigmatized by society in general for eons…It's something that concerns us and we would like to see reduced…" (Testimony of Dr. Michael Howlett, page 10317)

23 Testimony of Steven Lurie, pages 10745–10746

24 Testimony of Dr. Stephen Hucker, page 10186

25 Exhibit 61, Tab 59, RCMP interview, November 25, 2007 at page 18 (Dr. Hunter Blair)

26 Supt. William Moore testified that persons living with mental illness present at the CIT training programme, to "put a face to it" and reduce the stigma around mental illness. (Testimony of Supt. William Moore, page 4148)

27 Testimony of Dr. Stephen Hucker, page 10187

Excited Delirium

A Sharper Focus on the Controversy of Excited Delirium

I have concluded that Mr. Hyde's case illustrates the risks associated with too readily "seeing" excited delirium when a person presents in a state of great agitation. Likewise, identifying excited delirium as the cause of death is riddled with issues.

The evidence at this Inquiry should call into question the wisdom of training first responders such as police and correctional officers to identify excited delirium. I believe this emphasis should be re-visited. Notwithstanding the statement of Halifax Regional Police Service as expressed in their in-custody death training materials that the debate about the existence of "excited delirium" is "much less in question now that both the 'National Association of Medical Examiners' and 'The American College of Emergency Physicians' have issued reports endorsing its existence,"[1] this case should sound a loud alarm that resorting to "excited delirium" as an explanation for a person's behaviour and/or their death may be entirely misguided.

Dr. Michael Webster's[2] evidence underscored this point by noting that he did not see a behavioural crisis in the video surveillance of Mr. Hyde at either HRPS Booking or the CNSCF.[3] What he saw was a man who was acutely anxious and stressed.[4] There are significant problems associated with trying to train people to recognize "excited delirium" – what is it they are seeing? What frame of reference are they using to assess what they are seeing? Dr. Webster discussed the issue in the context of crisis intervention training for police:

> …I no longer use the term [hyperarousal] anymore and I don't like it to appear in the policeman's (sic) frame of reference either because it has been contaminated. Police people today will…if I use the term hyperarousal… confuse this with hyperarousal syndrome, which has become just another name for excited delirium.[5]
>
> …
>
> …Human beings function on three different levels…a cognitive level… an emotional level and on a behavioural level…When someone is in an acute stress response, cognitively, their cognitive process is disrupted and disorganized. They're not able to take in this information…and process it. They're not making good decisions. Don't have very good judgement. They're not able to help the police person solve the problem. On an emotional level, their emotions are labile. They're changing. The predominant emotion [of the person experiencing acute stress]…is anxiety [which is]… the human response to threat, danger, uncertainty. Behaviourally, when someone is in an acute stress response, their behaviour is somewhat random and unpredictable…[6]

There are considerable risks associated with educating first responders to identify "excited delirium". Not only are there concerns that first responders are not qualified to make diagnoses,[7], and may "see" something that is not there; as I firmly believe happened in Mr. Hyde's case, there is the potential for more people being subjected to the overwhelming force that is recommended as being required to rapidly subdue the individual.[8] Dr. Bowes, a member of the Nova Scotia Mental Health and Medical Experts' Panel that reviewed excited delirium, explained the Panel's recommendation for the use of overwhelming force to restrain notwithstanding the risks associated with restraint because of the danger that the struggle itself will worsen the hyperadrenergic state.[9] Assuming that an agitated psychiatric patient is experiencing a delirium may lead to a decision that "they need to be 'controlled' for that" when ideally they should be assessed and treated specifically for whatever condition they have.[10]

Identifying excited delirium may mean that responders don't try to de-escalate even though highly psychotic people can, with appropriate intervention, reduce their level of agitation.[11] Promoting the use of overwhelming force to restrain an extremely agitated person carries significant risks both from the effects of the restraint and in the use of a CEW to shorten the struggle. As Dr. Kerr noted in response to a question about the use of overwhelming force to bring to an end a struggle with a person identified as experiencing excited delirium:

> …I really can't say [whether if force must be used it would be better for it to be overwhelming rather than allow the struggle to be prolonged.] I know this is the argument for the use of CEW's and I am certainly not a law enforcement officer. So I really can't answer that question…you have two things offsetting, you have the fact that…if you use the CEW, it further enhances that hyperadrenergic state. It may shorten things, but…the other thing too about CEW discharges, that it works by disabling or activating the neuromuscular junctions, which…often causes titanic contraction, which in its own right could switch muscle over to anabolic metabolism and increase the metabolic abnormality directly by that. So I think there are offsetting issues.
>
> …
>
> …what I can tell you is that, clearly getting things over as quickly as possible is certainly the best way to handle it, so long as it's not at the expense of something else.[12]

The Nova Scotia Panel of Experts also expressed concerns, as noted by Dr. Bowes:

> However, given the current scientific understanding of the complex physiological processes at play in a situation where a person demonstrating symptoms of AHS[13] (either with or without the application of restraint) the panel is of the opinion that it is frequently not possible to determine the role (if any) that restraint (including CED's) played, if sudden death occurs. In the absence of a critical synthesis of available research regarding the individual or combined impact of various forms of restraint, it is not possible to draw definitive conclusions regarding the safety of these restraint mechanisms (including the CED) for individuals experiencing AHS.[14]

All that being said, it is my opinion that as long as there remain questions about the role of restraint in sudden deaths and the mechanism of respiratory compro-

mise, the potential exists that the over-identification of excited delirium cases will expose more people to the life-threatening risks that may be associated with the use of overwhelming force in restraint.[15]

And furthermore, increased identification of "excited delirium" may lead to more people being brought into hospitals for medical attention (with a "diagnosis" that may operate as a red herring) with the associated economic costs to the health care system.[16]

There is also the issue of cause of death. In cases of "excited delirium" the mechanism of death is unknown.[17] The term is not officially recognized in the psychiatric lexicon and has:

> …"drifted" into medical and public safety parlance with the one advantage of conveniently suggesting a number of clinical signs as a simple statement but the disadvantage of 'generalizing' ergo risk of misunderstanding including by psychiatrists who knowing their subject, understandably eschew the term *excited delirium* as being redundant *viz* The Diagnostic and Statistical Manual of Mental Disorders 4th ed. 1994. Misunderstanding includes that many e.g. public safety personnel, using the term may not understand anything about excited delirium. Not uncommonly as first responders they may have to make a diagnosis when faced with bizarre behaviour and act on that diagnosis.[18]

Simply substituting a different term – Autonomic Hyperarousal Syndrome – for excited delirium does not address the serious issues raised where agitated behaviour culminates in death.

The potential for resorting to excited delirium as the cause of death for any agitated person who dies in custody was described to this Inquiry as "worrisome."[19] Justice Braidwood expressed his own concerns, observing:

> …Assigning responsibility to such symptoms [as purportedly seen in cases of excited delirium] (in the guise of a diagnosis) conveniently avoids having to examine the underlying medical condition or conditions that actually caused death, let alone examining whether use of the conducted energy weapon and/or subsequent measures to physically restrain the subject contributed to those causes of death.[20]

Finding "a common denominator" in sudden death cases, which are "a mystery to the medical profession"[21] and having a single term to describe the pre-mortem condition is attractive. "It's easy to understand and if that appears to be the diagnosis then it's easy to try and find a remedy…Oh look, this is a case of excited delirium, well, now we know what we have to do."[22] The "common denominator" view is however not universally accepted.[23] "…if you think that you're looking simply at hyperactivity as producing an undesirable metabolic state [a metabolic state incompatible with life], there may be something else that is involved [in the sudden death that could be respiratory in nature.]"[24]

The use of excited delirium to explain sudden deaths with no anatomic findings implies that the person had something wrong with them that caused their inexplicable death.[25] Manner of death may then be classified as "natural" rather than 'accidental."[26] I take the same view as Dr. Butt on this issue[27] and do not accept that this would have been appropriate in Mr. Hyde's case or other similar cases.

Notes

1 Exhibit 271, Information as provided by Sgt. Dean Steinberg which includes in-custody death power point presentation

2 Dr. Webster was qualified by the Inquiry to give expert opinion evidence in crisis intervention in the context of use of force and as an expert in the psychology of conflict. See Transcript, page 10921 and *Re Hyde*, [2010] N.S.J. No. 111 (N.S.P.C.) Dr. Webster's curriculum vita was entered as Exhibit 279.

3 Testimony of Dr. Michael Webster, page 11009

4 Testimony of Dr. Michael Webster, pages 10952, 10956

5 Testimony of Dr. Michael Webster, page 10949

6 Testimony of Dr. Michael Webster, pages 10950–10951

7 Testimony of Dr. Joseph Noone, page 9198.

8 Testimony of Dr. Christine Hall, pages 8831–8832; Also, the ACEP's White Paper: "… control measures are a prerequisite for medical assessment and intervention. When necessary, this should be accomplished as rapidly and safely as possible." See also: the Report of the Nova Scotia Panel of Mental Health and Medical Experts' Review of Excited Delirium, page 15: "Use overwhelming force if restraint must be used…"

9 Testimony of Dr. Matthew Bowes, pages 8172–8173. The Nova Scotia Experts' Panel Report states at page 15: "Delays in subduing the individual may lead to life-threatening physiological changes."

10 Testimony of Dr. Joseph Noone, page 9185

11 Testimony of Dr. Joseph Noone, page 9232

12 Testimony of Dr. Charles Kerr, pages 9500–9501

13 Autonomic hyperarousal state

14 Testimony of Dr. Matthew Bowes, pages 8170–8171 referring to the Report of the Nova Scotia Panel of Mental Health and Medical Experts' Review of Excited Delirium, page 17

15 Testimony of Dr. Joseph Noone, page 9196. "…if the person is highly agitated…then you've got to get some control. But you've got to be careful that you don't over control the person because then you might end up with breathing problems."

16 Testimony of Dr. Christine Hall, pages 9019–9020

17 Testimony of Dr. John Butt, page 8317; Testimony of Dr. Christine Hall, page 8870

18 Exhibit 238, Dr. John Butt's Report, dated June 12, 2009, page 12, footnote 34

19 Exhibit 251, Dr. Noone's Report, dated May 31, 2009, page 7

20 Braidwood Commission on Conducted Energy Weapon Use, June 2009, Part 9, "Medical Risks", page 263

21 Testimony of Dr. John Butt, page 8343

22 Testimony of Dr. John Butt, page 8343

23 Testimony of Dr. John Butt, pages 8318 and 8343, referring to research done by Donald T. Reay, M.D. who maintains that some of these sudden deaths have a respiratory component, which Dr. Butt regards as "the proper perspective." (Testimony of Dr. John Butt, page 8318) Testimony of Dr. Butt, page 8343: "…I don't think it is at all plain what excited delirium is about."

24 Testimony of Dr. John Butt, pages 8343–8344

25 Testimony of Dr. Joseph Noone, page 9158

26 Exhibit 238, Dr. Butt's Report, dated June 12, 2009, page 15

27 Exhibit 238, Dr. Butt's Report, dated June 12, 2009, page 15. See also, Testimony of Dr. John Butt, page 8338.

Use of Force

Use of force is an obvious focus for the Inquiry's attention. I have dealt with its relevance to the cause of Mr. Hyde's death in Part III. This chapter will discuss the force used in relation to Mr. Hyde at HRPS Booking and the CNSCF from the perspective of its appropriateness.

In subsequent chapters I will be discussing use of force in the context of Conducted Energy Weapons (Chapter 44) and crisis intervention (Chapter 54).

The Inquiry heard a very considerable amount of evidence on use of force: I am not intending to examine that evidence exhaustively. It is available in the transcripts of witness testimony for anyone who wishes to read it.

The Use of Force in Relation to Mr. Hyde

The Inquiry heard from John McKay, a retired Inspector with the Vancouver Police Department who was qualified to give expert opinion evidence on use of force.[1] He prepared a report[2] and reviewed a significant amount of material including: the RCMP investigation into Mr. Hyde's death[3]; Reports prepared for the Nova Scotia Department of Justice[4] and the CNSCF[5]; materials from the Provincial Medical Examiner's office[6]; Nova Scotia Public Prosecution Service files[7]; and excerpted medical records for Mr. Hyde.[8] Mr. McKay's review of these materials included viewing the video surveillance from HRPS Booking and the CNSCF.

It was Mr. McKay's opinion that the force used on Mr. Hyde at HRPS Booking and the CNSCF was reasonable and proportionate. He noted that in both cases it was physical control[9] and team tactics that were principally used, with the exception of the use in Booking of the CEW, an intermediate weapon.[10] Mr. McKay saw no use of impact (punching, kicking, striking) by the police[11] or correctional officers[12] and concluded that the force used in each of the struggles was appropriate and according to training.[13] He saw no excessive use of force in any of the video surveillance footage from HRPS Booking or the CNSCF.[14] Mr. McKay emphasized that both in Booking and at the CNSCF, Mr. Hyde had to be brought under control and could not be permitted to get away.[15]

Mr. McKay commented on the challenges inherent in proportionate use of force:

> Delivering proportional and measured or reasonable force is very difficult. And I think it's more of an art form than a science. And the reason for that is that it's really impossible to tell how strong an individual is. It's impossible to tell what experience they have or the training they may have. A person may appear to be mentally ill or under the influence of a drug. It's impossible to determine how impervious to pain that individual may be based on his mental state and the levels of adrenaline. So what's happening

> here is that all use of force is based on estimations…by the law enforcement person. And it's a very difficult proposition to do.[16]
>
> …
>
> …So estimating how fast you need [to be], how close you need to be, how strong this person is, is a very difficult thing…it's very difficult to assess at any one time how strong an individual is[17]…[For] Law enforcement…It's not only difficult to estimate how much force is going to be delivered at you…it's also difficult to [know] how much force you should use and how much is too much and how much is not enough…it's more of an art than a science, it's not exact.[18]

The range of responses exhibited by Mr. Hyde at HRPS Booking in use of force terms[19] went from compliant (when he follows Cst. Edwards into the LiveScan Room at HRPS Booking) to actively resistant (when he pulled away from the officers in the LiveScan Room and then rushed past them to get away.) At the CNSCF Mr. Hyde engaged in behaviour that was compliant (following Correctional Officers Lloyd and Jones to the top of the long hallway) and actively resistant (trying to resist being propelled into the long hallway.[20]) As described by Mr. McKay, the situations at both HRPS Booking and the CNSCF were "fluid, it was back and forth, very chaotic. And at the time, the outcomes were unknown…Like you don't know how this is going to turn out. But they did control Mr. Hyde…"[21]

With the exception of the deployment of the CEW at HRPS Booking, an issue I will discuss shortly, I accept Mr. McKay's opinion that both the police and correctional officers controlled Mr. Hyde using reasonable and proportionate force that was within training and use of force guidelines.[22] Saying this however does not deal with the question of whether it would have been possible to avoid the circumstances that made use of force necessary nor does it amount to a dismissal of the concern raised by the facts that on both occasions when Mr. Hyde was "proned out" on his large belly after a struggle, he suffered a collapse.

Deployment of the CEW

The use on Mr. Hyde of the CEW in HRPS Booking was viewed by Mr. McKay as "a good move" by the police officers.[23] Other uses of force (impact or vascular neck restraint) could either have inflicted injuries or been counterproductive (Oleoresin Capiscum spray).[24] In Mr. McKay's opinion: "The Taser is a logical escalation."[25] Noting that "it's supposed to work"[26], he approved of using it on Mr. Hyde and did not see any opening to simply threaten him with it, "when the fight is on it is time to deploy that Taser. You know, it's like any weapon, there's no point bringing it out if you're not prepared to use [it]".[27]

Mr. McKay viewed Mr. Hyde's behaviour behind the Booking counter before the CEW deployment as "bordering on assaultive…"[28] He saw Mr. Hyde as again verging on assaultive behaviour when he "grabs the Taser and turns it on the officers…"[29] In concluding this, Mr. McKay did not have the benefit of the evidence provided to the Inquiry by the police officers involved in trying to restrain Mr. Hyde. They did not believe Mr. Hyde was trying to assault them. They described him as "actively resisting" and trying to get away,[30] flailing his arms but not kicking or punching,[31] and acting defensively in trying to move S/Cst. MacCormick's hand and the CEW away from his legs.[32]

I will repeat here what I said in Part II, Chapter 8 on the issue of whether Mr.

Hyde tried to assault any of the police officers:

> Even though S/Cst. MacCormick completed the Controlled Response Report to indicate that Mr. Hyde had "intentionally attempt[ed] to injure officer",[33] this did not reflect what the officers actually thought of Mr. Hyde's actions. Cst. Edwards did not believe that Mr. Hyde kicked him intentionally.[34] He did not observe any assaultive behaviour by Mr. Hyde toward S/Cst. MacCormick or Cst. Mitchell nor did Mr. Hyde threaten any of the officers.[35] S/Cst. MacCormick also did not see Mr. Hyde assault any of the officers.[36] He thought that Mr. Hyde's fending off the CEW could have constituted an assault "in a way" although he testified: "…I don't feel that I was assaulted."[37] The video surveillance makes it clear that Mr. Hyde was just desperately trying to ward off another painful application of the CEW.

Mr. McKay's assessment of what the police officers faced in Booking also had to have been coloured by his belief that Mr. Hyde was in a state of excited delirium. He described his opinion about this in his report:

> It is my belief that Mr. Hyde was in the full throes of an excited delirium episode at the HRP cells. Mr. Hyde was a diagnosed schizophrenic with a history of violence who had been institutionalized a few years earlier. On this occasion in HRP cells he spontaneously went beserk and attempted to get away from the officers. During the initial struggle Mr. Hyde was winning the engagement because as the officers said, he was extremely strong and seemed impervious to pain techniques used by the officers…Mr. Hyde was able to break zap strap restraints which are extremely strong. He then suddenly began to turn blue and his heart stopped. CPR was performed and fortunately he recovered…Mr. Hyde's behaviour is consistent with the full blown type of Excited Delirium Syndrome that I have observed many times in Vancouver.[38]

As indicated in Part III, Chapters 35 and 38, I have firmly rejected the suggestion that Mr. Hyde was experiencing an episode of "excited delirium." The description of him by Mr. McKay as exhibiting "superhuman strength, sweating, nonsensical words [and being] highly resistive to pain"[39] does not accord with the evidence before this Inquiry.

While I accept that the use of the CEW on Mr. Hyde was in accordance with the training S/Cst. MacCormick had received[40] and complied with existing use of force guidelines and HRPS policies[41], I believe it was ill-advised. The testimony of Dr. Noone is persuasive on this issue:

> …In my experience, mentally ill patients, particularly if they are psychotic and out of touch with reality, will not respond just to…the more force you use, the more they will disregard it, and I think it's counterproductive… [The use of a CEW] should be…a last resort.[42]
> …
> Question: You've referred to Mr. Hyde as a person with chronic, mental illness and he's relapsed and requires support to get back on medication… The use of pain on a person like Mr. Hyde…what would the effect, in your opinion, be?

> Answer: …there's clear documentation when one looks through the volumes of medical records that he has a specific fear of police and that he has a specific fear, in fact, of being Tasered, because he was Tasered, I think, on a previous time. I think it was 2005. He was reported to have some somatic delusions. In other words, false beliefs about his body that he believes were actually incurred from the Taser discharge…
>
> So here you have somebody who is psychotic, certifiable, and with a specific delusion of fear of law enforcement, and in my experience, acutely psychotic people like that will sometimes disregard direct orders. So you know, "stop" or "get down"…doesn't work very well on them. They're in a different reality. They're delusional…[43]

Even John McKay acknowledged that the application of the CEW made Mr. Hyde "…stronger and more resistant…"[44]

S/Cst. MacCormick was trained in the use of the CEW. He had no training in identifying or dealing with persons with a mental illness.[45] He would not have known that someone like Mr. Hyde might fail to respond to direction or that the application of pain to a person with a mental illness would only serve to aggravate an already fraught situation.[46] In Mr. Hyde's case it subjected an acutely anxious man to excruciating pain. "With mentally ill patients [pain] generally does worsen the situation."[47]

As for the issue of being unresponsive to direction, not only had Mr. Hyde been compliant until the lace-cutting tool was produced, no directions were offered to him by the officers before he was shocked during the struggle. Mr. Hyde's psychosis did not prevent him from trying to de-escalate the situation behind the Booking counter. The rapid deployment of the CEW offered no real opportunity for this and Mr. Hyde's cries that he was "sorry" went unheard and unheeded. Even upon being shocked, Mr. Hyde had the presence of mind to invoke his legal rights – "My lawyer!" – an indication that he understood he was not without rights, even in the police station.

In evaluating the use of the CEW against Mr. Hyde in HRPS Booking, I cannot help but look at the struggle on November 22 in the CNSCF at the top of the long hallway. Once again Mr. Hyde was quickly taken to the floor. Correctional officers then got control of him. The degree of force used to control Mr. Hyde was sufficient.[48] With no CEW's available, the correctional officers gained control by physical control and team tactics only.

Avoiding the Need to Use Force

In every situation where Mr. Hyde unraveled on November 21 and 22 there was a discernible reason: he hit Ms. Ellet because he was angry at her for making a call that he perceived might result in an intervention by the police or mental health systems and he reacted out of fear at HRPS Booking and the CNSCF. The triggering event in HRPS Booking seems to have been the lace-cutting tool and the words that accompanied it: "We'll have to cut one of those balls off."[49] I accept these words were uttered innocently with no appreciation of the effect they would have on Mr. Hyde.

John McKay testified that he would not have chosen those words and would have more plainly told Mr. Hyde: "We've got to take the string out of your pants."[50] He observed:

> …as a general rule, you want to be careful [when speaking to someone suspected of having a mental illness[51]]. What you want to be doing is you want to be calm, you want to not be threatening, you want to use language that's neutral, we're going to help you, we're going to get you through this thing. You try not to use language that may appear to be threatening or may cause…fear and anxiety on the patient's (sic) part."[52]

Although Mr. Hyde was transmitting no threat cues when he arrived with Cst. Edwards at HRPS Booking, he was experiencing an emotional crisis which had precipitated his assault on Ms. Ellet.[53] Crisis intervention techniques could have been used to try and defuse that emotional crisis through the police officers reassuring him "…that they weren't there to hurt him, that they were there to look after him, and that this process would be…as gentle as they could possibly make it…and try and lower that emotional crisis that he's in…"[54]

This is not to criticize the police officers who were oblivious to Mr. Hyde's internal anxiety and turmoil: it is to illustrate how training in crisis intervention techniques and dealing with persons experiencing an emotional disturbance could have better equipped the officers and led to a different outcome in Booking. The same can be said about managing Mr. Hyde's distress and fear at the CNSCF.

Although Mr. McKay noted that even using "all the right language and [being] warm and caring and empathetic and de-escalating agitation…" does not always work, in Mr. Hyde's case there are indicators that, despite his psychosis, he responded well to a nuanced and supportive approach. In his initial interactions with police officers he interacted well, he was compliant with Csts. Willett and Smith, and amenable to the CNSCF staff. The empathetic approach adopted by the Dartmouth courthouse deputy sheriffs was also successful in maintaining Mr. Hyde's equilibrium even after he became somewhat elevated upon learning that he was not getting released from custody.[55] As noted by the clinical psychologist Dr. Webster, "…people find it much easier to cooperate with, to comply with, to obey, to agree with…[someone] they see as willing to listen, understanding, worthy of respect, nonthreatening."[56]

Dr. Michael Webster was qualified by the Inquiry to give expert opinion evidence in crisis intervention in the context of use of force and as an expert in the psychology of conflict.[57] He reviewed the same material as John McKay. Like Mr. McKay, Dr. Webster saw grave risks in using language that could be readily misconstrued by a person experiencing a psychosis. "…talking about cutting off balls… you can imagine what a man suffering from elevated levels of suspicion like this, might be thinking as we're talking about cutting off balls."[58]

> …if you are fully trained [in CIT] you would not approach a man with elevated levels of suspicion like this with a knife…You need to have a Plan B. You can't push through this [removal of the string] – you're taking a chance of triggering his reactants, which [is eventually what happened.][59]

Dr. Webster identified how simple techniques of communication could have been employed by police to establish a "working alliance" with Mr. Hyde.[60] In such situations, where a person is unraveling because of a psychosis and "needs help centering himself", communications and interactions must be nonthreatening and transmit an officer's willingness to listen, understand and respect.[61] Referring to the officers' business-like demeanor in HRPS Booking, Dr. Webster told the Inquiry:

"In crisis intervention training, people are taught not to be talking uniforms."[62]

This idea of engagement and connection to help the person struggling with psychosis to stay grounded and calm emerged in Dr. Noone's testimony about what could have been done, with the right resources, when Mr. Hyde was pacing relentlessly in his cell at the CNSCF. Dr. Noone's opinion bears repeating: "…an experienced mental health professional would be able to get him talking…"[63]

The potential for connection and de-escalation exists even after there has been an agitated reaction. Dr. Noone noted that "even very psychotic people…may de-escalate if you can find something, some entry into their world…"[64] Dr. Hucker described what police and correctional officers need to know in order to deal effectively with someone like Mr. Hyde:

> What they really need to know…is to become familiar with how mental illness manifests itself and how you can best approach people who [have paranoid delusions and are terrified.]…I mean if we had a similar situation that was real, we would be terrified, too. And because that's their reality, that's how they respond. So pulling out knives and…not reassuring them that this is what it's to do and taking it in a much slower way and not assume you are dealing with somebody who has got all their faculties with them is the way to do it. And de-escalating an aggression because you can see an aggressive incident building up…the idea is to get the person to stop revving up and start scaling down again. It's partly something you can learn but it's also sometimes something that some people are very good at…[65]

An acutely agitated psychotic person is operating in a dysfunctional and disorganized way. The objective is to "get the acute stress level down and assist him in organizing himself again. Assist him in regaining his mental balance." This will improve the potential that directions and advice will be responded to appropriately.[66] When someone becomes agitated and balks, "You need to have a Plan B. You can't push through this."[67] In Mr. Hyde's case, pushing through the deteriorating situation both at HRPS Booking and the CNSCF meant that Mr. Hyde was subjected to use of force instead of possibly being de-escalated and taken for the help he needed. Dr. Hucker observed that:

> …had a mental health worker and a police officer trained in managing mentally ill individuals been involved, they might have been able to de-escalate the situation, and he could have been escorted away for a full mental-health assessment.[68]

Pushing through Mr. Hyde's agitation and distress led to Mr. Hyde's further disintegration at the CNSCF on November 22. John McKay's testimony that Correctional Officers Lloyd and Jones "couldn't just say, 'let's just forget about [going to court…]"[69], raises the question: "Why not?" A "Plan B" could have been the option of them easing off the throttle with Mr. Hyde and detouring to a more neutral environment for the purpose of trying to reassure him and secure his compliance. John McKay agreed this would not amount to backing down in the face of non-compliance and would represent "just another tactic" in achieving the objective of getting him safely to court. "…the idea that perhaps taking Mr. Hyde to another area, and…spend some time with him…could well have been done."[70]

It is legitimate that busy correctional officers have to try and get the job done

but being too single-minded about the objective (getting Mr. Hyde to court) can impair, as I believe it did in this case, the ability to see when alternative strategies are required. In fairness to the officers, they "didn't know what Mr. Hyde was doing"[71] which again is a problem that could be addressed through proper training in the recognition and management of prisoners with a mental illness.

Notes

1 Mr. McKay's curriculum vitae was entered as Exhibit 234. He was qualified by the Inquiry to give expert opinion evidence on "the use of force by peace officers, the development and practical application of use of force models and theory of use of force by police officers and by correction officers in a jail or a correctional facility and training in use of force theory and tactics." (Transcript, pages 7772–7773)

2 Exhibit 235

3 Exhibits 60 and 61 (Two large binders of investigative materials, including video surveillance from HRPS Booking and the CNSCF)

4 Exhibit 110, Independent Review of Circumstances Surrounding the Death of Howard Talbot Hyde on November 22, 2007 at the Central Nova Scotia Correctional Facility, Dartmouth, N.S., prepared by David Wojick dated July 3, 2008

5 Exhibit 130, Department of Justice Report re Death of Howard Hyde prepared by Cpt. Paul Dorrington dated November 22, 2007

6 Exhibit 113

7 Exhibits 122–125

8 Exhibit 236 (otherwise contained in Exhibit 79)

9 Testimony of John McKay, page 7791: "Empty-handed option, also called physical control, consists of techniques and tactics that do not use weapons. The techniques are derived from various eastern and western martial arts, and are aimed at overcoming resistance. They include team tactics that give the officers superior physical strength, pain techniques such as pressure points and joint locks, impact…"

10 Testimony of John McKay, page 7791

11 Testimony of John McKay, pages 7815, 7849–7850

12 Testimony of John McKay, pages 7874, 7899

13 Testimony of John McKay, pages 7825, 7875 (CNSCF); 7821 (HRPS Booking)

14 Testimony of John McKay, page 7928. See also, Testimony of John McKay, page 7820, referring to the struggle in HRPS Booking: "…they [the police officers] really only escalated in the team tactics to superior physical strength. They escalated once again when the Taser was used, to…an intermediate weapon. And then once Mr. Hyde was proned out in the hallway area by the door, they de-escalated. Force was not continued." And, Testimony of John McKay, pages 7821 and 7824 referring to the struggle in the CNSCF at the top of the long hallway: "They escalated as they needed to control Mr. Hyde, and they de-escalated as they needed to when they got control. There was no physical force directed towards Mr. Hyde after…I thought the officers escalated and de-escalated very appropriately."

15 Testimony of John McKay, pages 7921 (CNSCF); 8041 (HRPS): See also, Exhibit 235, John McKay's report, page 10

16 Testimony of John McKay, pages 7779–7780

17 Testimony of John McKay, page 8043

18 Testimony of John McKay, page 8045

19 Testimony of John McKay, pages 7787–7788 describing how subject behaviour is characterized in use of force terms: "…these are broad categories. They're not specific behaviours, but they're categories of behaviours. So generally, the first type is called compliance. The subject is compliant with police requests. Passive resistance: the subject

is not compliant, but is passive in that response. In other words, this is often seen as protests where protesters will occupy an office or a building and sit down. Very passive resistance. Active resistance: the subject is actively resisting by pulling away, hanging onto [objects], which impede law enforcement ability to control them. Assaultive behaviour refers to the language and actions the subject takes to the officer that would indicate an assault is imminent or is occurring. And deadly force: actions the subject takes that could cause officer death or grievous bodily harm. See also, Exhibit 235, John McKay's Report, page 4

20 Testimony of John McKay, page 7898 referring to Exhibit 184 "Situation Management/ Use of Force Model": "…he wasn't assaultive at all there. He was physically uncooperative. We would call that actively resistant in…the national use of force framework, but that'll do, physically uncooperative, yes." I accept this characterization by Mr. McKay of Mr. Hyde's reaction at the top of the long hallway. He seems to be saying something different in his report at page 10 – "I describe Mr. Hyde's behaviour at this point as actively resistant bordering on assaultive behaviour." Based on the video surveillance evidence from the CNSCF and my analysis of the testimony of witnesses, I do not accept that as an accurate characterization of Mr. Hyde's response to the correctional officers at any time.

21 Testimony of John McKay, page 7824

22 In addition to Mr. McKay's testimony, see Exhibit 235, John McKay's report, page 10

23 Testimony of John McKay, page 7816: See also, Exhibit 235, John McKay's Report, page 8

24 Testimony of John McKay, page 7816

25 Testimony of John McKay, page 7817

26 Testimony of John McKay, page 7817

27 Testimony of John McKay, page 8062

28 Testimony of John McKay, page 7979, referring to his report, Exhibit 235, page 8

29 Testimony of John McKay, page 8036

30 Testimony of Cst. Benjamin Mitchell, pages 2132; 2140; 2244–2245; 2301: Testimony of Cst. Jonathan Edwards, pages 898–899

31 Testimony of S/Cst. Gregory MacCormick, page 1793

32 Testimony of S/Cst. Gregory MacCormick, page 1809 referring to Exhibit 121A, view 4: Halifax Regional Police Service (HRPS) Booking Video from November 21, 2007, 02:09:27: "He's moving my arms away from his legs."

33 Exhibit 69, page 1

34 Testimony of Cst. Jonathan Edwards, page 1127

35 Testimony of Cst. Jonathan Edwards, pages 1160; 1167; 1813

36 Testimony of S/Cst. Gregory MacCormick, page 1812

37 Testimony of S/Cst. Gregory MacCormick, page 1812

38 Exhibit 235, page 7

39 Testimony of John McKay, page 7814

40 Exhibit 94, Training materials for S/Cst. Gregory MacCormick (Cross-reference Exhibit 63B)

41 Exhibit 82, Halifax Regional Police Service Policy and Procedures, Tabs A (Use of Force); B (Resistance and Control Levels); D (Incidents Involving Use of A Taser)

42 Testimony of Dr. Joseph Noone, page 9174

43 Testimony of Dr. Joseph Noone, page 9175

44 Testimony of John McKay, page 7812

45 Testimony of S/Cst. Gregory MacCormick, page 1756

46 Testimony of Dr. Joseph Noone, page 9220

47 Testimony of Dr. Joseph Noone, page 9220

48 Testimony of Renee Jones, page 6038

49 Exhibit 121A, view 3:Halifax Regional Police Service (HRPS) Booking Video from November 21, 2007: Cst. MacCormick thinks he said: "I just have to cut one of those balls off there." (Testimony of S/Cst. MacCormick, page 2005)

50 Testimony of John McKay, page 7953

51 I will note that S/Cst. MacCormick testified that it was not until the events of the night were over that it occurred to him Mr. Hyde may have had a mental illness. (Testimony of S/Cst. Gregory MacCormick, pages 1851–1852)

52 Testimony of John McKay, pages 7953–7954

53 Testimony of John McKay, page 8050

54 Testimony of John McKay, page 8051; see also, Testimony of Dr. Michael Webster, page 10958: Cst. Edwards could have expressed empathy, and reassured Mr. Hyde that he would make sure "nothing bad happens to you…"

55 Testimony of D/S Shirley Day, pages 4231–4232; 4387–4388

56 Testimony of Dr. Michael Webster, page 10948

57 Transcript, page 10921; See, *Re Hyde*, [2010] N.S.J. No. 111 (N.S.P.C.) Dr. Webster's curriculum vitae was entered as Exhibit 279.

58 Testimony of Dr. Michael Webster, page 10961

59 Testimony of Dr. Michael Webster, page 10961

60 Testimony of Dr. Michael Webster, page 10958

61 Testimony of Dr. Michael Webster, page 10959. Respect and professionalism are also the core values for Code White. (Testimony of Dr. Joseph Noone, page 9215)

62 Testimony of Dr. Michael Webster, page 10960

63 Testimony of Dr. Joseph Noone, page 9162

64 Testimony of Dr. Joseph Noone, page 9232

65 Testimony of Dr. Stephen Hucker, page 10068

66 Testimony of Dr. Michael Webster, page 10951

67 Testimony of Dr. Michael Webster, page 10961

68 Testimony of Dr. Stephen Hucker, page 10027

69 Testimony of John McKay, pages 7898–7899

70 Testimony of John McKay, page 8093

71 Testimony of John McKay, page 7899

Use of Restraint

The restraint used on Mr. Hyde was a significant concern for Joanna and Dr. Hunter Blair whose final submissions included a recommendation that the Province "develop polices on the use of prone restraint."[1] In light of this it is relevant to review the evidence heard by the Inquiry on the issue of policies and training relating to prone restraint.

Department of Justice/Correctional and Sheriffs' Officers – Use of Restraint

Prone restraint involves getting the prisoner flat out on his abdomen with his legs crossed, his hands behind his back and his head turned to one side. Once handcuffed (and searched if that is required), the prisoner is rolled onto his side and sat up.[2] Correctional officers may need to hold the prisoner's legs still, in the crossed position, so he cannot kick with them.[3] Other techniques may be employed in situations of spontaneous use of force:

> …it may be necessary to somewhat bridge the offender (sic)…to literally hold them down by their shoulders just placing a minimal amount of pressure or body weight[4] there on the offender (sic) till we can gain control or have a discussion with them…[5]
>
> …
>
> …just kind of bridging the offender back down to the floor or covering over them until we can gain control.[6]

Correctional officers receive training in prone restraint in the Corrections Enhanced Security course.[7] At the CNSCF, prone restraint is considered a "best practice" as it enables correctional officers to "gain control and…apply different techniques…" while safely managing the non-compliant prisoner.[8] The "bridging" technique however is not taught. It is "basically something we just spontaneously do…"[9] Training in the Basic and Enhanced Security Skills courses emphasize that weight is not to be placed on a "proned" prisoner's back.[10]

Prone restraint is one of the facets of use of force policy and training developed by the provincial Department of Justice under the leadership of Roy Kennedy, a policing consultant with the Department of Justice since 2007 and a Department of Justice use of force team leader since 1997.[11] In 2008 Mr. Kennedy was appointed the lead instructor for all Department of Justice Use of Force programmes.[12] The programmes developed by Mr. Kennedy are mandatory for correctional officers and sheriffs.[13]

Mr. Kennedy noted that the new five-module training programme began in January 2009.[14] The training covers basic use of force (5 intensive days)[15]; prisoner

escort (2 days); team intervention (3 days); firearms (2 days); and CEW training, in the development stage.[16] As of February 2010 when Mr. Kennedy testified before the Inquiry, approximately fifty percent of the correctional officers and sheriffs had taken the basic five-day use of force programme.[17] The training has been very well-received with extremely positive feedback from the participants. [18]

The training for prone-handcuffing has undergone modification so that searching is no longer done while the prisoner is in a prone position.[19] The training for prone-handcuffing also emphasizes the importance of not applying weight on the subject's upper torso where it is possible to avoid doing so.[20] This is not a new dimension of the training.[21] Safety concerns also underpin the objective of keeping a person in the prone position for no more than 3-minutes.[22] "…the goal is to have [the prisoner] restrained and in a recovery position within that three-minute period."[23] The prone position continues to be used because it is extremely difficult to gain control of a combative person who is standing or kneeling.[24]

Three minute prone-handcuffing is addressed in both the Team Intervention and Use of Force training.[25] Mr. Kennedy testified that it is sometimes beyond officers' control to know exactly how long the technique is going to take.[26] In the Use of Force training which deals with spontaneous (as opposed to planned) uses of force, the three minutes is timed from when the officers gain control.[27]

Notes

1 Final written submissions of Joanna and Dr. Hunter Blair, page 45

2 Testimony of Deputy Superintendent Tracey Dominix, page 7494

3 Testimony of D/Supt. Tracey Dominix, page 7507. D/Supt. Dominix testified that it is recommended officers not put a lot of weight on a prisoner's restrained legs, although some weight may be required. (Testimony of D/Supt. Tracey Dominix, pages 7508–7509)

4 D/Supt. Dominix testified that correctional officers are taught that applying "total pressure" on the prisoner's back with a shield or hands or body can cause the prisoner to experience breathing difficulties. (Testimony of D/Supt. Dominix, page 7508)

5 Testimony of D/Supt. Tracey Dominix, page 7507

6 Testimony of D/Supt. Tracey Dominix, page 7512

7 Exhibit 115, Department of Justice – Correctional Services "Security Course-Enhanced Skill Level"

8 Testimony of D/Supt. Tracey Dominix, pages 7486–7487

9 Testimony of D/Supt. Tracey Dominix, page 7515

10 Testimony of D/Supt. Tracey Dominix, page 7523

11 Mr. Kennedy spent 22 years as a police officer before joining the Department of Justice in 1997. When he left the HRPS he was the senior use of force instructor. His curriculum vitae was entered as Exhibit 276.

12 Exhibit 276

13 Testimony of Roy Kennedy, page 10501

14 Testimony of Roy Kennedy, page 10512

15 Exhibit 277 is the outline for the use of force programme.

16 As of February 2010 when Mr. Kennedy testified before the Inquiry.

17 Testimony of Roy Kennedy, page 10513

18 Testimony of Roy Kennedy, page 10511

19 Testimony of Roy Kennedy, pages 10516; 10555. It appears to me therefore that Lesson Plan 12 "Kneeling Search and Handcuffing Prone Handcuffing and Search" from

Exhibit 115, Instructor Manual from Department of Justice Correctional Services Security Course "Enhanced Skills Level" is outdated. Exhibit 277, Department of Justice Use of Force Training Module, introduced through Roy Kennedy, includes Prone Handcuffing as Lesson Plan 13 with a revised date of January 2010.

20 Testimony of Roy Kennedy, page 10517

21 Testimony of Roy Kennedy, page 10555

22 Testimony of Roy Kennedy, pages 10517–10518; 10556

23 Testimony of Roy Kennedy, page 10518

24 Testimony of Roy Kennedy, page 10518

25 Testimony of Roy Kennedy, pages 10532–10533

26 Testimony of Roy Kennedy, page 10533

27 Testimony of Roy Kennedy, page 10534

Conducted Energy Weapons

This Inquiry heard a range of submissions on the issue of CEW's from advocating a total ban on their use (the position of Joanna and Dr. Hunter's Blair and the Canadian Mental Health Association) to maintaining the status quo with continued documentation of deployment (Halifax Regional Police Service). The primary sources for standards with respect to the use of CEW's were cited as the Braidwood Inquiry, Part 10 Recommendations (June 2009); the report of the Advisory Panel to the Minister of Justice on the use of the Conducted Energy Device by Law Enforcement Agencies in Nova Scotia (June 30, 2008)[1]; and the "Provincial Governance Standard for CED's" revised July 10, 2008.[2]

While I believe it is imperative for governments and law enforcement agencies to continue to carefully assess the safety of CEW's[3], the evidence at this Inquiry does not assist on this issue. As I have discussed in Part III, Cause of Death, there is no evidence to indicate that Mr. Hyde died because the CEW interfered with the functioning of his heart. What my mandate does require me to consider is the evidence that may shed some light on the appropriate standards for CEW deployment.

The Nova Scotia CEW Advisory Panel criticized the existing Provincial Governance Standard[4] as "unacceptably vague and that the institution of more objective provincial usage standards would lead to greater uniformity and provide more clarity, direction and certainty." It therefore recommended a full policy review by the provincial Department of Justice "to include an examination of the nature of CED use in the province and an analysis of 'best practices' with a view to establishing a more prescriptive set of provincial use of force standards and procedures."[5] The Panel then made a recommendation for an interim Provincial Governance Standard for CEW use:

> In the interim, until the policy review is completed, the panel recommends that the use of the CED be restricted to situations of "violent or aggressive resistance or active threat that may cause serious injury to the law enforcement officer, the subject, or the public.[6]

In response to this recommendation, the Department of Justice on behalf of the provincial Attorney General issued a revised directive on CEW use, dated July 10, 2008, which increased the threshold for CEW deployment.[7] The July 10, 2008 directive provides:

> Operational police officers' decision to discharge, in the execution of their duty, a Conducted Energy Device, to control a subject will be based upon the officer's perception of the threat and the officer's perception of the subject's ability to carry out that threat taking into consideration the totality of the situational risks.

> A police agency Conducted Energy Device is only to be discharged in the execution of police officer duty, and where a subject exhibits behaviour consistent with: aggressive or violent resistance[8] or active threat, that may cause serious injury to the police officer, the subject, or the public.

This is the directive that is in force presently and has been distributed to all police agencies in Nova Scotia.[9]

The Braidwood Inquiry had the benefit of the Nova Scotia CEW Advisory Panel Report.[10] In formulating his recommendations on CEW deployment, Justice Braidwood considered the medical risks of these weapons[11], and the issue of proportionality, which he examined in the context of what he described as "an application of Canadian values."[12] He defined "Canadian values" for the purposes of his discussion about the use of CEW's as including, "…matters such as respect for the individual, the public's right to personal safety, and fairness."[13] He rejected a "subject behaviour threshold of active resistance as "not egregious enough to warrant deployment of a weapon that is designed to inflict intense pain and to totally incapacitate the subject."[14] Active resistance, said Justice Braidwood, is defined as focusing principally on pulling away from the officer. That was the nature of Mr. Hyde's behaviour at HRPS Booking.

Justice Braidwood settled on using *Criminal Code* terminology to frame the subject behaviour threshold for CEW deployment.[15] Having decided that "…importing the *Criminal Code* standard of common assault sets too low a threshold", Justice Braidwood settled on the "threshold approximating the *Criminal Code* definition of assault causing bodily harm found in s. 267(b)…" taking into account the medical risks and his "sense of proportionality."[16] He noted that "bodily harm" is defined in section 2 of the *Criminal Code* as "any hurt or injury to a person that interferes with the health or comfort of the person and that is more than merely transient or trifling in nature."[17] He determined that imminent bodily harm should be included as a feature of the deployment standard.[18] He recommended the prohibition of a CEW by provincially regulated law enforcement agencies unless the subject is causing bodily harm, or, the officer is satisfied, on reasonable grounds, that the subject's behaviour will imminently cause bodily harm.[19]

The "bodily harm" standard recommended by Justice Braidwood is a lower threshold for CEW deployment than Nova Scotia's July 10, 2008 revised directive standard of "serious injury", a point made by the Attorney General in closing submissions.[20]

Justice Braidwood's recommendations emphasized the necessity of considering and utilizing, where appropriate, less force, and de-escalation/crisis intervention techniques:

> I recommend that, even if the threshold set out in Recommendation 2 is met, an officer be prohibited from deploying a conducted energy weapon unless the officer is satisfied, on reasonable grounds, that:
>
> - No lesser force option has been, or will be, effective in eliminating the risk of bodily harm; and
> - De-escalation and/or crisis intervention techniques have not been or will not be effective in eliminating the risk of bodily harm.[21]

Corrections policy and training in Nova Scotia is said to be consistent with these standards.[22]

Justice Braidwood also recommended an enhanced deployment standard in the case of emotionally disturbed persons:

> I recommend that officers of provincially regulated law enforcement agencies, when dealing with emotionally disturbed people, be required to use de-escalation and/or crisis intervention techniques before deploying a conducted energy weapon, unless they are satisfied on reasonable grounds, that such techniques will not be effective in eliminating the risk of bodily harm.[23]

Again, this is considered by Corrections to be consistent with best practice standards at provincial correctional institutions.[24] HRPS also described its training model as consistent with this recommendation.[25]

The Nova Scotia July 10, 2008 revised directive for CEW's does not include any restrictions on use of the weapons with emotionally disturbed persons. HRPS policy expressly provides for the discretionary use of CEW's against "an emotionally disturbed person who is perceived to be violent."[26] Policy provisions urge officers to use "good judgment" and carefully consider "all other options" before deploying a CEW against: persons in wheelchairs or who are in control of a vehicle; pregnant women; the elderly and other persons who are likely to be injured by a fall; handcuffed prisoners.[27]

Expert opinion that persons showing signs of excited delirium should be subdued as quickly as possible with a minimum of struggle may fuel the use of CEW's with emotionally disturbed persons. The influence of these opinions plays out in HRPS training:

> …the experts are telling us that we need to minimize the amount of struggle that occurs as quickly as we can. That the struggle is potentially very, very dangerous for these people…and we use the Taser appropriately and we get a good hit and we can, in fact, incapacitate the person quickly, while the Taser is running you need to get in there and get them handcuffed and get their feet secured so that it can happen in a timely and efficient manner.[28]

Dr. Joseph Noone, referring to the counterproductive effects of force and pain in dealing with persons with a mental illness, recommended against use of CEW's with emotionally disturbed persons. He qualified this by saying "there are always times when it may be necessary" but cautioned that it should be "a last resort."[29]

Other concerns about this intermediate weapon include "usage creep"[30], and the deployment of CEW's in circumstances where a lesser degree of force and/or crisis intervention and de-escalation techniques are feasible and appropriate. The compelling argument for not completely banning the use of CEW's is their role as a substitute for more lethal weapons. However as I have already found, there remains the real danger that deployment of a CEW will worsen an already deteriorated situation.

Department of Justice – CEW Training

William Darnborough, a former police superintendent with HRPS and now the Use of Force manager for the Department of Justice, is coordinating the CEW training which is presently under development. Roy Kennedy testified that the objective is

to develop a programme in conjunction with the total law enforcement community who utilize CEW's. The programme development team includes Mr. Kennedy and Mr. Darnborough, municipal police master instructors, a master instructor from the DOJ, an instructor with CEW training from the sheriffs' department, and an instructor from the Atlantic Police Academy.[31] Once training standards are established, governance standards will be created with Mr. Darnborough discharging the responsibility of auditing those practices.[32]

Mr. Darnborough, with input from Roy Kennedy, will be reviewing, for the Department of Justice, the 48 changes to CEW policy being implemented by the RCMP.[33] Once the policies have been determined and the training designed, Mr. Kennedy will be actively involved in the delivery of CEW training for the Department.[34]

It was reassuring to hear that Mr. Darnborough is "well aware" that training and certification standards for CEW use should not simply be based on criteria established by the manufacturer, Taser International.[35] There is however a clear need for an overhaul of the DOJ training manual used for CEW training in view of the exclusive reliance on Taser International material in the Department of Justice's "Taser Training – Participant Workbook".[36] For Lesson Plans 1 through 26, the only resource cited is "Taser International Inc. PowerPoint Presentation, Version 13.0. Released: May 2006." Topics relevant to the issues in this Inquiry, such as, "Deployment Considerations" – Lesson Plan 16, "Taser Deployment and Control" – Lesson Plan 17, "Emotionally Disturbed Persons" – Lesson Plan 20, "Sudden Unexpected Deaths" – Lesson Plan 24, and "Legal" – Lesson Plan 25, refer to no other source materials for their content. The Department of Justice should ensure it develops and utilizes material that is seen to be and is in fact, expressly and wholly independent of the explicit or implied corporate interests of Taser International. HRPS indicates they have moved away from Taser International's training and developed their own.[37]

To this point, CEW training for Corrections has been delivered through the two-day course outlined in Exhibit 119, involving theory and hands-on practical exercises with officers deploying a CEW.[38] On a voluntary basis, staff can experience the effects of being the target of a deployment.[39]

Notes

1 Exhibit 126

2 Exhibit 246

3 See Recommendation 6 of Exhibit 126, The Advisory Panel to the Minister of Justice on the use of the Conducted Energy Device by Law Enforcement Agencies in Nova Scotia (June 30, 2008), pages 6 and 19: "The panel is aware there are presently no globally accepted safety parameters established for the CED. Accordingly: It is recommended that federal, provincial and territorial authorities responsible for law enforcement establish a mechanism to ensure an independent, rigorous assessment of the risks and benefits of any device to be used by law enforcement that has the potential for causing harm."

4 "[The CED] is only to be discharged in the execution of police officer duty, and where risk from aggression, violence or other reasonable conditions exist given the articulation of circumstances are in the interests of public or officer safety" and "in keeping with police agency approved use of force policy and training." (Reproduced in Exhibit 126, Report of the Advisory Panel to the Minister of Justice on the use of the Conducted Energy Device by Law Enforcement Agencies in Nova Scotia (June 30, 2008), page 20

5 Exhibit 126, page 22

6 Exhibit 126, page 22, Recommendation 8

7 Testimony of Robert Purcell, Executive Director of the Provincial Department of Justice, Public Safety and Security Division, pages 8722–8723, referring to Exhibit 246

8 "Aggressive resistance" is not a term found in the Resistance and Control Levels section of the Halifax Regional Police Standard Operational Policy and Procedure Manual (Exhibit 82, Tab B, Chapter Seven 17.1 Resistance and Control Levels) which refers to "active aggression", behaviour that is defined as occurring: "…when a subject attacks the officer to defeat attempts of control. The attack is a physical assault on the officer in which the subject strikes or uses techniques in a manner that may result in injury to the officer or others."

9 Testimony of Robert Purcell, page 8733

10 Braidwood Commission on Conducted Energy Weapon Use, Part 10: Recommendation 1, page 298

11 Braidwood Commission, Part 10: Recommendation 1, pages 299–303. Taser International sought declaratory and injunctive relief against Justice Braidwood's conclusion [Braidwood Commission, Part 9] that there is some risk of death or serious injury associated with the use of CEW's which required a risk-benefit analysis of their use and deployment and led to him making a series of recommendations [Braidwood Commission, Part 10.] Taser International's application was dismissed, the court holding, *inter alia*, that there was "nothing in the report on which I could base a conclusion that the Commissioner's findings were unreasonable." (*Taser International, Inc. v. British Columbia (Commissioner)*, [2010] B.C.J. No. 1578 at paragraph 52 (B.C.S.C.))

12 Braidwood Commission, Part 10: Recommendation 1, pages 303–307

13 Braidwood Commission, Part 10: Recommendation 1, page 303

14 Braidwood Commission, Part 10: Recommendation 1, page 303

15 Braidwood Commission, Part 10: Recommendation 1, page 307: "…because police officers are familiar with those categorizations, and judicial interpretation over the years gives such terms some certainty of meaning."

16 Braidwood Commission, Part 10: Recommendation 1, page 307

17 Braidwood Commission, Part 10: Recommendation 1, page 307

18 Braidwood Commission, Part 10: Recommendation 1, pages 307–308

19 Braidwood Commission, Part 10: Recommendation 2, page 308

20 Submissions of the Attorney General of Nova Scotia, pages 11178, 11204

21 Braidwood Inquiry, Part 10: Recommendation 3, pages 308–309

22 Testimony of Sean Kelly, page 7544. Sean Kelly is the Director of Corrections for the Province, with the responsibility for oversight of five adult institutions and two youth facilities. (Testimony of Sean Kelly, page 7525)

23 Braidwood Commission, Part 10: Recommendation 5, page 310

24 Testimony of Sean Kelly, page 7546

25 Testimony of Sgt. Dean Stienberg, page 7049

26 Exhibit 82, Tab D, Halifax Regional Police Standard Operational Policy and Procedure Manual, Chapter 17.3 "Incidents Involving Use of A Taser", #6 a.

27 Exhibit 82, Tab D, Halifax Regional Police Standard Operational Policy and Procedure Manual, Chapter 17.3 "Incidents Involving Use of A Taser", #8 a - d.

28 Testimony of Sgt. Dean Stienberg, page 7083, referring to Exhibit 63C "Training disclosure materials Disk 3 (Excited Delirium)" Sgt. Stienberg added: "Now we're very clear to the officers. Tell them, this doesn't mean you automatically go to Taser under every circumstances in any way, shape or form." (Testimony of Sgt. Dean Stienberg, page 7083) Sgt. Stienberg stated further: "I don't want anyone left with the impression that I think it's an absolute that you're absolutely going to use a CEW under those

circumstances [where a person is perceived as experiencing excited delirium]. But I do believe that there is a time when it is appropriate, yes." (Testimony of Sgt. Dean Stienberg, page 7113)

29 Testimony of Dr. Joseph Noone, pages 9174–9175

30 Exhibit 126, The Advisory Panel to the Minister of Justice on the use of the Conducted Energy Device by Law Enforcement Agencies in Nova Scotia (June 30, 2008), page 21

31 Testimony of Roy Kennedy, pages 10508–10509

32 Testimony of Robert Purcell, page 8724

33 Testimony of Roy Kennedy, page 10509

34 Testimony of Roy Kennedy, page 10509

35 Testimony of Robert Purcell, page 8725, referring to Exhibit 126, The Advisory Panel to the Minister of Justice on the use of the Conducted Energy Device by Law Enforcement Agencies in Nova Scotia (June 30, 2008), Recommendation 12, which states: "Accreditation of use of force instructors be based on provincial standards, not merely on the basis of criteria established by the manufacturer."

36 Exhibit 119, Department of Justice "Taser Training"

37 Testimony of Sgt. Dean Stienberg, page 7023; Sgt. Stienberg testified that he is alive to the importance of scrutinizing CEW training material to ensure it is independent and reliable. (Testimony of Sgt. Dean Stienberg, page 7241)

38 Testimony of D/Supt. Tracey Dominix, page 7478

39 Testimony of D/Supt. Tracey Dominix, page 7478

Mobile Mental Health Crisis Team

The Mobile Mental Health Crisis Team (MMHCT) was the first service that Ms. Ellet turned to when she was desperately trying to deal with Mr. Hyde's escalating symptoms on the night of November 20/21. The manager for the MMHCT, Susan Hare described it to the Inquiry as "…a combined service, an integrated partnering service between the IWK, Halifax Regional Police, Emergency Health Services, and Capital Health." The MMHCT provides crisis intervention services over the telephone and in the community and has a mandate "to support individuals who are in crisis in the community to access the services they need."[1] It is a service that is available to anyone in the community.[2]

The MMHCT is governed by a Memorandum of Understanding[3] signed by the partners to the service.

The MMHCT's telephone line is operated in the Halifax Regional Municipality 24 hours a day, seven days a week by clinical staff with a background in nursing, social work or occupational therapy and through this service "a fair bit of triage" is done.[4] The mobile service of clinicians and designated police officers[5] in plain clothes[6] attending to calls in the community operates from 1 p.m. until 1 a.m.[7] There are two teams each comprised of a clinician and a police officer.[8] Although a 24/7 mobile service "would be great", resources are limited.[9] The 12 hours during which the mobile service is available represent the busiest hours for people presenting to the emergency departments and having contact with police.[10] Patrol officers can access the mobile crisis team through the triage line for assistance on a call.[11]

Police officers assigned to the MMHCT participate in "Crisis Intervention Team Training" followed by on-site training and mentoring from more experienced officers.[12] The training is provided by the Capital District Health Authority.[13] Known as the Memphis model of crisis intervention training it incorporates, over four days, fairly intensive training on the signs and symptoms of mental illness, role playing, how to respond to certain situations, information about community resources and participation from persons living with a mental illness.[14]

There is no specific training offered to police members of the MMHCT on court-ordered assessments.[15] The officers and civilian members of the team participate in a mental health orientation and as a result receive a general overview of the services available at the East Coast Forensic Hospital and the Mentally Ill Offender Unit.[16]

The MMHCT model is not a "first responder" model of crisis intervention.[17] The mobile team "is not a primary response unit to any type of violent situation."[18] If a call to MMHCT involves violence or a person who is out of control, it is treated as an urgent matter and the police respond.[19] The police have a better ability to respond quickly and can better deal with any safety risks and stabilize the situation.[20] The MMHCT, whose clinicians are not trained in use of force, then stands by in the

event the police call them in to assist.[21] There was nothing to preclude Csts. Gillis and Jardine on November 21 asking the MMHCT to attend.[22]

It was indicated to the Inquiry that,

> …it is not uncommon for mentally ill persons to become involved in minor acts of aggression when they are agitated, suspicious or frankly delusional, as it appears that Mr. Hyde was on this occasion. Had a mental health worker and trained police officer been involved the situation may have been de-escalated and Mr. Hyde escorted away for a mental health assessment.[23]

The mobile team will respond anywhere, including to HRPS Booking should the police request their services.[24] There seems to be a reasonably high level of awareness about the team's services amongst police officers[25] and health care professionals[26]. The courthouse sheriffs although not knowledgeable about the MMHCT [27] expressed enthusiasm for what the service can offer.[28] However it appears that once a person has been arrested and charged, the MMHCT have not attended for calls beyond HRPS cells. Supt. William Moore testified that he was "not aware that [the team] have gone…when that person is transferred from our cells either to court or from our cells to a remand directly to the Central Nova Scotia Correctional Facility.[29] He agreed that it was fair to say the reason for this was because there is an assumption that once the person goes to court, all of the relevant information about their need for a psychiatric assessment is "following them into the system."[30]

The goal of the MMHCT is to support "personal agency" in the least intrusive way possible.[31] The principle of "personal agency" contemplates people using the service making,

> …decisions about healthcare that makes sense for them always weighing… personal safety and public safety in the midst of that…we want to step into the situation being as least intrusive as possible and then based on the information we have, either from family or community or even from police, we may need to change our approach based on that information and what we're seeing.[32]

The first step in assisting a person is to try and get them settled and stable so they can start to develop a plan. If this can be accomplished the MMHCT will try to connect the person with services in the community to help support them. If the person is too ill to function effectively, the MMHCT will facilitate getting them help through a further assessment or an admission to hospital.[33] Where the team has done the initial assessment and made a recommendation that the person needs admission to the psychiatric emergency services to see a psychiatrist, the police have typically acted on that recommendation with the team initiating the assessment process and sharing their information with the psychiatric emergency service.[34]

The assessment done by the MMHCT clinician "in the field" is the same as the assessment conducted by a psychiatric liaison nurse at the Emergency Department.[35] The same standardized brief mental health assessment is prepared for these assessments.[36] An MMHCT "field" assessment provides the benefit of focusing and streamlining the psychiatric liason nurse's work.[37]

Information obtained by the MMHCT is respected as confidential information like any other health information.[38] A Ministerial authorization from the Depart-

ment of Health permits the sharing of information with the designated MMHCT police officers but not police officers in general.[39] The police members of the team are provided only with the information "that's relevant to what we need to do in the moment."[40] There is no transfer of medical information from the mental health team to the police file.[41]

Because of confidentiality requirements[42], police officers responding to a call involving a person with a mental health issue, who are not members of the MMHCT, do not have any access to information about the person kept by the MMHCT even though it might be helpful for them to have it.[43] Accordingly none of the officers responding to Albro Lake Road knew that Mr. Hyde had experienced a mental health crisis just over seven months earlier.[44] However because police first responders do not necessarily have, and in the case of Csts. Gillis, Jardine and Edwards, did not have, the training that MMHCT clinicians do, they may not have been able to "use that information in a way that will actually improve outcomes."[45] Other jurisdictions using mental health crisis intervention teams do not disclose their information to non-member police first responders.[46]

Supt. William Moore testified that the MMHCT triage clinician has options for assisting the officers responding at the scene without compromising the person's confidential medical information:

> …the clinician is not going to go into the full medical history of the individual, but they may be able to say something [like] 'we know Mr. Smith…We know he has called before. This is what I would suggest for Mr. Smith, knowing his treatment. Or I know Mr. Smith. Put Mr. Smith on the phone…' and go that way."[47]

In the event that the MMHCT had responded to Ms. Ellet's call by attending at Albro Lake Road with Csts. Gillis and Jardine, the designated MMHCT officer would likely have assumed some leadership of the situation because of the combined factors of having a specialized skill set and MMHCT's familiarity with Mr. Hyde's case. They would not have shared the confidential information held by MMHCT but would have provided direction in light of it.[48]

To ensure that service users, having the assurance of anonymity[49], will be more inclined to access the service, the records of the MMHCT are not available through hospital databases.[50] The MMHCT does share their information with the emergency department if the Crisis Team has an involvement with a person who is referred to the ER.[51] If, subsequent to the involvement of the MMHCT and without them being aware, the individual is transported to the ER, the only way information about the MMHCT contact would become available to the Emergency Department staff is if they realized there had been an involvement with the MMHCT and called the team.[52]

In the case of Ms. Ellet's call to MMHCT on November 20/21, 2007, a file would have been created under her name, not Mr. Hyde's, because she initiated the contact.[53] The notes concerning the call reference Mr. Hyde's file number [54] and Mr. Hyde's file from the April/May 2007 MMHCT contact would have been accessible by the clinician talking to Ms. Ellet on November 21.[55]

Where the police respond to a situation involving someone they determine to be "an emotionally disturbed person", they complete an emotionally disturbed person form which is forwarded to the MMHCT. Receipt of the EDP form by the MMHCT enables the team to decide how to proceed,

> …there would be a number of options. So we might check out to see what the disposition was. We might check out to see if the person is still home, if they're interested or needing us to come see them, or are they just looking for information.[56]

Equipped with the EDP form, the MMHCT may be able to intervene proactively with individuals who have not yet become involved with the criminal justice system and require assistance to stabilize and be healthy.[57]

In Mr. Hyde's case, the EDP form[58] was completed by Cst. Gillis on November 21.

In circumstances where the person who has been the subject of a contact with the team ends up arrested and held in custody for court, the MMHCT will wait to see whether the court orders a *Criminal Code* assessment in which event the team would not follow up.[59] Should the person be released back into the community then the police members of the team would determine where the person is located so that the team could decide if they can assist further.[60]

In Mr. Hyde's case there would not have been much to offer him or Ms. Ellet, given the time of night, and typically the MMHCT would follow up the next day[61], "determine where the individual ended up, and see if there was any more service that we could provide or if they were already on a path to receiving service or involvement somewhere else."[62] However, by the next day, because Mr. Hyde was in custody and proceeding through the criminal justice process, "…there was not much more we could offer at that point in time."[63]

In Booking, after Mr. Hyde returned from the hospital, the likely perception was that his issues had been attended to in the ER, so that even in the face of references on the HIT Form to schizophrenia and psychosis, aggression and potential for self-harm, no thought was given to calling in the MMHCT. S/Cst. Daniel Fraser testified when asked about this:

> I'm guessing as to what I would've been thinking at the time, but I'm assuming that because he had been already released from the hospital [those issues would have been dealt with.] And they were probably better suited [to deal with them] than just a crisis unit.[64]

HRPS Booking could have called the MMHCT to cells to assess Mr. Hyde but the team could not have administered any medication and any medical issues would have to be addressed by EHS.[65] The MMHCT could however make an assessment that a prisoner was becoming more delusional which could trigger a return to the ER.[66]

The MMHCT was aware from Mr. Hyde's history with the service that he had a diagnosis of schizophrenia.[67] There was information in the MMHCT records about Mr. Hyde's mental health crisis in April/May 2007. There is no indication that there was any follow-up on November 21 by the MMHCT to see what had happened to Mr. Hyde.[68] There was no review of why the clinician who spoke with Ms. Ellet and then 911 did not recommend that Mr. Hyde be taken directly to hospital in view of his history and his condition at the time.[69] The post-November 21 debriefing of how Mr. Hyde's case was handled was not recorded in any manner as there is no policy requiring such records to be made.[70] The MMHCT did identify that as a general rule, more follow-up than occurred in this case would be beneficial.[71]

Notes

1 Testimony of Susan Hare, page 3671

2 The MMHCT operates anywhere in the Capital Health District. (Exhibit 78, Psychiatric Emergency Service Orientation Guide, page 24) see also: Testimony of Susan Hare, page 3690

3 Exhibit 273

4 Testimony of Susan Hare, pages 3671, 3672

5 The police officers on the MMHCT volunteer. (Testimony of Supt. William Moore, page 4054)

6 Testimony of Susan Hare, page 3848; Testimony of Supt. William Moore, page 4021: "The thought process…is that the officers were to be…low key…so that when the [clinician] that's there is doing their assessment…the police officer should blend into the background."

7 Testimony of Susan Hare, page 3673

8 Testimony of Supt. William Moore, page 4001

9 Testimony of Susan Hare, page 3693

10 Testimony of Susan Hare, page 3691

11 Testimony of Supt. William Moore, page 4016

12 Testimony of Susan Hare, page 3674

13 Testimony of Susan Hare, page 3674; Testimony of Supt. William Moore, page 4003

14 Testimony of Susan Hare, page 3675

15 Testimony of Susan Hare, page 3700

16 Testimony of Susan Hare, pages 3700–3701

17 Testimony of Susan Hare, page 3712; Testimony of Supt. William Moore, page 4112

18 Testimony of Supt. William Moore, pages 4023, 4098

19 Testimony of Susan Hare, page 3675

20 Testimony of Susan Hare, pages 3967–3968; Testimony of Supt. William Moore, page 4097

21 Testimony of Susan Hare, pages 3675, 3969; Testimony of Supt. William Moore, pages 4023, 4113

22 Testimony of Supt. William Moore, page 4067

23 Exhibit 265, Report of Dr. Stephen Hucker, dated May 28, 2009, page 9

24 Testimony of Susan Hare, page 3692

25 For example, Testimony of S/Cst. Gregory MacCormick, page 2079: "…if we…see someone [in Booking] that (sic) is obviously ill…we would call the Mobile Mental Health Team to come in…"; Cst. Bradley Jardine, page 738–739; S/Cst. Shannon Coombs, pages 1686–1687; Cst. Benjamin Mitchell, pages 2199, 2315; Testimony of Cst. Christopher McMahon, pages 2527–2528; Cst. Steven Hillier, page 2570; S/Cst. Daniel Fraser, page 2813; Cst. Kathryn Willett, pages 3054, 3158.

26 For example, Testimony of Glenda Keyes, R.N., page 3794; Testimony of Dr. Janet MacIntyre, page 4939

27 Testimony of Deputy Sheriff Shirley Day, page 4286

28 Testimony of Deputy Sheriff Shirley Day, page 4299 "…we would welcome the resource. A unit that would come in to make our job and…that person safer."

29 Testimony of Supt. William Moore, page 4042

30 Testimony of Supt. William Moore, page 4043

31 Testimony of Susan Hare, page 3676

32 Testimony of Susan Hare, page 3676

33 Testimony of Susan Hare, page 3698

34 Testimony of Susan Hare, page 3699

35 Testimony of Susan Hare, page 3905

36 Testimony of Susan Hare, page 3905, referring to Exhibit 78, Psychiatric Emergency Services Orientation Guide, Capital District Health

37 Testimony of Susan Hare, page 3906

38 Testimony of Susan Hare, page 3677

39 Testimony of Susan Hare, pages 3677, 3708

40 Testimony of Susan Hare, page 3709

41 Testimony of Supt. William Moore, page 4025. See, also: Exhibit 273, Memorandum of Understanding, Part 2, paragraph 7

42 Exhibit 273, Memorandum of Understanding , Part 2, paragraph 6 provides that: "Each party [to the MOU] shall take reasonable steps to ensure that only MCT clinical staff, designated constables and those permitted by law shall have access to any information exchanged in the course of the administration of MCT, and that access is exclusively for the purposes of MCT."

43 Testimony of Susan Hare, page 3873

44 Testimony of Susan Hare, page 3873

45 Testimony of Susan Hare, page 3879

46 Testimony of Susan Hare, page 3879

47 Testimony of Supt. William Moore, pages 4115–4116

48 Testimony of Susan Hare, page 3931

49 Testimony of Susan Hare, page 3900

50 Testimony of Susan Hare, page 3678

51 Testimony of Susan Hare, pages 3678, 3900

52 Testimony of Susan Hare, page 3710

53 Testimony of Susan Hare, page 3858

54 Testimony of Susan Hare, page 3863 referring to Exhibit 79A, Tab 4, Mobile Crisis Client Intervention Notes for November 21, 2007

55 Testimony of Susan Hare, pages 3868–3869

56 Testimony of Susan Hare, page 3694

57 Testimony of Supt. William Moore, page 4002

58 Exhibit 137

59 Testimony of Susan Hare, pages 3696, 3717–3718

60 Testimony of Susan Hare, page 3697

61 It appears this follow-up would have been the responsibility of the MMHCT police officer. (Testimony of Susan Hare, page 3934)

62 Testimony of Susan Hare, page 3713

63 Testimony of Susan Hare, page 3714

64 Testimony of S/Cst. Daniel Fraser, pages 2813–2814

65 Testimony of Supt. William Moore, page 4124

66 Testimony of Supt. William Moore, page 4125

67 Testimony of Susan Hare, page 3871

68 Testimony of Susan Hare, page 3876

69 Testimony of Susan Hare, page 3893

70 Testimony of Susan Hare, page 3926

71 Testimony of Susan Hare, page 3924

Psychiatric Emergency Services at the QEII Emergency Department

Psychiatric Emergency Services in 2007

In November 2007, the psychiatric services at the QEII Emergency Department were comprised of a psychiatric liaison nurse working 9 a.m. to 9 p.m., seven days a week. On weekdays, a psychiatrist would have been available during regular work hours, with an on-call resident and psychiatrist accessible after hours and on weekends and holidays.[1] This changed in July 2009 to a 24/7 service.[2]

The system in place in November 2007 was a "linear" system that situated the ER physician as the decision point for determining if a person should be referred for emergency psychiatric care.[3] The doctor would decide if any non-psychiatric medical issues needed attention and the individual would have to be capable of participating in a psychiatric assessment.[4] The decision of whether or when to refer the person for a psychiatric assessment was left to the doctor's medical judgment.[5]

As Mr. Hyde's case indicates, a doctor would have had to initiate the assessment process with the psychiatric liaison nurse if a decision was made that an assessment was required.[6] During hours when the psychiatric liaison nurse was not on duty, the ER doctor "would page the resident directly, and the resident would then come in and do the assessment."[7]

In Mr. Hyde's case, given that he was resting comfortably and it was the middle of the night, the decision was made not to contact the psychiatry resident.[8] The psychiatric liaison nurse was due in at 09:00. Mr. Hyde was the only patient in the ER with a psychiatric issue and in all likelihood could have had his assessment by the psychiatric liaison nurse completed by 10:15.[9]

An Enhanced Role for the Mobile Mental Health Crisis Team?

Had the MMHCT been able to assess Mr. Hyde, the assessment process at the QEII Emergency Department by the psychiatric liaison nurse would have been streamlined.[10] The MMHCT service reports that 80 to 85 percent of the individuals brought to the ER by the MMHCT require admission, a statistic that contrasts sharply to the experience of front-line police officers who testified to their experience that only a very low percentage of the people they take to the ER are admitted.[11] This suggests there is a potential benefit in expanding the role of the MMHCT to assist the police, who are not trained in making assessments[12], with assessments "in the field" to determine if a person should be referred to psychiatric emergency services.[13] The MHCT could also assist by offering advice about mental health supports and resources in the community.[14]

Psychiatric Emergency Services in 2010

All psychiatric emergency services have been consolidated at the new ER department at the QEII so that there is now a 24/7 psychiatric nursing service. The new services offers significantly improved privacy, more space and 24 hour specialty nursing care.[15] A "parallel patient-care process" has been developed so that the psychiatric nurse takes referrals from the charge nurse in the ER "to try and initiate some contact and do some of the assessment pieces prior to seeing the emergency physician."[16]

> …when someone comes into the emergency department, if it's a priority medical issue and the person needs to be seen right away, or if their health is so compromised that they can't engage in the psychiatric assessment, then the medical piece would take priority. But if the medical piece is not a high priority, then …the psych service will take the lead on it. The psych nurse might simply liaise with the emergency physician and make a treatment plan and a decision that they don't need to go further and [the person] can be discharged with good follow-up support, or they might make a decision that the individual requires a full ... a psychiatrist to do the assessment for potential admission.[17]

If an assessment is made that a person needs to be admitted for in-patient psychiatric assessment and care, the person will be admitted for this purpose irrespective of a police involvement or presence.[18]

In the case of a person who has been charged criminally and is being committed civilly, arrangements will be made for an admission to an in-patient acute care bed with it being documented in the assessment process that there are criminal charges.[19] There is no protocol or policy around connecting with the police once the person who is facing criminal charges has been discharged from hospital.[20]

The Administration of Olanzapine to Mr. Hyde

Mr. Hyde received an intramuscular injection of 10 mgs. of olanzapine at 02:50 on November 21. According to Dr. Noone that administration of olanzapine would have had some effect for about 24 hours. Without information as to what medications Mr. Hyde was on or how recently he had been taking them, the appropriate approach is to be more cautious.[21] Although 10 mgs. of olanzapine is "a rather low level for emergency management" and "may not be enough to settle a person",[22] observations that the patient is sleeping, non-combative, and largely cooperative would indicate that the medication is having the desired effect. [23]

Even though Mr. Hyde appeared to understand the procedures to take his blood and monitor his vital signs[24], and the administration of the olanzapine[25], the exchange with him was to assess whether he was going to be aggressive (he was not) and not to obtain his consent to these procedures.[26] No thought appears to have been given to seeking Mr. Hyde's consent to be injected with an anti-psychotic medication.[27] In the opinion of Dr. Michael Howlett,[28] the accepted principle is to always obtain consent. He suggested that consent is implied where a person presents at the emergency department "on their own recognizance."[29] Mr. Hyde of course was taken to the hospital by the police and remained there under their custody, a fact known to the ER staff and physicians.

Notes

1 Testimony of Susan Hare, page 3684

2 Testimony of Susan Hare, page 3971

3 Testimony of Susan Hare, pages 3911–3912

4 Testimony of Susan Hare, pages 3912–3913

5 Testimony of Susan Hare, page 3917

6 Testimony of Susan Hare, page 3684

7 Testimony of Susan Hare, page 3685

8 See, Part II, Chapter 13

9 Testimony of Susan Hare, page 3685

10 Testimony of Susan Hare, page 3906

11 Testimony of Susan Hare, page 3907 referring to Exhibit 78, Psychiatric Emergency Services Orientation Guide, Capital District Health

12 Testimony of Susan Hare, page 3908

13 Testimony of Susan Hare, page 3910

14 Testimony of Susan Hare, page 3911

15 Testimony of Deborah Phillips, R.N., pages 9774–9775

16 Testimony of Susan Hare, pages 3685–3686

17 Testimony of Susan Hare, page 3686

18 Testimony of Susan Hare, page 3719

19 Testimony of Susan Hare, page 3687

20 Testimony of Susan Hare, page 3688; Testimony of Supt. William Moore, page 4007

21 Testimony of Dr. Joseph Noone, page 9285

22 Testimony of Dr. Joseph Noone, page 9285

23 Testimony of Dr. Joseph Noone, page 9286

24 Testimony of Laura Morgan, R.N., page 3668

25 Testimony of Laura Morgan, R.N., pages 3668–3669

26 Testimony of Laura Morgan, R.N., page 3668

27 Testimony of Laura Morgan, R.N., page 3667

28 Dr. Michael Howlett was qualified by the Inquiry to give expert opinion evidence as an emergency room doctor with expertise in emergency medicine around the emergency care provided to Mr. Hyde on November 21, 2007 at the QEII Health Sciences Centre Emergency Department. (Transcript, page 10225)

29 Testimony of Dr. Michael Howlett, page 10351

Code White

Code White is a recognized term denoting a trained response to aggressive behaviour by healthcare patients.[1] Paged in a hospital it signifies a behavioural emergency.[2] Code White training is provided to health care personnel, and can include hospital security.[3] In addition to training individuals, it is "risk-specific" training that recognizes the context of a hospital having a duty to respond to aggressive behaviour by patients.[4]

The Inquiry heard evidence from Dr. Joseph Noone who has been actively involved in Code White training in British Columbia.[5] Theoretical aspects such as statistics and definitions and examining attitudes toward aggressive behaviour are features of the training programme. The basic training focuses primarily on communication and "basically not getting assaulted."[6] Dr. Noone explained that Code White training draws its approach from well accepted core principles:

> One is the attitudinal principle that the philosophy should be respect and professionalism. Unfortunately, at times, power and control becomes the attitude, and that becomes the attitude, and that's felt not to be very productive. So there's also an emphasis on prevention. Because…most violence occurs in a contextual framework…so staff are taught to intervene early rather than just letting things build up until people get more frustrated and more likely to act out.[7]

Other Code White principles are hands-on control as a last resort and no pain compliance, which means no painful wrist locks, no impact, no pressure points. "The ideal is it must be done in a way that the person is supported and hopefully that the relationship with the patient is maintained."[8] Code White employs de-escalation by:

> …observing a person who's getting mounting aggression, mounting emotional (sic), and trying to communicate with them in a way that's respectful, that shows that you're there to help them, and you'd like to help them, and how can you help them. [9]

De-escalation techniques can include diverting the person's attention to something else and creating an alliance with them.[10]

> …the idea is to get the person to come down the mountain, to get their anger down, get their frustration down. And it's not easy work to do and it's hard to do under stress. And that's why it requires training and…practice…these are just skills.[11]

Dr. Noone identified Code White as sharing a common approach with verbal

de-escalation techniques employed by police officers, such as Verbal Judo.

> It's mostly trying to get at attitudes so that the person's attitude is appropriate. And again, getting away from the power and control and getting more into the respect.[12]

Although Code White team numbers vary, the training programme in British Columbia emphasizes never using fewer than three trained members for an intervention.[13] The more usual team complement is five.[14] Dr. Noone confirmed that in British Columbia, occupational health and safety requirements in hospitals underpin the standard of having Code White teams available to assist in the management of aggressive patients.[15]

There is no Code White team at the QEII Emergency Department. With "tighter, closer quarters…people are available all of the time, so we haven't really found a need to have a specific Code White team." [16]

Notes

1 Testimony of Dr. Joseph Noone, page 9094

2 Testimony of Dr. Joseph Noone, page 9293

3 Testimony of Dr. Joseph Noone, page 9103

4 Testimony of Dr. Joseph Noone, page 9121

5 See Exhibit 249, Dr. Noone's curriculum vitae, page 10. From 1992 to the present, Dr. Noone has been the Director of the Code White training programme (prevention, de-escalation, self-protection and team intervention skills) in British Columbia.

6 Testimony of Dr. Joseph Noone, page 9121

7 Testimony of Dr. Joseph Noone, page 9121

8 Testimony of Dr. Joseph Noone, page 9122

9 Testimony of Dr. Joseph Noone, page 9221

10 Testimony of Dr. Joseph Noone, page 9221

11 Testimony of Dr. Joseph Noone, page 9222

12 Testimony of Dr. Joseph Noone, page 9223

13 Testimony of Dr. Joseph Noone, page 9107

14 Testimony of Dr. Joseph Noone, page 9107

15 Testimony of Dr. Joseph Noone, page 9111

16 Testimony of Deborah Phillips, R.N., pages 9776–9777

Mental Health Services: The Courts

Notwithstanding Mr. Hyde's significant mental health issues, the deputy sheriffs at the Dartmouth Provincial Courthouse, notably Deputy Sheriffs Shirley Day and James Crook, were able to manage his anxiety and maintain his equilibrium. Using an approach that was calming and reassuring, these officers helped Mr. Hyde deal with the stress of his court appearance and the news that he would not be released on bail and would spend the night in custody.

Had the officers needed some assistance with Mr. Hyde, they would not have known to contact the Mobile Mental Health Crisis Team, which was available to them. When asked about the MMHCT, D/S Day indicated she really didn't know anything about the team.[1]

An obvious way to better equip court staff with information about available services is education. Additional on-site resources would also be helpful, to the courts, court staff and the accused person. The Inquiry heard that court support services can provide

> … advice to the justice system about what are the resources that are required to…get a person bail, to connect them with treatment…and community supports as well as providing advice to the person living with mental illness and his or her family, if they're involved, about how to navigate the justice system and how to achieve diversion where that's possible.[2]

Court support services have been highly effective in Ontario in connecting clients to community mental health services, reducing court backlogs and improving the functioning of the court system.[3]

Mr. Hyde's November 21 court appearance was a first appearance and was dealt with in the regular arraignment court. At the time the Mental Health Court had not been established[4] and even if it had been operating, it would have dealt with Mr. Hyde only on the basis of a subsequent referral, not for his first appearance.[5] To be of assistance for first appearances like Mr. Hyde's, court support services/workers would have to be available in the arraignment court for persons in custody with mental health issues.

It is unclear whether existing resources, other than possibly the MMHCT, would have been helpful or even appropriate for Mr. Hyde. There is a procedure in place to have psychiatrists from the East Coast Forensic Hospital attend at either the Halifax or Dartmouth Provincial Courthouses where there is a question about whether or not an accused should be sent for a *Criminal Code* assessment. Dr. Scott Theriault explained this psychiatric consultancy service:

> …we…go from the hospital, go over to cells…see the person, and then make a quick determination as to whether we think there's sufficient

grounds to ask for an assessment order.[6]

However, in Mr. Hyde's case, an assessment was not requested on his behalf. His lawyer confirmed that he acted in accordance with Mr. Hyde's instructions at the arraignment appearance.[7] Therefore, as Mr. Hyde appears not to have been interested in seeking an assessment, or was advised against it, this was not a case where a visit from an ECFH psychiatrist would have been animated by his defence counsel.

Crown counsel gave no consideration to asking for a psychiatric assessment of Mr. Hyde under section 672.12 of the *Criminal Code* for fitness and NCR[8], a request that typically came from Defence counsel.[9] The Crown had to be able to satisfy the court that there were "reasonable grounds" to doubt that Mr. Hyde was fit to stand trial and/or criminally responsible, on account of mental disorder, for the alleged offences.[10] Crown counsel testified that she had been presented with no such grounds[11] even though, according to Sergeant Kevin Murphy of the HRPS Quality Assurance office, the notation in the file materials of "Mental health, unsafe to release" was "an instruction to the Crown to ask for an assessment from the presiding judge."[12] An ECFH psychiatrist could have attended at cells and been consulted on the issue of grounds.

In conclusion however on this issue, and most importantly, it was not a "forensic" assessment that Mr. Hyde needed. The evidence indicates that on November 21, 2007 he needed a psychiatric assessment, as would have been available through the QEII Emergency Department, for the purpose of determining how to address his current mental health issues.

Notes

1 Testimony of D/S Shirley Day, page 428

2 Testimony of Steven Lurie, pages 10671–10672; see also, pages 10720–10722

3 From material supplied by Steven Lurie, Systems Enhancement Evaluation Initiative (SEEI) Final Report "Moving in the Right Direction", March 31, 2009, page 24

4 Nova Scotia's Mental Health Court has been operating since November 2009 at the Dartmouth Provincial Court. It only deals with matters that have occurred in the Halifax Regional Municipality or transferred in from elsewhere in the Province because the accused has a substantial connection to the HRM. The Inquiry did not hear evidence concerning the Court or whether it would have been of assistance to Mr. Hyde had it existed in 2007. (It is to be remembered that Mr. Hyde's mental illness was not raised in court when he appeared and was remanded over to the following day.) Supt. Moore characterized the Nova Scotia Mental Health Court as a "downstream process." It does not have a pre-charge disposition approach. (Testimony of Supt. William Moore, page 4058) An accused must be judicially referred to the Mental Health Court and there is an approximate delay of about two weeks before the accused appears in the Court.

5 See the Nova Scotia Department of Justice Mental Health Court Program Overview, page 2: "An accused may be identified as a potential participant for the Mental Health Court Program upon their first appearance in Court (arraignment) or at a subsequent appearance…The identification of a potential participant for the Nova Scotia Mental Health Court is to be communicated to the Judge presiding in the "originating" court through the Crown Attorney or Defence Counsel, and the presiding Judge may refer the matter to the Nova Scotia Mental Health Court."

6 Testimony of Dr. Scott Theriault, page 9593

7 As noted in Part II, Chapter 21, solicitor-client privilege precluded any evidence about Mr. Hyde's instructions to his lawyer.

8 Testimony of Cheryl Byard, pages 5286–5287; 5340

9 Testimony of Cheryl Byard, page 5271

10 *Criminal Code*, sections 672.12 (2) (b) and (3)(b)

11 Testimony of Cheryl Byard, page 5352

12 Testimony of Sgt. Kevin Murphy, page 3294

Release from Custody: Temporary Supportive Housing

When Mr. Hyde appeared in court on November 21, the Crown was prepared to consent to his release provided he entered into a recognizance with a surety secured in the amount of $1500.[1] Ms. Byard wanted someone to assume responsibility for Mr. Hyde to ensure that he attended court and complied with his release conditions.[2] Although her proposed release conditions[3] do not indicate whether personal property (as opposed to real property) would be sufficient to justify the $1500, it is safe to assume this as it would be the common practice.[4]

A recognizance represents a higher level of release than an undertaking with conditions or a recognizance without a surety.[5] There is nothing in the evidence to indicate who might have been prepared to act as Mr. Hyde's surety and pledge $1500 of personal property to secure his release.[6] The responsibility for finding a surety would have been Mr. Hyde's.[7] In the alternative, he would have been entitled to a bail hearing[8] or perhaps the Crown would have been amenable to modifying its position.

Ms. Byard, having reviewed Mr. Hyde's criminal record, was not concerned that Mr. Hyde, if released, was likely to commit a criminal offence.[9] She was concerned about him returning to Ms. Ellet's apartment, contrary to release conditions intended to protect her.[10]

Mr. Hyde's defence counsel did indicate to the court that a release plan was being developed although he didn't have sufficient time to get it in place that day.[11] The evidence does not indicate what that plan may have involved. What is apparent from the evidence is that Mr. Hyde, like many people with a chronic mental illness living in relatively marginalized circumstances, did not have many supports in the community. It is my opinion that the requirement for a surety in these circumstances potentially represented a significant barrier to Mr. Hyde's release although the court, by way of a bail hearing, may have set less onerous conditions.

For Mr. Hyde the charge against him for assaulting Ms. Ellet carried significant implications for his liberty. The challenge presented by having to find a surety raises the question of whether the option of supportive temporary housing for Mr. Hyde might have resulted in his release from custody on November 21.

Given how seriously intimate partner assault is now treated, if there are concerns about a complainant's safety and if the accused is not confined to hospital as an involuntary patient under the *Involuntary Psychiatric Treatment Act*[12], then "there may be a difficulty in getting conditions [in place] to ensure the complainant's safety."[13] Removing the problem of the accused person's immediate housing needs would serve the interests of both the accused and the complainant.

Various witnesses identified stable housing as a significant issue for people liv-

ing with mental illness.[14] Steven Lurie, the Executive Director since 1979 of the CMHA, Toronto branch and chair of the Service Systems Advisory Committee, Mental Health Commission of Canada[15] described safe supportive housing as one of the determinants of mental health.[16] Susan Hare identified the need for persons living with a mental illness to have access to "more supportive living environments in the community…there are some significant issues around access to shelters for individuals, for crisis housing, and for regular housing…"[17]

Supportive crisis-housing is a service that could possibly have assisted either Ms. Ellet or Mr. Hyde, had it been available.[18] Drawing on their experiences, police officers identified housing as an issue for people with mental illness[19] and agreed that housing with clinical supports would be "a great asset" for people experiencing a psychiatric crisis.[20]

There is no mental health crisis housing in Halifax.[21] This deficit has been identified by the MMHCT "especially in the middle of the night when most resources and services are not available."[22] Crisis housing offers

> An opportunity for somebody to become settled and stabilized that doesn't need hospital admission…often…there [are] other factors involved. It could be…difficulty with a partner, difficulty with a landlord, feeling unsafe in their apartment because their illness symptoms are exacerbating…they typically stay for a few days, get some support…it's usually not a medical intervention. It would be linking the individual back up with their medical team and supporting them to regain their [tenancy] back in their own place of residence.[23]

The MMHCT can respond to a person with a mental illness who is in need in the middle of the night but there is nowhere to take the person in the Halifax Regional Municipality other than temporary shelters like Metro Turning Point for adults or Phoenix Youth Shelter for young people if they cannot go home or do not have a home.[24] A person with a mental illness, charged with assaulting an intimate partner and released on conditions not to have contact with the victim who has been his support system, may require supports that the temporary shelters are not able to provide.[25]

The Toronto CMHA has approximately 526 supportive housing units, 300 of which are dedicated to people involved with the justice system. Turn-over is minimal however, with only about 15 units coming available in a year, limiting access.[26] Crisis housing has also been established; a network of crisis residential safe beds where people released from custody can stay for up to 30 days with supports to help them "design a care plan to link them with services in the community."[27] It is Toronto's experience that the demand for longer-term supportive housing and crisis housing for persons with mental illness is acute.[28]

Notes

1 Exhibit 178-D, Release Conditions Proposed by Crown Attorney, Cheryl Byard

2 Testimony of Cheryl Byard, pages 5266, 5267. The proposed release conditions included a prohibition against Mr. Hyde returning the apartment he shared with Ms. Ellet. (Testimony of Karen Ellet, page 120: Question: And did you eventually move in and live with Howard? Answer: Yes, I did…we moved to Albro Lake Road, Dartmouth.)

3 Exhibit 178D, Release conditions proposed by Crown Attorney, Cheryl Byard

4 Author's experience.

5 *Criminal Code*, section 515(2) (a), (b) and (c)

6 Deputy Sheriff Shirley Day thought at one point on November 21 that Mr. Hyde's sister was "going to sign for him" which suggests there may have been some discussion about Mrs. Blair acting as surety but, as we know, that did not come about and Mr. Hyde was remanded.

7 Testimony of Cheryl Byard, page 5267

8 *Criminal Code*, section 515(1)

9 Testimony of Cheryl Byard, pages 5264–5265

10 Testimony of Cheryl Byard, page 5292: "I was not about to release him on his own undertaking not knowing where he would go. He might go back to her residence, and I wasn't going to take that chance."

11 Testimony of Cheryl Byard, page 5279

12 *2005, c. 42*, section 1

13 Testimony of Supt. William Moore, page 4041

14 See, for example, Testimony of Susan Hare, pages 3683, 3946; Testimony of Dr. Scott Theriault, pages 9619, 9700

15 Exhibit 278, curriculum vitae of Steven Lurie

16 Testimony of Steven Lurie, page 10599

17 Testimony of Susan Hare, page 3683; see also, Testimony of Susan Hare, page 3946

18 Testimony of Susan Hare, page 3895

19 See, for example, Testimony of Kathryn Willett, page 3151

20 See, for example, Testimony of Cst. Bradley Jardine, pages 849–850

21 Testimony of Susan Hare, page 3894

22 Testimony of Susan Hare, page 3894

23 Testimony of Susan Hare, page 3895

24 Testimony of Supt. William Moore, pages 4183–4184

25 Testimony of Supt. William Moore, page 4184

26 Testimony of Steven Lurie, page 10604

27 Testimony of Steven Lurie, page 10708

28 Testimony of Steven Lurie, pages 10604, 10708

Mental Health Services: The Central Nova Scotia Correctional Facility

Although this Inquiry heard some evidence about how health care is delivered to prisoners at the Central Nova Scotia Correctional Facility[1], this report will focus on health care coverage available to a newly-admitted remand prisoner who is scheduled to attend court in the morning.

The Admission Health Information Assessment Process

When Mr. Hyde was admitted to the CNSCF, the regular Admissions nurse, Cheryl Champion, was not working. She testified that had she done his intake, in view of the direction on the HIT Form, she would probably have called the hospital to see if they wanted him back.[2] (She may well have received the same response that Maureen Walford did when she made this inquiry; that Mr. Hyde did not need to be returned to the ER.[3]) The significant difference between the Admissions assessment Mr. Hyde received and the one Ms. Champion would have conducted appears to be that Ms. Champion would have made some further inquiries about Mr. Hyde having no medications with him notwithstanding the indication on his HIT Form that he had "conditions requiring ongoing attention: psychosis/schizophrenia"[4]. She testified:

> Well, I think I would have called the hospital and maybe tried to get hold of the doctor that wrote it or tried to get hold of some medical records, if that's possible. There's nothing even documented on the [HIT Form] that he was given medications…[5]

Ms. Champion would have wanted to know from the ER any information about what happened at the hospital: "treatment, medication, anything."[6] Had such inquiries been made, presumably they should have uncovered the injection of olanzapine that Mr. Hyde had received approximately 15 hours earlier.

The CNSCF admissions assessment process for Mr. Hyde was very brief. It was conducted in 5 minutes.[7] This is a triage-length assessment time.[8] A very comprehensive psychiatric nursing assessment done at the QEII emergency department takes approximately 40 minutes to an hour.[9] Although the CNSCF Admission Health Assessment, unlike the QEII ER psychiatric assessment, is not part of a treatment approach, the nurse conducting the CNSCF assessment is required to:

- identify health issues;
- identify offender (sic) needs;
- assist offenders (sic) in assuming responsibility for their own health and well-being; and

- take a proactive approach to potential health and safety risks to offenders.[10]

The mandated objectives of the assessment procedure are plainly focused on the longer-stay prisoner who has either been sentenced or is remanded for more than an overnight stay. While the CNSCF assessment may permit a determination to be made about how best to house and manage the new admission, in Mr. Hyde's case it did not ascertain how ill he was.

Pacing and Shouting

When Mr. Hyde arrived at the CNSCF late in the afternoon on November 21, 2007 he was not perceived as acutely ill even though his behaviour was regarded by C/O Christopher Dixon as "very bizarre."[11] A decision was made that he should be placed in a Health Segregation cell.[12] His conduct through the night raised concerns that made their way to the health care night-staff who was responsible for Health Care from 19:00 – 07:00. There was a brief, through-the-door discussion with Mr. Hyde and nothing more.

While the existence of a diagnosis of psychosis does not necessarily mean that the prisoner represents an emergency medical situation, the degree to which symptoms are being well controlled is very relevant. As Cheryl Champion testified in addressing this issue:

> [The diagnosis of psychosis] could be a diagnosis [the prisoner] has had in the past. And even if someone comes in with schizophrenia written [on their HIT Form], if they're on their meds and well-medicated and stable it's sort of irrelevant, right? Because they're…not ill at the time.[13]

Mr. Hyde was, of course, not on his medications and was in fact, very ill. He was "very tenuously maintained"[14] on a low and depreciating dose of olanzapine.

The extent of Mr. Hyde's relentless pacing through the night of November 21/22 was either not fully appreciated by health care and correctional staff[15] or it was simply not seen as requiring an urgent, or indeed any, response. It seems to be the rare person that recognizes the very restless prisoner may need help: "[In the event of witnessing intensive pacing]…I would question if there's anything that I can help them with or anything bothering them. Inquire."[16]

Generally speaking, pacing and shouting are such commonplace behaviours in the correctional setting that they have become normalized and staff habituated to them.[17] Although they can indicate a psychotic episode[18], correctional officers regard them as very common behaviours and not a cue that a mental health crisis is underway.[19]

Describing pacing as "as a relatively mild form of agitation", Dr. Scott Theriault[20] pointed to the relevance of context: "…in the correctional environment… states of mild agitation are quite common."[21] Even if continual for hours on end, pacing alone "…probably still wouldn't trigger an emergency assessment of an individual in the correctional environment…"[22] The problems associated with this emerge from Dr. Hucker's comments: although he testified that it is "very difficult to ascertain somebody's mental state when all they're doing is pacing in the cell"[23], Mr. Hyde was still in "an acutely disturbed mental state."[24]

"Containment" appears to be "part of the management of the acutely ill psychiatric patients…"[25] and security issues also operate to trump any consideration of

assessing and alleviating the prisoner's distress. "If they're constrained and there's no immediate self-harm involved…then in all likelihood we would tend to keep the person there [on the correctional side] and try and get a more definitive view of the person over a period of time."[26] However, with a prisoner like Mr. Hyde, who was due to return to court in the morning, the option of observing him over time would not be a relevant factor.

I feel confident that if a properly trained health care professional[27] had met with Mr. Hyde during the long night of November 21/22 the severity of his illness would have been apparent. Proper consideration could then have been given to whether Mr. Hyde was well enough to attend court in the morning and most importantly, whether he should be receiving psychiatric care on an urgent basis. Surely the need for such care would have been obvious. Dr. Hucker agreed that the immediate treatment for Mr. Hyde following a psychiatric assessment before he went to court could have simply been another dose of olanzapine.[28] However Mr. Hyde's acute psychosis would once again be only temporarily held in check.[29]

Psychosis: What to Look For

It would be expected that in the case of a prisoner with a diagnosis of schizophrenia and psychosis, correctional staff would be provided, not with the diagnosis (because of confidentiality requirements[30]), but with information about symptoms to look for that merited alerting health care staff.[31] Unfortunately the labile nature of psychotic symptoms as illustrated by Mr. Hyde's case[32] does not seem to have been recognized. The evidence before the Inquiry indicated that the information to be provided to correctional workers would depend "…on the assessment of the nurse at the time, what symptoms the offender (sic) was exhibiting on admission and what they might expect through the night."[33] Relying on untrained correctional officers to interpret what they observed of Mr. Hyde, the health care providers at the CNSCF did not realize that his psychosis was developing and that he was profoundly distressed and disordered. No one working the night shift was given any information about what to look for.[34]

Other than through Health Care staff meetings and discussion of specific cases with Health Care staff, there does not appear to be any policy or other guidance given to health care providers at the CNSCF as to what behaviours correctional staff should be watching for in the management of a prisoner with a diagnosis of psychosis.[35] Existing policy does not assist correctional staff.[36]

Getting an After-Hours Psychiatric Assessment

Mr. Hyde was scheduled for court on November 22. Staff at the CNSCF ensured he was safely housed in a Health Care Segregation cell overnight and monitored during rounds. Had his behaviour been understood as an indication that he needed immediate psychiatric attention and care, there were options for getting an assessment done of his condition. The RN on duty until 19:00 hours, or after that the PRAXES[37] employee, could have contacted the on-call doctor[38] to discuss a transfer from the OHU to the Mentally Ill Offender Unit at the ECFH.[39] Either the psychiatrist on call[40] or the on-call GP[41] could have dispatched a psychiatric nurse from the Mentally Ill Offender Unit to the OHU to assess Mr. Hyde.[42]

It remains somewhat unclear to me whether a psychiatric referral for Mr. Hyde during the night of November 21 could have gone directly to the MIOU psychiatric nurses after a consultation with the on-call doctor, as Ms. Champion's evidence

suggests, or if there would have been the added layer of consultation by the on-call doctor with an on-call psychiatrist as the PRAXES protocol indicates.[43] The latter referral process seems quite bureaucratic to me with the potential for the re-telling to dilute the vividness and urgency that may be apparent to the front-line health care provider. I note that Dr. Scott Theriault, testifying on this issue, said that once the psychiatric nurse does her assessment, she contacts the psychiatrist on call for a decision to be made about whether the prisoner needs to be transferred over to the MIOU or should be seen right away by the psychiatrist.[44] Dr. Theriault was clear that the decision to dispatch a MIOU psychiatric nurse after-hours over to the CNSCF to assess a prisoner is made by the on-call psychiatrist.[45]

The MIOU

It is not likely that bed access would have been an issue as the 12 available MIOU beds[46] are rarely utilized by the CNSCF and usually only partially occupied.[47] The MIOU does not offer a different physical environment for the prisoner experiencing a mental health crisis: the cells look like typical jail cells[48] with stainless steel fixtures (e.g., toilet) and cinderblock walls.[49] The area is constructed to a higher security standard, to withstand fairly aggressive behaviour.[50] The main differences between Health Segregation and the MIOU is that the MIOU has nursing staff on duty 24/7 with responsibility to many fewer prisoners and there is daytime access to psychiatrists.[51]

Obtaining an emergency psychiatric referral and having a prisoner assessed by a psychiatric nurse from the MIOU is "an extreme case" and "doesn't happen very frequently."[52] The more common approach would be to keep the prisoner safe overnight[53], and have them seen by the GP first thing in the morning, "if it happens to be a day that they're on" or a referral through the psychiatric nurses in the MIOU to a psychiatrist.[54]

Even a transfer to the MIOU would have likely provided Mr. Hyde only with medication, if he was treated at all.[55]

The problem with the usual protocol is that, even if his needs had been recognized, it would not have addressed the situation presented by Mr. Hyde: a prisoner in need of immediate psychiatric care who was about to be handed back over to the court system. The protocol is designed to deal with prisoners who will still be at the CNSCF the next morning when a doctor or psychiatrist can assess them.

PRAXES

PRAXES Emergency Specialists is a private company that provides health care to industry and government.[56] It has a contract[57] with CDHA to provide two services to the CNSCF: (1) a 24/7 access to certified emergency physicians for health care consultations and (2) to provide health care staff for the night shift at the CNSCF.[58] PRAXES contracts with its health care providers[59] and supplies its CNSCF night staff with a "core work instruction manual[60]…designed to provide orientation and reference" for PRAXES services. The CNSCF through CDHA is not PRAXES' only client.[61]

PRAXES night staff at the CNSCF are either paramedics, or physicians assistants who have primarily obtained their skills and qualifications through the Canadian Armed Forces.[62] PRAXES staff discharge two principle roles: (1) ensuring that prisoners receive their medications; and (2) providing basic life support services in the case of an emergency.[63] There is an ancillary role of completing HIT Forms for prisoners going to court in the morning.[64]

For the purposes of the mandate of this Inquiry, it is the training, skill and practice of the PRAXES night staff that is of most relevance. PRAXES advised the Inquiry that the paramedics and physicians assistants "would all have had some initial introduction to psychiatric patients in their training, but we don't provide additional training."[65] There is no in-house training for PRAXES employees on dealing with prisoners with mental illnesses.[66] Such training would be helpful to PRAXES employees.[67]

PRAXES does have clear policy requirements for night staff assessing a prisoner for psychiatric issues. The employee would be expected to be

> …looking at things like [the prisoner's] orientation, do they know where they are, do they know their name, do they know what's happening to them, are they describing hallucinations or delusions or stating they're going to harm themselves or feel they're going to be harmed…[68]

Dr. Theriault testified that the ECFH has not indicated to PRAXES that the on-call psychiatrist should be contacted if certain behaviours are observed.[69]

In terms of providing good health care to persons with serious mental illness, both Drs. Noone and Hucker testified to the benefits obtained from using specialized psychiatric nursing staff.[70]

Mr. Hyde's Long Night Alone

The "assessment" Mr. Hyde received from PRAXES in response to C/O Kayongo's concerns was wholly inadequate.[71] Mr. Hyde needed a properly trained mental health professional to assess him during the night of November 21 when he was decompensating in his cell. Monitoring him closely with no clear understanding of what was being observed was not what he needed so much as human contact and appropriate, compassionate intervention by a properly trained health care professional. As the General Manager for PRAXES noted in his testimony:

> …if you're just observing…you're having no conversation, you don't understand [the prisoner's] thoughts or you don't understand if they're oriented or anything like that."[72]

There does not appear to be a culture that encourages more direct contact with prisoners experiencing mental illness. Although as a manager, Ms. Casey-Gomes does not deliver direct nursing services to prisoners, she did not contemplate personal contact with prisoners when asked about health care staff responding to a prisoner exhibiting signs of a mental illness.

> Question: And if a prisoner was in the MIOU cell, would there be any intervention of any kind…intervention to mitigate a prisoner's distress…?
>
> Answer: Monitoring and possible treatment. It would also depend on whether the individual was certified, because they can't force medication… unless they were certified…so that type of intervention.[73]

This contrasts sharply to the approach Dr. Noone saw as appropriate for a person in Mr. Hyde's condition:

> …You know, you can't really control the other person but you can control yourself and therefore influence the other person. So it depends a lot on

> your approach, your style. Looking at the tapes, and I must say I didn't view all the tapes of the night at Corrections just because they took so long, but I certainly got the impression that he was up most of the night, and he was pacing, and shouting…what I was doing was looking at him and thinking, now…if I was in the room with him…how would I handle it…one would get an entry pretty quickly into interviewing him…maybe once or twice he'd tell you to get lost, but…an experienced mental health professional would be able to get him talking…[74]

This was consistent with Dr. Webster's opinion that Mr. Hyde's pacing in the cell indicated an emotional crisis. The indications were that Mr. Hyde was "beginning to lose his balance…beginning to disorganize." A trained person would know that it was time to intervene.[75]

For a psychotic person, the isolation of a cell could be "very disorganizing."[76] Interaction with another person provides necessary structure and assists the person with a psychosis being able to regulate and stabilize himself. Making a connection and developing a rapport is essential to getting the person settled down.[77]

PRAXES acknowledged in evidence before the Inquiry that "direct contact with a patient *could* be part of the assessment" conducted by a PRAXES night-staff employee at the CNSCF subject to any security issues.[78] Security did not factor into the way Mr. Hyde's assessment was conducted.[79] Nor should it have as Mr. Hyde showed no aggressive tendencies during his admission or while housed in Health Segregation.

Even though Gordon Hamilton, the General Manager for PRAXES agreed that a prisoner exhibiting agitation and delusional thinking constitutes an urgent or emergent situation,[80] it is significant that a PRAXES night-shift assessment is primarily directed at determining if the prisoner is in danger of harming himself.[81] Although even a prisoner's emotional crisis may be enough to trigger PRAXES night-staff contacting the on-call doctor for a general consult, it is the risk of self-harm that seems most likely to animate an after-hours decision to consult.[82] If the prisoner is "not acting out or [an] immediate harm to themselves", the approach would be to "essentially maintain them in the cell until day shift comes, when they have the resources to start actively treating on an ongoing basis…"[83]

While this may help to explain why Mr. Hyde did not receive more effective assessment and care over the long night he spent pacing his cell, PRAXES night-staff are nevertheless expected to perform "comprehensive medical examinations" and "dig into the details" when assessing a prisoner with psychiatric issues.[84]

Clinical Notes

PRAXES staff are expected to make a clinical note of any assessment made of a prisoner such as occurred in Mr. Hyde's case when Ken Murray attended briefly at the door of his cell in response to a request from C/O Kayongo.[85] The Inquiry was informed that PRAXES searched its records and found none for Mr. Hyde.[86] Multidisciplinary notes for Mr. Hyde show no entry for the brief contact by PRAXES.[87]

No Formal Review

No formal review[88] involving the manager of the OHU was done of the delivery of health care in Mr. Hyde's case and the fact that no information about Mr. Hyde was provided to correctional officers by the admissions nurse only came to the atten-

tion of the manager at the Inquiry.[89] PRAXES also did not conduct a review of its contact with Mr. Hyde at the CNSCF.[90]

Notes

1 Capital District Health Authority provides health care in the CNSCF. (Testimony of Charlene Casey-Gomes, page 6923) The only provincial correctional institution in Nova Scotia with 24 hour health care coverage is the CNSCF. (Testimony of Charlene Casey-Gomes, page 6929) See also, the testimony of Cheryl Champion, R.N.

2 Testimony of Cheryl Champion, page 6788

3 Testimony of Maureen Walford, page 5790

4 Exhibit 159, Tab 4; Also filed as Exhibit 68

5 Testimony of Cheryl Champion, page 6790

6 Testimony of Cheryl Champion, page 6792

7 Although Sandra McLeod testified to her belief that the interview with Mr. Hyde lasted 15–20 minutes (Testimony of Sandra McLeod, R.N., page 5626), the video surveillance evidence from the CNSCF shows Mr. Hyde being interviewed for 5 minutes, from 17:02:39 – 17:07:41 on Exhibit 60, Tab 9, 17 clips "medical questions"; also Exhibit 170, in a format edited to protect the identity of other individuals.

8 Testimony of Deborah Phillips, page 9739 referring to the triage assessment conducted by a paramedic at the QEII psychiatric emergency department.

9 Testimony of Deborah Phillips, R.N., page 9800. Ms. Phillips worked for many years as a psychiatric assessment nurse at the QEII emergency department.

10 Exhibit 188, Capital Health Offender Health Services, Policy & Procedure "Initial Nursing Assessment"

11 Testimony of Correctional Officer Christopher Dixon, pages 5544–5545. Had Mr. Hyde presented as an emergency upon admission or been assessed as someone who could not be properly cared for at the institution then the Admissions Nurse could have requested the sheriffs who transported him to transfer him to the Dartmouth General Hospital ER. If the sheriffs had left, or the prisoner's condition was very unstable, 911 would have been called. (Testimony of Charlene Casey-Gomes, pages 6849, 6913)

12 Although in Mr. Hyde's case this decision was made by the Correctional Officer Christopher Dixon, the ultimate authority for placing a prisoner in a Health Care cell rests with nursing staff. (Testimony of Charlene Casey-Gomes, page 6929)

13 Testimony of Cheryl Champion, R.N., page 6831

14 Testimony of Dr. Stephen Hucker, page 10125

15 Correctional Officer Stephen Kayongo did raise concerns about Mr. Hyde and directed them appropriately to the PRAXES employee on site, Ken Murray.

16 Testimony of Matthew Atwell, pages 8560–8561

17 Charlene Casey-Gomes, the RN in charge of the Offender Health Care Unit (OHU) at the CNSCF as the Health Service Manager, testified that whether yelling and pacing would constitute an acute psychiatric emergency would depend on the context. These behaviours would not necessarily represent an emergency situation. "[Yelling and pacing is often behaviour we see that is] just triggered by the fact that they're going to court the next day." (Testimony of Charlene Casey-Gomes, page 6890) Ms. Casey-Gomes noted that a "substantial" number of prisoners admitted to the CNSCF have a mental illness: "…it's probably daily…if not daily, every other day occurrence." (Testimony of Charlene Casey-Gomes, page 6866) See also, Testimony of Correctional Officer Renee Jones, page 6004: "…we recognize unusual behaviour on a daily basis." Testimony of Correctional Officer Cameron Lamond, page 6199

18 Testimony of C/O Cameron Lamond, page 6202

19 Testimony of C/O Cameron Lamond, page 6213; see also, Testimony of Dr. Michael

Webster, page 11037: "And if the staff is not specifically trained, they habituate to that kind of behaviour…it's not salient for them any longer because they see it so often… if you're trained it stands out for you. However, in that setting, it tends to become routine."

20 Dr. Theriault is the clinical director of the East Coast Forensic Hospital.

21 Testimony of Dr. Scott Theriault, page 9599

22 Testimony of Dr. Scott Theriault, page 9726

23 Testimony of Dr. Stephen Hucker, page 10078

24 Testimony of Dr. Stephen Hucker, page 10083

25 Testimony of Dr. Scott Theriault, page 9655

26 Testimony of Dr. Scott Theriault, page 9727

27 Psychiatric nurses bring distinct skills that enable them to provide specialty care for persons with a mental illness or in crisis. (Testimony of Deborah Phillips, R.N., page 9775)

28 Testimony of Dr. Stephen Hucker, pages 10167–10168

29 Testimony of Dr. Stephen Hucker, page 10178

30 Testimony of Charlene Casey-Gomes, page 6933. An exception to this would be if the prisoner was asked for and provided an informed consent for the information to be disclosed to the correctional staff. (see, Testimony of Charlene Casey-Gomes, page 6909)

31 Testimony of Charlene Casey-Gomes, page 6878. After-hours, correctional staff monitor the Health Segregation cells and bring to the attention of PRAXES staff anything they feel "needed to be assessed by health care." (Testimony of Matthew Atwell, page 8560)

32 "People who are actively psychotic are not psychotic at the same intensity all the time and they vary in the same way as in how much they're in touch with reality." (Testimony of Dr. Joseph Noone, page 9184)

33 Testimony of Charlene Casey-Gomes, page 6879

34 Testimony of Sandra McLeod, R.N., pages 5685; 5713

35 Testimony of Charlene Casey-Gomes, page 6868. "I can't think of [when we have done cross-training with health care workers and correctional officers.]" See also, Testimony of Charlene Casey-Gomes, page 6900

36 Exhibit 181, Correctional Services Policy & Procedures, "Special or Suicide Watch": "Correctional staff must closely monitor an offender (sic) who 1.1.1 appears intoxicated; 1.1.2 demonstrates drug or alcohol withdrawal symptoms; 1.1.3 is at risk for self-harm; 1.1.4 is identified as suicidal."

37 PRAXES Emergency Specialists Inc. (Testimony of Charlene Casey-Gomes, page 6928) Registered nurses at the OHU are on duty from 07:00 to 19:00 hours and are then relieved by PRAXES staff. (Testimony of Charlene Casey-Gomes, page 6923–6924)

38 It is/was also an option for PRAXES staff to call the administrator on call to initiate the process of contacting a doctor. The administrators on call are a group of managers from the ECFH and OHU who provide on-call services seven days a week. (Testimony of Charlene Casey-Gomes, page 6851) PRAXES can also call their own on-call doctors who are emergency department doctors from CDHA providing services to PRAXES. (Testimony of Charlene Casey-Gomes, page 6931)

39 Testimony of Charlene Casey-Gomes, page 6856. The relevant policy is set out in Exhibit 187.

40 Psychiatrists at the MIOU are typically on site during regular business hours and are otherwise accessible through an on-call rotation. (Testimony of Charlene Casey-Gomes, page 6855)

41 Testimony of Cheryl Champion, page 6879–6800

42 Testimony of Charlene Casey-Gomes, page 6885; see also, Testimony of Cheryl Champion: "Depending on the time of day…our doctors are on till seven…if the patient was in danger of harming themselves or just couldn't calm down, I would have to call the GP and fill out an emergency psych referral and get one of the nurses from the MIOU to come down and assess them. That would be the protocol I would follow…And that was the protocol in November of 2007." See also; Testimony of Dr. Scott Theriault, pages 9578–9579

43 Testimony of James Hamilton, pages 8463, 8498–8499. This protocol is contained in Exhibit 242, page 10 at #'s 4 and 5. On this issue, see also Exhibit 186, Capital Health Offender Health Policy & Procedure, "After Hours and Weekend Access to Emergency Mental Health Services for CNSCF" which provides in section 5, page 2: "If need for Emergency Psychiatric Assessment is identified [by the on-call GP], the GP will contact the psychiatrist on call. The psychiatrist will contact MIOU staff if they deem urgent consult is necessary." See also, Testimony of Matthew Atwell, page 8536; Testimony of Kenneth Murray, pages 8610, 8611

44 Testimony of Dr. Scott Theriault, pages 9578–9579

45 Testimony of Dr. Scott Theriault, page 9642

46 Of 24 MIOU beds, 12 are designated for prisoners on court-ordered assessments and 12 are for prisoners with a mental illness who cannot be cared for at the CNSCF. (Testimony of Charlene Casey-Gomes, page 6852)

47 Testimony of Charlene Casey-Gomes, pages 6891, 6907, 6924

48 Testimony of Charlene Casey-Gomes, page 6862

49 Testimony of Charlene Casey-Gomes, page 6938

50 Testimony of Dr. Scott Theriault, page 9550

51 Testimony of Charlene Casey-Gomes, page 6938

52 Testimony of Charlene Casey-Gomes, page 6801; See also, Testimony of James Hamilton, page 8500

53 Cheryl Champion, R.N. referred to keeping the prisoner safe over night "in a [suicide] gown" which suggests that the primary psychiatric emergency is a suicide risk. (Testimony of Cheryl Champion, page 6801) Mr. Hyde's psychiatric vulnerability may not have been what nursing staff and correctional officers were most used to dealing with. To the untrained eye it would also have been less obvious than someone threatening or trying to kill themselves.

54 Testimony of Cheryl Champion, page 6801

55 Testimony of Dr. Scott Theriault, page 9710: "We wouldn't normally bring somebody over [to the MIOU] for treatment unless that at least included pharmacological treatment."

56 Testimony of Gordon Hamilton, page 8457

57 Exhibit 240

58 Testimony of Gordon Hamilton, pages 8457–8458

59 Exhibit 241. PRAXES Employment Contract. Schedule "B" attached describes the scope of practice. PRAXES' employees are generally employed in other positions full-time. PRAXES would employ registered nurses escept "most of them simply probably wouldn't want to do it for the rate." (Testimony of Gordon Hamilton, pages 8471–8472)

60 Exhibit 242, PRAXES Emergency Specialists Inc. Employee Work Instructions. Exhibit 242 was revised in August 2009. The earlier version which would have been in effect in November 2007 was created in October 2004. The changes to the earlier version do not appear to be relevant to this Inquiry. (Testimony of Gordon Hamilton, pages 8472–8473)

61 Testimony of Gordon Hamilton, page 8477. This means that the on-call ER doctors and psychiatrists potentially have other PRAXES' clients, in addition to the CNSCF,

calling them for services.

62 Testimony of Gordon Hamilton, page 8459. Mr. Hamilton testified that PRAXES hires the highest level of physician assistant – Q6-B, who are capable of "independent practice within the Forces…they would be the people that provide medical care on board the warships, this type of thing. So they've had some very, very good training." (Testimony of Gordon Hamilton, page 8466) Notwithstanding, physicians' assistants employed by PRAXES have the same scope of practice as paramedics. (Testimony of Gordon Hamilton, page 8494)

63 Testimony of Gordon Hamilton, pages 8459–8460. It was disconcerting to learn from Mr. Hamilton that "virtually every [prisoner] in there is on some medication, multiple medications." (Testimony of Gordon Hamilton, pages 8459–8460)

64 Testimony of Gordon Hamilton, pages 8459–8460. See also, Testimony of Matthew Atwell, page 8515

65 Testimony of Gordon Hamilton, page 8461

66 Testimony of Gordon Hamilton, pages 8461–8462

67 Testimony of Matthew Atwell, page 8511

68 Testimony of Gordon Hamilton, page 8469

69 Testimony of Dr. Scott Theriault, page 9617

70 Testimony of Dr. Joseph Noone, page 9288; Testimony of Dr. Stephen Hucker, pages 10181–10182

71 Matthew Atwell, an Intermediate Care paramedic and team leader for PRAXES, described what an assessment of a prisoner experiencing a "psychotic event or self harm or an emotional event" would involve. (Testimony of Matthew Atwell, page 8513)

72 Testimony of Gordon Hamilton, page 8475

73 Testimony of Charlene Casey-Gomes, pages 6939–6940

74 Testimony of Dr. Joseph Noone, pages 9161–9162. In referring to the Health Care Segregation cell video surveillance of Mr. Hyde, Dr. Noone may have been conflating his observations of Mr. Hyde overnight in the cell with the evidence (including video surveillance) about Mr. Hyde during the high-profile escort the next morning. In the former, Mr. Hyde can be seen but not heard as there is no audio. In the latter, Mr. Hyde talked about being an RCMP officer and needing a haircut. Dr. Noone references these themes in reiterating his observations of Mr. Hyde in the Health Care cell: "…I was looking at him and thinking, now…if I was in the room with him…how would I handle it. Now, he was talking about different things, you know. He liked the RCMP, he didn't like the RCMP, he wanted a haircut because he wanted to become an RCMP officer. I mean…there was lots of stuff there…so one would get an entry pretty quickly into interviewing him…" The reference to Mr. Hyde not liking the police may indicate that Dr. Noone was recalling Mr. Hyde's monologue when he first arrived at HRPS Booking. Even if Dr. Noone's recall was that Mr. Hyde said all these things in the Health Segregation cell, I do not see that as detracting from the point he was making. Dr. Noone understood there was a lot going on in Mr. Hyde's mind and it would not have been difficult for a trained mental health professional to have engaged him during the night of November 21 at the CNSCF.

75 Testimony of Dr. Michael Webster, pages 11039–11040

76 Testimony of Dr. Jacqueline Kinley, page 9896

77 Testimony of Dr. Jacqueline Kinley, pages 9846, 9897

78 Testimony of Gordon Hamilton, page 8474

79 Testimony of C/O Stephen Kayongo, page 5862: "Yes, it was [an option for Mr. Murray to have gone into Mr. Hyde's cell to assess him.]"

80 Testimony of Gordon Hamilton, page 8492

81 Testimony of Gordon Hamilton, page 8473

82 Testimony of Kenneth Murray, pages 8536–8537, 8611–8612

83 Testimony of Gordon Hamilton, page 8474. See also, Exhibit 241, PRAXES Employment Contract, Schedule "B", Scope of Practice – Range of Services Permitted

84 Testimony of Gordon Hamilton, page 8481

85 Testimony of Charlene Casey-Gomes, page 6875; Testimony of Gordon Hamilton, pages 8487, 8506; Testimony of Matthew Atwell, pages 8522, 8529 "If we see anybody in the facility, we do document on it."

86 Testimony of Gordon Hamilton, page 8464

87 Testimony of Matthew Atwell, page 8520

88 "We sat down with health care staff [after Mr. Hyde's death.] It wasn't a formal review. It was more like a crisis-type intervention to let the girls debrief…let their emotions out." (Testimony of Charlene Casey-Gomes, page 6893)

89 Testimony of Charlene Casey-Gomes, page 6893

90 Testimony of Matthew Atwell, pages 8489–8490. "I was left with the impression that we did not have any real involvement with [Mr. Hyde] on the night shift. See also, Testimony of Matthew Atwell, page 8538

The Health Information Transfer (HIT) Form

The HIT Form has a narrative of its own. It emerged from the recommendations of the Clarke Inquiry in 1998.[1] An earlier fatality inquiry, the Legge Inquiry (1988), and a later one, the Comeau Inquiry (2002), also considered the transfer of health information.

The Clarke Inquiry recommended that

> …the Joint Committee on Forensic Services develop a protocol to facilitate the transfer of information as previously recommended by the Legge Inquiry. A single page form documenting the circumstances which led to the arrest of the individual, known persons or institutions providing care or treatment, known diagnosis (provisional or otherwise), allergies and medications would be a step forward. Too much time has passed since the Legge Inquiry for this not to be in place.[2]

The HIT Form used in Mr. Hyde's case[3] was intended

> …to provide enough health information so that when a prisoner was being transported there was key information there that would assist with their care should they require care during transit and also…where the start and end of the process were health officials to provide key information from one health official to another.[4]

Police, sheriffs and correctional officials in Nova Scotia are authorized by ministerial fiat to receive information about the health of a person in their custody.[5] A HIT Form can include any information additional to "hospital records and information" deemed by the attending physician to be necessary.[6]

The original HIT Form was formulated in 2002 and updated in 2006.[7] No new Ministerial Authorization was signed at the time of the 2006 revisions to the Form.[8] The HIT Form used in Mr. Hyde's case was the 2002 version of the form.[9]

The HIT Form was changed in 2006 as a result of the proclamation of the *Correctional Services Act* that replaced the *Corrections Act.* Regulations were either added, or updated like the *Sharing of Health Information Regulation,* under which the HIT Form was created, and attached to the new legislation.[10] The new HIT Form contained a section "Present status and direction for continuity of care" which had not appeared in the old Form. The wording in the old Form was: "Conditions requiring ongoing attention…"[11] However, while the new Form was formulated with some changes to organization and language to make it easier for users to fill it out "accurately and completely", the Form's original purpose and intent remained the

same.[12] No substantive changes were made.[13] The Form continued to have the very specific purpose of ensuring that

> …law enforcement personnel were provided with sufficient information to assist them as they moved someone who was in custody through the system.[14]

The HIT Form "basically provides a documented medical history or history of the person's interaction with the medical system as they are transferred between custody of the hospital, the police department, and then on in the criminal justice system."[15] The delivery of the HIT Form from one location to another with the prisoner is the responsibility of the "transferring officer"[16], a police officer, sheriff or correctional facility employee.[17]

The HIT Form's function as a conduit of patient health information is reflected in the Capital Health Administrative Manual[18] which refers to the requirement for a completed HIT Form before a "remanded patient" can be transported to or from a healthcare facility and provides that, "This form is required so that the law enforcement agency may appropriately respond to emergency medical needs…[19]

As indicated in the 2001 Information Release forwarded to health care administrators in the roll-out of the original Health Information Transfer Form, confidentiality concerns on the part of health care professionals had inhibited the transfer of health care information:

> Because of the sensitive nature of health information there has been a reluctance by professional healthcare staff to provide to police, sheriff and correctional officers a health history with respect to the person taken into custody. However, significant health information as outlined in the "Inter-departmental Health Information Transfer" form (attached) must be provided to the receiving custodians, in order that they may appropriately respond to the emergency needs of the person in custody…It is incumbent on healthcare staff to ensure that the custodian receiving a patient into their care has sufficient information to safely transport a person…The Minister of Health has, under Section 71(5)(e) of the *Hospitals Act*, …authorized police, sheriff and correctional officers to receive information as required by the inter-departmental Health Information Transfer form…[20]

Nurses working for Capital District Health and the Registered Nurses' Association in particular raised significant concerns about the extent of the health information that might be disclosed.[21] Particularly in relation to persons with mental illness, it was feared that wide dissemination of information about diagnosis could further stigmatize and traumatize.[22] A policy decision was made however that health transfer information should include diagnosis.[23]

The emphasis in the HIT Form was explicitly on information.[24] Neither of its versions was intended to operate as a means of directing medical care.[25] The evidence at the Inquiry was conclusive on this point: the Form was "never intended as a means to delegate care that should be received in a hospital to the custodians in the criminal justice system."[26] Its purpose is to share a prisoner's relevant health information where custody of the prisoner is being transferred from one facility to another so that the prisoner's health care needs could be met, to the extent possible, during transport and at the receiving facilities.

Understanding the HIT Form's Purpose and Function and Acting on Its Content

The evidence before the Inquiry established that the HIT Form's use and purpose is not well understood. Front-line police officers did not have a consistent view of how the HIT Form functioned and even a senior officer like Superintendent Moore thought it was an internal police form although he understood that there "may be some provincial direction behind its use."[27] He was unaware until the Inquiry proceedings that the HIT form is legislated and not just a product of internal police policy.[28]

Supt. Moore did show a clear understanding of the limitations facing the police in the event Mr. Hyde was not sent for a forensic assessment by the court. Referring to Mr. Hyde's HIT Form, he testified:

> …when I read this, I understand what is being asked, but if the person is not sent for a psychiatric [assessment] the police cannot pick the person up again and bring them back [to the hospital]…from a policing perspective, me reading it knowing what I know about the system, I would have questioned it and said, I'm sorry. This doesn't happen. I need to know what do you mean by this? If you have concerns, then the person can stay here now. This is your kick at the cat...If we go the other way, there is no mechanism for police to activate that individual to bring them back around again unless there's something new that comes about.[29]

Dr. MacIntyre, who filled out Mr. Hyde's HIT Form did not understand this. Using a 2002 Form,[30] she completed the "Upcoming Appointments" section with the words **"Patient discharged in police custody for court appearance. If patient not sent for forensic psychiatric assessment police are to return patient to Emergency Department"** thinking that the police retained custody over Mr. Hyde and could bring him back to the ER if he was not sent for a court-ordered assessment.[31] Dr. Howlett, qualified as an expert in emergency medicine, also held this erroneous view:

> Question: Did you consider what authority the police would have to return Mr. Hyde to the emergency department?
>
> Answer: No, I just assumed that it would be done.[32]

Dr. Howlett's testimony about Dr. MacIntyre's use of the Form indicates that he also does not understand its purpose and function:

> …Dr. MacIntyre understood the nature and purpose of the use of the HIT Form, the principles that were its legal basis, and diligently took care to ensure that an outstanding medical condition would receive continuity of care. Her actions were in accordance with my understanding of the contemplated function of the form and her instructions were simple and clear.[33]

Like Dr. MacIntyre, Dr. Howlett seems to regard the HIT Form, when completed by a physician, to be "a form of doctor's orders."[34] It was Dr. Howlett's testimony that doctors are "used to having our orders followed."[35] The HIT Form was not a doctor's order: once Mr. Hyde left the QEII ER, his attending physicians were no

longer his primary care-providers and did not have the ability to provide direction or orders to prospective health-care providers at other institutions.[36]

The HIT Form did not prompt Ms. McLeod, the nurse who did Mr. Hyde's health care admission at the CNSCF, to make any specific inquiries about Dr. MacIntyre's direction.[37] The HIT Form indicated to Ms. McLeod that Mr. Hyde had been medically cleared.[38] It was not, in her opinion, a doctor's order.[39] In her experience with Capital Health, doctors' orders were prepared on physicians' "prescription papers" for the Health Authority.[40]

Ms. McLeod was accustomed to a different HIT Form for prisoners' follow-up appointments that indicated the place and time of the scheduled appointment and who the prisoner was to see.[41] Had Mr. Hyde come in with Dr. MacIntyre's direction on the HIT Form she was familiar with, Ms. McLeod would have contacted the CNSCF on-call doctor and "an appointment would have been made for [Mr. Hyde] to go back [to the QEII] the next day."[42] On the Form she was used to seeing, Ms. McLeod would have expected Dr. MacIntyre's direction to have appeared in the section for: "Treatment provided, present status and direction for continuity of care."[43] As it was, Dr. MacIntyre's direction appeared in Mr. Hyde's HIT Form under "upcoming appointments."[44] Ms. McLeod did not see this as Dr. MacIntyre having made an appointment for Mr. Hyde.[45] A HIT Form indicating that a prisoner had an upcoming medical appointment would state a specific time to return to a specific department of the hospital.[46]

The purpose of the HIT Form was, and is, to transfer health information with a prisoner being transported to another facility.[47] As this case illustrates, a HIT Form direction does not constitute a form of doctor's orders and cannot trump a court's warrant of committal remanding a prisoner to a correctional facility. It was not a situation, as Dr. Howlett framed it in his testimony[48], where health-care providers and custodians who saw the HIT Form decided that they did not need to give effect to Dr. MacIntyre's direction: to the extent they understood the "direction", no one had any authority to give effect to it. Without realizing it, once Dr. MacIntyre "medically cleared" Mr. Hyde and discharged him into the custody of the police, she lost the ability to manage his health care. As she said in her evidence, had she known what would happen she would not have discharged him.[49]

Police Understanding of the HIT Form

Police officers had differing levels of understanding of the limitations of their authority in relation to a physician's direction like Dr. MacIntyre's: Cst. Gyles Gillis testified that, if presented with such instructions, he should implement them.[50] Cst. Bradley Jardine on the other hand indicated that if there is no remand and the prisoner is released from custody, the police have no authority to take him back to hospital.[51] Cst. Kathryn Willett would have asked Dr. MacIntyre for clarification "so that he could get help."[52]

In 2002, an HRPS Department Order was disseminated to "all ranks" explaining the implementation of the HIT Form which had been "developed by the Provincial Government…" pursuant to legislation. The Order indicated that "the transfer form must be completed and accompany a person in all instances where s/he is in custody and is transferred, from a hospital to a facility; from a facility to a hospital; and between facilities."[53] The Order did not explain the purpose of Health Information Transfer Form. There was no indication in the evidence before the Inquiry that police officers were provided any training about the Form and its function.

Sgt. Dean Stienberg was unable to advise whether HRPS officers are presently given any training in relation to the HIT Form suggesting that such training might be through the MMHCT.[54]

It is likely there continues to be some confusion about the Form. Supt. William Moore believes that to be the case.[55] He recommended training that would ensure everyone involved with using the HIT Form understood their role.[56] He testified that the form should be a chronology "in relation to health treatment" that would record "day-to-day operations for whomever had care and custody of the person.[57] It should supply a good understanding of what has occurred previously with respect to the individual and information for whomever will next have them in their custody.[58]

Sheriffs Officers' Understanding of the HIT Form

The sheriffs' officers who testified at the Inquiry showed a strong understanding of the HIT Form, its purpose and function.[59] They understood that they could not hold Mr. Hyde if he was released from custody by court order nor could they transport him anywhere other than the CNSCF if he was remanded.[60] Deputy Sheriff Shirley Day understood that the HIT Form could be distributed only amongst the police, sheriffs and correctional officials.[61]

Inclusion of the HIT Form in the Crown File

In 2008, HRPS instituted a practice of making the HIT Form available to the Crown through disclosure.[62] According to HRPS policy, the HIT Form must now be placed in HRP master file.[63]

Apparently in about June 2009, a decision was made by the Executive Director of Court Services, without Ministerial Authorization, to allow sheriffs' officers to share health information with the Crown and Defence "in certain limited circumstances pending the recommendations" that may come from this Inquiry.[64] It should be noted that Sheriff Laurel Purcell told the Inquiry she had some reservations about the wording of the revision to the policy: "I don't believe that the wording adequately reflects the intent that I believe the Department of Justice is trying to achieve."[65]

In the consultative process that led to the formulation of the HIT Form, a process in which the Public Prosecution Service but not the Defence Bar was represented, neither the Crown nor the Defence was seen as an entity that needed to receive the Form.[66]

The view was expressed at the Inquiry that there should be some prohibition against its use in a criminal proceeding to ensure that accused persons are prepared to supply the information required to manage their health care in custody. HIT form information gathered from accused persons by police is gathered as part of their administrative function not their investigative, evidence-gathering function and there are no warnings or cautions provided to an accused person before they divulge the information.[67]

Deputy Sheriff Shirley Day also identified risks associated with the HIT Form going to the Crown: she viewed this as having the potential to inhibit the prisoner's willingness to divulge confidential health information and she was concerned that sensitive information might get revealed in ways the prisoner would not have wanted.[68]

Information Omitted from Mr. Hyde's HIT Form

When asked about Dr. MacIntyre not including on the HIT Form that Mr. Hyde had received a dose of olanzapine, Dr. Howlett stated the view that: "…a physician might not always put…down [when medication was last administered.]" And even though he testified that in his view it is good practice to do so,[69] he made the remarkable statement that he did not think Dr. MacIntyre omitting this information from Mr. Hyde's HIT Form was significant.[70] In response to being asked whether he thought this would be useful information for people receiving Mr. Hyde into their care to know, that he had received an injection of olanzapine which had a half-life[71] and would eventually wear off, Dr. Howlett had this to say:

> No, because she covers that in her instructions.[72]

I have been unable to make sense of this response as Dr. MacIntyre did not make any mention of the medication in her instructions on the HIT Form. Those instructions do not reveal that she thought the psychiatrist managing Mr. Hyde's care should address the issue. I think it is most likely that confronted in a busy ER with a situation where there was police involvement and a pending court appearance, Dr. MacIntyre simply forgot to note the olanzapine injection that had been administered before she came on duty.

The olanzapine issue is a significant one in light of the facts in Mr. Hyde's case: Although the drug might have about 24 hours of effectiveness[73], after a period of abstinence, a 10 mg. dose may not have been enough to stabilize him.[74] Of course, neither Dr. Curry nor Dr. MacIntyre knew how long it had been since Mr. Hyde had taken any olanzapine. It appears to have been July 2007, a considerable period of time.[75]

Notes

1 Testimony of Diana MacKinnon, page 7273.

2 Report of the Fatality Inquiry into the Cause of Death of Richard Albert Clarke, July 24, 1998

3 Exhibit 68; also Exhibit 159, Tab 4

4 Testimony of Diana MacKinnon, page 7276

5 Exhibit 193, Ministerial Authorization dated December 17, 2001, signed by the then Minister of Health, the Honourable Jamie Muir

6 Exhibit 193, Ministerial Authorization

7 Exhibit 159, Tab 1; Testimony of Diana MacKinnon, pages 7276–7277

8 Testimony of Diana MacKinnon, page 7395

9 Testimony of Diana MacKinnon, pages 7249–7250

10 Testimony of Diana MacKinnon, pages 7276–7277, 7401–7402

11 Testimony of Diana MacKinnon, page 7278

12 Testimony of Diana MacKinnon, pages 7278–7279; see also, pages 7285, 7297, 7374–7375

13 Testimony of Diana MacKinnon, page 7315

14 Testimony of Diana MacKinnon, pages 7286–7287

15 Testimony of Supt. William Moore, page 4018

16 Sharing of Health Information Regulations, N.S.Reg. 93/2006, section 3(1)

17 Sharing of Health Information Regulations, N.S.Reg. 93/2006, section 2(g)

18 Exhibit 77, QEII Policies and Procedures entitled "Interacting with Law Enforcement Agencies"

19 Exhibit 77, QEII Policies and Procedures entitled "Interacting with Law Enforcement Agencies", page 11

20 Exhibit 191, Information Release dated May 17, 2001, Release of Information to Police – *Hospitals Act*, Section 71(5)(e) re Health Information Transfer Form

21 Testimony of Diana MacKinnon, page 7358

22 Testimony of Diana MacKinnon, page 7287

23 Testimony of Diana MacKinnon, page 7359

24 Diana MacKinnon in her testimony explained that Exhibit 191, the Information Release was intended to "provide information to the health authorities and others about a plan to have the Minister of Health authorize under that section of the *Hospitals Act* [section 71(5)(e)] police, sheriffs and corrections officials to receive information as required on the interdepartmental Health Information Transfer Form."

25 Testimony of Diana MacKinnon, page 7325

26 Testimony of Diana MacKinnon, pages 7276–7296

27 Testimony of Supt. William Moore, page 4043

28 Testimony of Supt. William Moore, page 4121

29 Testimony of Supt. William Moore, pages 4071–4072

30 The HIT Form Dr. MacIntyre used was faxed over from HRPS Booking. (Testimony of Cst. John Haislip, page 2723: Testimony of S/Cst. Daniel Pelletier, page 2925)

31 Testimony of Dr. Janet MacIntyre, page 4868

32 Testimony of Dr. Michael Howlett, page 10315

33 Testimony of Dr. Howlett, page 10232

34 Testimony of Dr. Michael Howlett, page 10316

35 Testimony of Dr. Michael Howlett, page 10289

36 Testimony of Dr. Stephen Curry, pages 4690–4691

37 Testimony of Sandra McLeod, R.N., page 5659

38 Testimony of Sandra McLeod, R.N., page 5643

39 Testimony of Sandra McLeod, R.N., page 5641

40 Testimony of Sandra McLeod, R.N., pages 5707; 5742

41 Testimony of Sandra McLeod, R.N., page 5699

42 Testimony of Sandra McLeod, R.N., page 5700

43 Testimony of Sandra McLeod, R.N., page 5706, referring to Exhibit 79A, Tab 5, page 11

44 Testimony of Sandra McLeod, R.N., page 5706, referring to Exhibit 68

45 Testimony of Sandra McLeod, R.N., pages 5729–5730

46 Testimony of Sandra McLeod, R.N., page 5729

47 Testimony of Diana MacKinnon, pages 7322–7325

48 Dr. Howlett testified: "If the physician is going to give them information, you should do this, and then they're going to make an independent consideration that, oh, they seem okay, I don't have to act on the doctor's information, it defeats the purpose of the whole process." (Testimony of Dr. Michael Howlett, page 10248)

49 Testimony of Dr. Janet MacIntyre, pages 4868, 4766–4767, 4869

50 Testimony of Cst. Gyles Gillis, page 355

51 Testimony of Cst. Bradley Jardine, pages 852–853

52 Testimony of Cst. Kathryn Willett, page 3145

53 Exhibit 76, Halifax Regional Police Service Departmental Order #20-02; also found in

Exhibit 285

54 Testimony of Sgt. Dean Stienberg, pages 7204–7205

55 Testimony of Supt. William Moore, page 4026

56 Testimony of Supt. William Moore, pages 4026, 4044

57 Testimony of Supt. William Moore, page 4126

58 Testimony of Supt. William Moore, page 4126

59 Testimony of D/S Shirley Day, pages 4371–4374; Testimony of Sheriff Laurel Purcell, page 4960; Testimony of D/S James Crook, page 5207

60 Testimony of D/S Shirley Day, pages 4332, 4378, 4379; Testimony of Sheriff Laurel Purcell, pages 4961, 4962, 4982; Testimony of D/S James Crook, pages 5207, 5221

61 Testimony of D/S Shirley Day, page 4371

62 Testimony of Diana MacKinnon, pages 7364–7365

63 Testimony of S/Cst. Fraser, pages 2881–2883; Exhibit 159, Tab 6: HRP Standard Operational Policy & Procedure Manual, Chapter 2 – Booking, 2.6 "Injured, Ill or Unconscious Prisoner, C - 2

64 Testimony of Diana MacKinnon, page 7294. Specifically, Sheriffs Services Standard Operational and Administrative Policy and Procedure "Prisoner Transfer of Health Information", 14.18 provides: *If a HIT Form contains information or remarks in respect to a medical condition that is unusual or out of the ordinary; or during the completion of a HIT Form the Sheriff Officer becomes aware of a medical condition that is deemed out of the ordinary, they shall bring the issue to the attention of both Crown and Defense counsel and provide them with a copy of the HIT form in respect of the person in custody.* Exhibit 169

65 Testimony of Sheriff Laurel Purcell, page 4974. Sheriff Purcell testified that the "executive director" [of Court Services?] had indicated that "they" were willing to "take another look to see whether the wording is appropriate."

66 Testimony of Diana MacKinnon, pages 7288, 7346–7347

67 Testimony of Supt. William Moore, page 4175

68 Testimony of D/S Shirley Day, pages 4375–4376

69 Testimony of Dr. Michael Howlett, page 10310

70 Testimony of Dr. Michael Howlett, page 10311

71 The half-life of olanzapine means that it is "metabolized to half the original dose" in 21-54 hours from administration. (Testimony of Dr. Stephen Curry, page 4519) Olanzapine might have about 24 hours of effectiveness, (Testimony of Dr. Steven Hucker, page 10161; Testimony of Dr. Joseph Noone, page 9285) except that after a period of abstinence, a 10 mg. dose would not be enough to stabilize. (Testimony of Dr. Joseph Noone, page 9285)

72 Testimony of Dr. Michael Howlett, pages 10311–10312

73 Testimony of Dr. Steven Hucker, page 10161; Testimony of Dr. Joseph Noone, page 9285

74 Testimony of Dr. Joseph Noone, page 9285

75 See Part II, Chapter 3

Communication, Information-Sharing, and Confidentiality

Although we can never know with certainty what effect more comprehensive information-sharing may have had in Mr. Hyde's journey through the criminal justice and health care systems, the evidence shows us that information could have flowed downstream more effectively and it is reasonable to think this would have made some difference along the way. This is particularly likely to be the case when combined with enhanced training.

There was information that did not follow Mr. Hyde. That requires an examination of what was done with what information was known and consideration of the role of confidentiality in how mental health information is managed. The discussion in this Chapter is undertaken without any reference to the Health Information Transfer Form issue which was dealt with separately, in Chapter 51.

Information about Mr. Hyde's mental health was immediately available to the officers who first responded to Albro Lake Road. Ms. Ellet filled them in on the fact that Mr. Hyde had a diagnosis of schizophrenia and was "off his medications." Neither Cst. Gillis nor Cst. Jardine passed this along to Cst. Edwards or S/Cst. MacCormick in Booking.[1] It appears that Cst. Jardine was also told by Ms. Ellet at Albro Lake Road that Mr. Hyde had previously been tasered[2] although, testifying at the Inquiry, he no longer had an independent recollection of Ms. Ellet giving him this information.[3]

Cst. Jardine did however radio Cst. Edwards that Mr. Hyde was "mentally unstable", information that, in Dr. Michael Webster's opinion, would have been very useful to Cst. Edwards for the purpose of building an alliance with Mr. Hyde during the transport to HRPS Booking.[4]

Information about Mr. Hyde's mental health contained in Cst. Jardine's Versadex[5] report - that he had a diagnosis of schizophrenia and had been off his medications - was seen by Staff Sergeant Sean Auld who reviewed the file. He did not consider having Mr. Hyde taken to hospital for a psychiatric assessment because by that time, he had already been to the ER and "…looked at medically, mentally." S/Sgt. Auld believed Mr. Hyde would have already been "checked out."[6]

Dr. MacIntyre's concern, reflected in the HIT Form, that Mr. Hyde receive a psychiatric assessment was not referenced in the entry made by Cst. Hillier into Versadex, upon leaving the hospital.[7] Although Cst. Hillier testified that he would expect he'd remember being told by Cst. Haislip about the HIT Form direction and does not[8], I found in Part II, Chapter 17 that it is highly probable this information was shared between the patrol partners, a likelihood Cst. Haislip testified to.[9]

Cst. Haislip was not advised to make a Versadex entry or any kind of supplementary report about its contents.[10] Neither did any other police officers make any

Versadex entries about the HIT Form[11] or that a psychiatric assessment should be undertaken.[12]

The only reference in the November 21 Versadex entries about Mr. Hyde's mental condition was Cst. Jardine's notation in relation to bail: "Mental health, unsafe to release" made once he had observed Mr. Hyde at the hospital. He testified he believed that "someone who read the file [downstream] would be under the impression that Mr. Hyde needed to see a psychiatrist at some time."[13] He thought Mr. Hyde's mental health issues would have been dealt with at the QEII.[14] It was open to Cst. Jardine to go back into Versadex and add to the file that he had concluded Mr. Hyde should be seen by a mental health professional. [15]

Information about Mr. Hyde's mental health history located in police databases by an RCMP investigator after Mr. Hyde's death would have been relevant to the issue of obtaining a court-ordered psychiatric assessment for him.[16] The Versadex system did not flag prior mental health calls so the information located after Mr. Hyde's death would not have been readily available when Mr. Hyde was processed at HRPS Booking.[17]

At least one police officer testified that knowing what was learned after Mr. Hyde's death would not have changed how he interacted with him.[18] However, Steven Lurie testified that "…the critical piece is making sure that the arresting officer can connect with a mental health service."[19] A service such as an emergency department, through electronic health records, may be able to access mental health history and determine the issues that need to be addressed.[20]

The evidence before the Inquiry has established that information about Mr. Hyde's mental health was useful for Correctional Officer Christopher Dixon to have[21] although it did not find its way to any of the correctional officers who were monitoring the Health Segregation cells over the night of November 21/22. Having information about Mr. Hyde would have been useful to these officers as well.[22] However it would be naïve to think that awareness of Mr. Hyde having mental health issues would necessarily have animated a more proactive response to his pacing and agitation. Nevertheless, correctional officers were given no information about what symptoms to look for in the case of a prisoner with psychosis.[23]

Health care providers at both the CNSCF and the QEII were operating in the dark with respect to Mr. Hyde's mental health and prescription drug history. Health care providers at the QEII would have benefitted from knowing what medications Mr. Hyde had been prescribed and when that prescription had run out.[24] Even though in Mr. Hyde's case there was information, supplied by Ms. Ellet to the police, that he had been off his medications, the nature of those medications and how long it had been since he had taken them was not fully or accurately known.[25]

The Inquiry heard that access to this kind of information is available in British Columbia through PharmaNet, a province-wide system that enables hospital health care providers to obtain information about what medication had been prescribed and how recently the prescription had been dispensed.[26] Dr. Joseph Noone who explained British Columbia's PharmaNet system to the Inquiry, agreed with the suggestion that a comparable system in Nova Scotia would be very valuable.[27] The costs, however, are significant.[28]

Mr. Hyde's mental health issues were unknown to the correctional officers who were tasked with escorting him on November 22. They were given no information about him having a diagnosis of schizophrenia or being off his medications.[29] C/O

Peter Lloyd testified that "Any information …would have been helpful", but then told the Inquiry that he would have done nothing differently if he had had that information.[30] He would not have spoken to Mr. Hyde any differently because "I don't know how" and he would have engaged in the same use of force because Mr. Hyde had to be restrained once he tried to get away.[31] His escort partner that morning, C/O Renee Jones, responded similarly: information about Mr. Hyde's mental health was not relevant to them once he became non-compliant.[32] However, Dr. Michael Webster testified that information about Mr. Hyde would have been a valuable asset to the escorting officers.[33] It would have helped them understand Mr. Hyde's "frame of reference."[34]

Other information and communication gaps were revealed by the evidence. Dr. MacIntyre was not told that once Mr. Hyde left the custody of the police, neither they nor any other justice system officers had the authority to act on her HIT Form direction and return him to the hospital . She discharged Mr. Hyde to attend court without knowing that information. The Inquiry was told by a senior police officer that Dr. MacIntyre should have been informed as soon as it was determined the police could not comply with her direction to have Mr. Hyde brought back to the ER. "The emergency room doctor should be told that [her direction] is problematic for police"[35] even if that means a phone call back to the ER after the police have left.

When Ms. Walford called the QEII Emergency and spoke with the charge nurse, Glenda Keyes, she was told Mr. Hyde did not need to return there.[36] This is not what Dr. MacIntyre would have said if she had known that Mr. Hyde was now in a jail and not a psychiatric facility.[37] The evidence suggests that Ms. Keyes apparently didn't know about, and presumably had not been informed of [38], Dr. MacIntyre's opinion that Mr. Hyde would not be safe in jail and urgently needed psychiatric assessment and care.

And at the CNSCF, correctional officers and health care staff did not know because no one told them about Mr. Hyde's olanzapine injection at the ER and that in Booking on the morning of November 21, there were signs that he had been on medication that was wearing off.[39]

Confidentiality

The information that Mr. Hyde had a diagnosis of schizophrenia and was "off his medications" was originally disclosed by Ms. Ellet. That information by itself would be of little assistance to police or correctional officers with no training on what to look for or anticipate. And even if information about Mr. Hyde's mental health could have been of some help, had that information come from a health record, it would have been subject to legislated confidentiality protections.[40]

Confidentiality issues were also identified in relation to the records kept by the MMHCT. Although it can readily be seen that information in the hands of the MMHCT could be very helpful to front-line police officers, the Inquiry heard about concerns relating to this information being shared:

> …the concern is the [significant] infringement on a person's personal health information…there's a significant amount of health information that isn't required in order to intervene and do what we need to do from our end…the issues around confidentiality and how we work with folks are so significant that we just need to be very careful about how we share that

> information…the more people that have it, the easier it is for…the line to move and for [an] individual's information to get shared inappropriately.[41]

If individuals needing to reach out to the MMHCT knew their confidential health care information was being shared with police officers, this likely would create issues around their willingness to access the service.[42]

When asked about including information on Versadex about a person's psychiatric diagnosis, Supt. William Moore expressed concerns about labeling and the potential of stigmatizing. He identified the problem of information finding its way into police files with little or no foundation and further pointed out that "just because someone has a mental illness [that] doesn't necessarily mean that they're presenting in crisis all the time."[43]

> …I don't think there's a real understanding…just because someone is schizophrenic (sic) doesn't necessarily mean they're going to present any differently when we go to the door in a nonviolent situation.[44]

Confidentiality considerations also emerge in the context of an apprehension under IPTA where the person is also charged criminally: are health care professionals entitled to advise police of an IPTA patient's release from hospital once the person is no longer subject to involuntary committal?[45]

In Dr. Noone's opinion, there needs to be a way to get around confidentiality barriers to exchanging information in the emergency setting. This can be achieved by obtaining consent from the patient – "all you have to do is ask and explain the context" – or restricting access to key information concerning medication, length of previous stay in hospital.[46] A "very good step" is electronic access to patient information at any hospital within the Health District,[47] which is available to health care providers in the Capital District Health Authority through the Horizon Patient Folder system.[48]

At the CNSCF, since the summer of 2009, limited information about prisoners in the Health Care Segregation has been posted on clipboards placed on the outside of the cell doors. The clipboard system indicates to the correctional officers why the prisoner is housed in the Health Care cell: "drug withdrawal; wired jaw; suicide watches; mental health issues" are examples of the descriptions provided [49] while respecting prisoners' rights of confidentiality in their medical information.[50]

Charlene Casey-Gomes testified that because of confidentiality requirements nursing staff at the CNSCF do not disclose a prisoner's diagnosis – such as "schizophrenia/psychosis"[51] - to correctional officers. They disclose the information that is required to enable correctional officers to take the necessary precautions to keep themselves and the prisoner safe.[52] Where a HIT Form indicates "schizophrenia/psychosis", Ms. Casey-Gomes testified that she would probably complete the CNSCF Health Admissions Form by stating, "mental health issues exhibited" and listing the symptoms.[53] Communicating the symptomatology is important for equipping the staff with the information about what to look out for while the prisoner is in their care.[54]

A misunderstanding about prisoner confidentiality, which is intended to limit the release of health information, seems to have prevented critical information about Mr. Hyde being received where it was needed, the CNSCF. When Ms. Ellet called the CNSCF on the evening of November 21 to tell them that Mr. Hyde should be in a hospital to get proper treatment for his psychosis, the staff person she spoke

to "would not talk" about any of the prisoners.[55] It appears that this resulted in Ms. Ellet not providing the information or if she did[56], it not being communicated to anyone, something that could have been done without any implications for confidentiality obligations.

Notes

1 Testimony of Cst. Gyles Gillis, pages 227–228, 237; Testimony of Cst. Bradley Jardine, page 536

2 Testimony of Cst. Bradley Jardine, page 535, referring to his RCMP statement of November 25, 2007

3 Testimony of Cst. Bradley Jardine, page 535

4 Testimony of Dr. Michael Webster, page 11029

5 Versadex is an HRPS database for police officers for reporting, writing and information queries. (Testimony of Cst. Bradley Jardine, page 582) Entries into the system can be made at computer terminals in the police station and also by using the patrol car computers. (Testimony of Cst. Bradley Jardine, page 588)

6 Testimony of S/Sgt. Sean Auld, pages 3170–3171

7 Exhibit 125, page 76 (reverse side), Cst. Steven Hillier's supplementary report; Testimony of Cst. Steven Hillier, pages 2606, 2608

8 Testimony of Cst. Steven Hillier, pages 2605, 2606

9 Testimony of Cst. John Haislip, pages 2689–2690

10 Testimony of Cst. John Haislip, page 2693

11 Testimony of S/Cst. Daniel Fraser, page 2827. Any police officer with relevant information about an accused can get the incident number and make an entry on the Versadex system. (Testimony of Sgt. Kevin Murphy, page 3312)

12 Testimony of Cst. Bradley Jardine, page 612

13 Testimony of Cst. Bradley Jardine, page 644

14 Testimony of Cst. Bradley Jardine, page 653

15 Testimony of Cst. Bradley Jardine, page 643

16 Testimony of Cst. Gyles Gillis, pages 224–225

17 Testimony of S/Cst. Gregory MacCormick, pages 1782–1783

18 Testimony of Cst. Jonathan Edwards, pages 885–886: "It would've been helpful, but it wouldn't have changed…what I had done…I approach everyone that I deal with in my line of work with dignity, respect. I talk to them very politely. And that's…what I did with Mr. Hyde on that evening, and I wouldn't have changed anything at that time."

19 Testimony of Steven Lurie, pages 10686

20 Testimony of Steven Lurie, pages 10686–10687. Mr. Lurie noted that electronic health records are being developed in a number of Canadian jurisdictions. CDHA has created the Horizon Patient Folder (HPF) system that was used in Mr. Hyde's case and enables health care providers to retrieve medical information about a patient's previous contacts with the health authority. See further, note 48 below.

21 Testimony of Dr. Michael Webster, pages 11029–11030

22 Testimony of Dr. Michael Webster, page 11036

23 Testimony of Sandra McLeod, R.N., pages 5685; 5713

24 Testimony of Dr. Joseph Noone, page 9282. I note that Sandra McLeod, the RN at the CNSCF got this information by asking Mr. Hyde the name of his pharmacy and then calling the pharmacy.

25 See Part II, Chapter 3

26 Testimony of Dr. Joseph Noone, page 9247

27 Testimony of Dr. Joseph Noone, page 9282, responding to a question from counsel for Dr. Janet MacIntyre

28 Testimony of Dr. Joseph Noone, page 9283

29 Testimony of C/O Peter Lloyd, pages 6394–6395; Testimony of C/O Renee Jones, pages 5946–5947. C/O Jones testified that she would have expected that any pertinent information about a prisoner would have been passed on to them, as the escorting officers, by the correctional officers in the cells area.

30 Testimony of C/O Peter Lloyd, pages 6395, 6417

31 Testimony of C/O Peter Lloyd, pages 6460–6461

32 Testimony of C/O Renee Jones, pages 5905–5906

33 Testimony of Dr. Michael Webster, page 11049

34 Testimony of Dr. Michael Webster, page 11050

35 Testimony of Supt. William Moore, pages 4145–4146

36 Testimony of Maureen Walford, pages 5790, 5778, 5770

37 Testimony of Dr. Janet MacIntyre, page 4924

38 Testimony of Dr. Janet MacIntyre, page 4938

39 None of this information was included on the HIT Form that passed from Dr. MacIntyre's hands to HRPS Booking and accompanied Mr. Hyde through to the CNSCF.

40 *The Hospitals Act*, *R.S. 1989, c. 208,* section 71

41 Testimony of Susan Hare, page 3965

42 Testimony of Susan Hare, pages 3966–3967. "Those are the kinds of barriers that we struggle with all the time…there are times in urgent and emergent situations where we share a small amount of information [that we have]…because the police need to be able to respond if we're not able to be there. (Testimony of Susan Hare, page 3967)

43 Testimony of Supt. William Moore, page 4107

44 Testimony of Supt. William Moore, pages 4107–4108; and pages 4176–4177

45 Testimony of Dr. Scott Theriault, pages 9673–9674

46 Testimony of Dr. Joseph Noone, pages 9242–9243

47 Testimony of Dr. Joseph Noone, page 9246

48 The HPF system was available at the QEII ER in November 2007. (Testimony of Glenda Keyes, R.N., page 3803) It contains in electronic form patient files and previous CDHA admissions. (Testimony of Glenda Keyes, R.N. , pages 3802, 3803) It was relatively new in November 2007 but Dr. Steven Curry consulted it when Mr. Hyde was in the ER and saw that he had been admitted to the Nova Scotia Hospital "not that long ago." (Testimony of Dr. Steven Curry, pages 4429, 4676) The Horizon Patient Folder system was not available to the CNSCF nursing staff in November 2007 although it is now. (Testimony of Sandra McLeod, R.N., page 5754)

49 Testimony of Cheryl Champion, pages 6814, 6818

50 Testimony of Cheryl Champion, page 6819

51 Testimony of Charlene Casey-Gomes, page 6876; see also, Testimony of Sandra McLeod, R.N., page 5611

52 Testimony of Charlene Casey-Gomes, page 6857

53 Testimony of Charlene Casey-Gomes, page 6877

54 Testimony of Charlene Casey-Gomes, page 6879

55 Testimony of Karen Ellet, page 129

56 It is not entirely clear to me from the evidence if the CNSCF staff person speaking to Ms. Ellet effectively cut her off from saying anything substantive about Mr. Hyde's condition. I believe that is what Ms. Ellet's evidence indicates.

Police Report Preparation and Note-Taking

In addition to the Versadex entry issues I have identified in Chapter 52, it is also relevant for me to address the clear evidence about police note-taking and report preparation that indicates a failure to meet appropriate standards of completeness, accuracy and independence. For example, the testimony established that Cst. Edwards looked at and repeated portions of S/Cst. MacCormick's occurrence report in his own.[1] This did not represent the highest professional standard of report preparation. There is also the matter of the Controlled Response Report[2] and the fact that S/Cst. MacCormick's preparation of the Controlled Response Report was not as accurate as it should have been. The incident did not take place "outdoors"; various uses of force indicated were not actually employed[3]; there were not "3 officers actively controlling the subject" as S/Cst. MacCormick had no role in trying to control Mr. Hyde other than by deploying the CEW; and there was no "officer verbal direction" as indicated by S/Cst. MacCormick in the report. "I guess at the time [of completing the report] I must have thought I told him to get down…"[4] Staff Sgt. Sean Auld who reviewed the Controlled Response Report testified that "defensive resistance" rather than "active aggression" would have been a more accurate description for Mr. Hyde's behaviour.[5] As I have already discussed[6], S/Cst. McCormick did not actually believe that Mr. Hyde intentionally attempted to injure, although he indicated that in the Controlled Response Report by checking off "active aggression."

Staff Sergeant Auld advised the Inquiry of a change in the requirements for preparing Controlled Response Reports since November 2007: now each individual officer involved submits his or her own report.[7] This should ensure a greater likelihood of accuracy and an opportunity to compare the various reports and identify any discrepancies.

Note-taking is another area where additional training would be valuable. Despite the existence of the HRPS policy "Approved Note-Taking Format"[8], S/Cst. Gregory MacCormick, as a Booking officer, had never received any training in note-taking. Indeed, he was unaware of the policy until it was shown to him at the Inquiry.[9] When asked about some deficiencies in his notes from November 21, S/Cst. MacCormick testified that he learned about note-taking on the job, just from colleagues in Booking.[10]

Finally, as I have discussed in Part III, Chapter 35 (The Cause of Death Was Not Excited Delirium), note 103, a note-taking issue arose in the context of the investigation into Mr. Hyde's death. Cst. Bonvie of the RCMP failed to mention the broken zip tie in his supplemental occurrence report of November 22, 2007 or his notes, notwithstanding ample evidence of its existence. This led to speculation by

Mr. Hyde's family that the zip tie never existed. A more complete record would have avoided this and eliminated any basis for accusing the police, as Mr. Hyde's family did, of fabricating the zip tie for self-serving purposes to amplify the evidence of Mr. Hyde's strength during the struggle in HRPS Booking.

Notes

1 Testimony of Cst. Jonathan Edwards, page 1393

2 Exhibit 69

3 Testimony of S/Cst. Gregory MacCormick, pages 1855–1856. The only force used by S/Cst. MacCormick in the Booking area was the CEW. (Testimony of S/Cst. Gregory MacCormick, page 1856)

4 Testimony of S/Cst. Gregory MacCormick, page 1855. Staff Sgt. Sean Auld, viewing the HRPS Booking video, did not see any verbal directions to Mr. Hyde. (Testimony of Staff Sgt. Auld, page 3215)

5 Testimony of S/Sgt. Sean Auld, page 3211

6 Part II, Chapter 8 and Part IV, Chapter 42, Use of Force

7 Testimony of S/Sgt. Sean Auld, page 3267

8 Exhibit 82, Tab L

9 Testimony of S/Cst. Gregory MacCormick, pages 1881–1882

10 Testimony of S/Cst. Gregory MacCormick, page 1882

Mental Health and Crisis Intervention Training

Halifax Regional Police – Mental Health Training

Contemporary policing is "multifaceted and complex"[1] and increasingly, police officers, as part of their broad responsibilities to serve the community, are called upon to address the needs of persons with mental illness who come to their attention. Police officers require enhanced skills and strategies in order to effectively problem-solve "social issues in consultation and collaboration with the parties involved and/or with other human service agencies." [2]

Training of HRPS officers in mental health issues follows a four tiered structure with basic training delivered to HRPS cadets by the MMHCT, followed by the Canadian Police Knowledge Network "Recognizing Emotionally Disturbed Persons" on-line course which ensures that even police recruits joining the force from other jurisdictions will have this level of training. Crisis Intervention training is the next tier with the objective of HRPS to train a percentage of officers who will be working "in the field". The final training tier is for police officers with placements on the MMHCT. A fifth training segment has been designed for CIT trainers to receive specialized training as instructors.[3] The mental health and CIT training now being provided to HRPS officers was not available until after November 2007.[4] Verbal de-escalation however has been part of HRPS' use of force training "for a considerable period of time."[5]

The delivery of training to in-service HRPS members through "Block" training is a "new and innovative training approach" that represents a commitment on an annual basis to provide "a dedicated number of hours of training which are set out in learning blocks – this usually entails between 30 – 40 hours of training per officer annually depending on job function. The program content and number of hours committed to the Block Program are dependent upon a number of factors that include: the identified training needs for the service, the recognition of emerging issues that will impact training of officers, risk management principles, as well as provincial mandatory training requirements." Block training in 2010 included a new component of training with respect to persons with mental illness, and a training session on In-Custody Death (with a segment on excited delirium.) Upcoming Block training will focus on "Verbal Judo" intended to "train officers to use effective verbal communication skills to de-escalate potentially hostile situations without having to resort to force – in other words provide officers with better communication strategies to generate voluntary compliance."[6]

The training provided by the HRPS on dealing with persons with mental illness has been described as "relatively comprehensive", a term also applied to the training programmes developed by the Ontario Provincial Police, the Canadian

Mental Health Association (CMHA)-BC Provincial Police collaboration, and the Halton Regional Police.[7]

The HRPS training approach is outlined in a memorandum prepared by Supt. William Moore, "HRP Approach to Dealing with Persons with Mental Illness, Version 1.0."[8] Supt. Moore's memorandum sets out ten principles, Principles 4 and 5 being relevant to the training issue. They provide[9]:

> **Principle 4** – Each police organization should ensure that their first responders/patrol staff have an appropriate basic level of knowledge and skill in order to deal with PMI (persons with mental illness)
>
> The HRP has been providing mental health training to their officers through the Recruit Training. The HRP has adopted a Training Continuum which outlines the plan to build on the basic training a patrol officer receives through the use of both on-line and in classroom training. This will be augmented with more highly trained individuals who have successfully completed the Crisis Intervention Team training and who will be deployed through the front line police units. Layered upon this is the Mental Health Mobile Crisis Team, a 24-7 phone triage and assistance line and a 12 hour per day mobile response capability.
>
> **Principle 5** – Each police organization should have a clearly defined policy and procedure by which personnel can access mental health expertise on a case-by-case basis.
>
> It is unrealistic to expect that all police officers will develop the level of knowledge and skill to deal with all interactions with PMI, for this reason the HRP is adopting a continuum of care where we will provide a layering of trained officers throughout the response units. There will inevitably be times when they need the assistance of specially trained police officers or mental health professionals to sort out issues related to such things as suicide. The Continuum of training approach attempts to provide a wider coverage across the department to call upon for assistance.

HRPS cadet training[10] includes approximately 20 hours of specific mental health training in a structured format delivered by the MMHCT. Cadets are required to complete and pass the Canadian Police Knowledge Network (CPKN) on-line course.[11] Mental health training is also being delivered to police cadets in concert with use of force training.[12] Since 2008, the cadet training programme has included a 16 hour component on "verbal judo" which focuses on teaching police officers how to de-escalate a situation with a view to resolving it without having to resort to the physical use of force.[13] Although verbal judo is not specifically designed for dealing with situations involving a person with a mental illness, it provides valuable communication and de-escalation strategies of general application for police officers.[14]

"Lateral" hires, including from the Atlantic Police Academy receive a four-week training course with HRPS that includes 3.5 hours of training by the MMHCT. HRPS is confident that police officers who have received their training from other training institutions will have had "as a basic component of police training in Canada" some level of mental health training.[15] As of January 2010, block training for all serving HRPS officers will include mental health training to ensure "…consis-

tency and that all police officers are receiving that training."[16]

HRPS is working on bringing its use of force and mental health training together so that officers recognize the inter-relationship between the two and can acquire "strategies and best practices."[17] This will include teaching police officers to recognize "certain things…Like symptoms or signs of potential impending excited delirium."[18]

HRPS has drawn from the American College of Emergency Physicians' Task Force White Paper Report on Excited Delirium Syndrome ("the ACEP's White Paper") dated September 10, 2009 for developing its training for serving police officers.[19] A recent conference[20] sponsored by the Institute for the Prevention of In-Custody Death, which included a presentation by one of the authors of the ACEP White Paper, was regarded as very useful for assisting HRPS in deciding how to incorporate the latest research on excited delirium and in-custody death into training for front-line officers. "…it [the conference] was of great benefit and we will be incorporating a significant amount of the information we learned."[21] HRPS trainers concluded that much of what was presented at the conference was a confirmation of what HRPS is doing in its training and response models [22] and not just with respect to excited delirium but mental health more broadly.[23]

The view that Mr. Hyde presented as a case of excited delirium has had an influence of HRPS training:

> We basically have two situations to draw upon within this province. There is the Hyde incident, and there is the Saulnier incident in Digby. And when we look at those two incidents, there are some correlations and things there that we can compare to what the medical experts are now telling us that would confirm to us that we're moving in the right direction.[24]

As indicated, I have determined however that Mr. Hyde was <u>not</u> experiencing what has been called "excited delirium"[25] and have critiqued the trend toward identifying it in sudden death cases.[26]

Police Training – *Criminal Code* and Civil Assessments

Currently missing from the HRPS curriculum is training on the different types of assessments relevant to persons with mental illness: *Criminal Code* "forensic" assessments under section 672.11 and "civil" or "hospital" assessments under IPTA.[27] Information about court-ordered assessments is apparently delivered to patrol officers by departmental memo with shift supervisors or sergeants fielding any questions.[28] There is a clear need, illuminated by the evidence at the Inquiry, for specific training in this area to be provided.[29]

Halifax Regional Police – Crisis Intervention Training[30]

Crisis intervention officer training is delivered by the MMHCT in partnership with the Capital District Health Authority in a 40 hour programme. This training

> …is geared around giving officers more advance knowledge and experience and training of how to deal with potential parties that may be suffering from mental illness or are potentially in crisis. And the idea is that we will get a number of people trained across the shifts and they will be able to be a resource for the front line officers…[31]

When Supt. Moore testified before the Inquiry in August 2009, HRPS was working toward this goal of having a critical mass of police officers trained in CIT and available to be dispatched to a call for intervention. Supt. Moore indicated the goal was to have the necessary training done so as to achieve this "in the next year."[32] Supt. Moore, tasked by the Chief of HRPS with "the responsibility for issues related to people in the community with mental illness",[33] would like to see approximately 16 – 20 officers per watch[34] available with CIT training to respond to calls for service, which he described as "probably sufficient"[35].

> The idea of having all front-line patrol members trained in CIT…would be nice…but the reality is I don't know if we could really do every officer with that amount of training…[36] What we train the rest of those officers in is recognition, understanding, first response, and then knowing that they have something they should…they could elevate it either to a CIT officer or elevate to the Mobile Mental Health Team. So those are the training components that are together and we're moving ahead with all those in parallel.[37]

By December 2009 when Sgt. Dean Stienberg testified, 39 uniformed police officers had been trained in CIT with another 24 to be trained in 2010 with distribution of these officers throughout the shifts "as evenly as we could…we are working towards having a reasonable number of these officers on the street [by the end of 2010] so there's always access."[38]

Although the take-up for this training and the CPKN on-line course was slow at first, Supt. Moore reported that an increasing number of police officers are becoming interested in the training.[39] Crisis intervention training has, in particular, been very well received by HRPS officers.[40] Supt. Moore supports training police officers who are interested in acquiring the skills. "…I would rather have people that want to be there and do it."[41] Having all Booking officers trained in CIT was identified by Supt. Moore as producing the best return for the investment.[42]

Dr. Michael Webster who provides CIT training to Vancouver Police Department officers expressed the opinion that "the best practice model is a primary intervention model" which requires that all patrol officers be trained. In Dr. Webster's view, the training will get an officer thinking that the "soft data" they receive from dispatch could indicate that crisis intervention skills are called for.[43] The demands on police officers as first responders to persons with mental illness makes the case, in Dr. Webster's opinion, for crisis intervention training to be provided as part of basic training programmes.[44]

Enhanced and more comprehensive training, connected with mental health services and followed up by policy and protocol, has led to better outcomes for persons with mental illness and the police officers dealing with them. Research indicates that aggression and violence have been reduced and more access to services has been achieved. "…having a well-trained first responder be the first person to arrive on the scene has a significant impact on the outcome of the intervention."[45] This leads to Susan Hare's view that such training should be comprehensive for patrol officers and mandatory:

> Question: Because the difficulty [if the CIT training is not mandatory and universal] is you are going to have…some officers who are going out with that training dealing with someone with mental illness and others without it.

Answer: Exactly. And the practice clearly indicates that improved first response is going to have improved outcomes. So the more training your front-line officers have, the better the outcome.[46]

It was also the opinion of the use of force expert who testified at the Inquiry that all patrol officers, indeed, - "everybody who is operational" - should be trained in crisis intervention.[47] "There's nothing worse than the guy (sic) who didn't get trained shows up to the worst call, and he's thinking, well, what do I do with this."[48]

The vital importance of training police officers as mental health first responders was also identified by Dr. Stephen Hucker. Describing this as "particularly important"[49], he recommended to the Inquiry that training continue of police officers "in the management of mentally ill offenders (sic)."[50]

> …in most Canadian jurisdictions the police have in many cases become the main front line community mental health intervention workers. It is therefore essential that officers be provided with the skills that will help them deal with acute situations and thereby minimize potential harm to the individual, the officers themselves, and others who may be involved.

Dr. Hucker noted that without the requisite training, a police officer will

> …fall back in what [they] are trained to do and it may not be the most appropriate and effective way of managing somebody who is acutely psychotic…police officers are the ones who often get the acute hot case. So I think it's important that they have whatever skills they can be given for managing these appropriately.[51]

Studies show there is,

> …growing evidence that [CIT] might reduce officer injuries, minimize the use-of-force, improve officer knowledge, improve the identification of mental illness, improve attitudes of police personnel and their confidence in responding to persons with mental illness, at least in the short term, as well as increase transports to emergency treatment facilities and referrals to mental health services…[52]

Crisis intervention training can reassure police officers that "by abandoning their…strong arm methods…they're going to be able to handle the situation actually more effectively."[53] For the Vancouver Police Department, the introduction of CIT training had led to fewer shootings of persons with mental illness. "[Our success is measured by the fact that] we have been able to resolve these potentially violent situations in a much better way."[54] Persons with mental illness and the police dealing with them are "safer" where there has been CIT training. Officers have a much better understanding of the difference between an emotional disturbance and a behavioural disturbance and learn to resolve incidents with "presence and communication" and through demonstrating empathy.[55]

Both Dr. Hucker and Dr. Webster spoke about the importance of de-escalating the person's anxiety and aggression to increase the chances of building a working alliance.[56] This takes training and skill. In Mr. Hyde's case, there were immediate opportunities, at the point of the initial police contact, to build a working alliance, demonstrate empathy and communicate reassurance.[57] There was also a crisis intervention opportunity at Booking before the situation unspooled in the LiveScan

Room.[58] It is critical in crisis intervention to employ good listening skills.[59] Officers trained in crisis intervention can identify the cues that will enable them to respond effectively to the situation confronting them[60], using verbal skills to create a safe, non-threatening environment.[61]

The value of CIT training for police was also acknowledged by the Braidwood Commission, which noted the

> …unanimous view of mental health presenters…that the best practice is to de-escalate the agitation which can best be achieved through the application of recognized crisis intervention techniques.[62]

Justice Braidwood recommended the incorporation of crisis intervention training without delay in recruit training for officers of provincially regulated law enforcement agencies; and that all currently serving officers of provincially regulated law enforcement agencies satisfactorily complete the training within a time frame established by the Ministry of Public Safety and Solicitor General.[63] Sgt. Stienberg described HRPS training as complying with this recommendation:

> I think the intent of the recommendation was to ensure that all police officers of provincially regulated forces receive some type of crisis intervention training…I feel that we do comply with it, we are training our people, and that…on an ongoing basis this type of training [is going to be] provided to all of our police officers.[64]

Canadian Police Knowledge Network On-Line Course

For HRPS police officers, the Canadian Police Knowledge Network (CPKN) on-line course "Recognizing Emotionally Disturbed Persons"[65] is intended to act as a refresher for officer who received mental health training before being hired by HRPS and to provide consistency in training for the force generally.[66] Earlier training may not have been retained.[67] Any police officer joining HRPS, whether as a graduate of the Atlantic Police Academy or another training programme, has to complete and pass the CPKN course before being hired.[68]

Corrections and Sheriffs officers are also receiving mental health training through the CPKN on-line course. The course seems to have been reasonably well received[69] although the Inquiry heard a consistent theme of criticism that the format did not offer the opportunity for an interactive educational experience. For example, Deputy Sheriff James Crook found the course helpful but thinks it would have been "…more appropriately delivered in a classroom setting, so we could have had some interaction with the presenters."[70] He explained the benefits of a more interactive format:

> As an adult learner, I feel it's always more appropriate to have an instructor and expert. I know in some online courses, the goal is to basically get through it and get your ticket punched. At the end, …you may not have taken in all you could have. You might not have had your questions answered…this course had self-tests. And you know, if you got an answer wrong, they explained it. But you might want to argue, Why is that wrong?[71]

D/S Crook also identified the importance of getting enough information to make an informed decision about what to do in the case of a prisoner exhibiting signs of having a mental illness.[72]

S/Cst. Gregory MacCormick, who did not learn as much as he would have liked to from the CPKN course[73], had a similar outlook on acquiring the necessary skills to deal appropriately with persons experiencing a mental health crisis:

> …It's hard reading something from the internet and trying to make it operational. I know there's courses where you can talk to people…And I find, personally, I learn more hearing from a person than I do reading from the internet about how…an illness may work or affect a person…[74]

Superintendent William Moore also recognized that the optimal format for adult learning includes dynamic interaction with an instructor. John McKay held this opinion as well.[75] Supt. Moore testified that he would like to see "…more in relation to judgmental scenario-based training…" so that police officers could take the content from the CPKN course and "…make the jump from theory to practical applications."[76] Training that enables police officers to interpret field experiences more effectively can dramatically change outcomes. As Supt. Moore described it:

> …we do judgment training in relation to use-of-force options. I would like to see a little more emphasis on more mental health scenario-based…for instance, [an] autistic person with a lot of hand movements…if the officer had not been trained, they might take that as a threat cue…But if they understand it in that scenario and they couple that with something else that's going on, they may be thinking, well, maybe this person is not necessarily attacking me. They may be autistic…And then they would take different steps to approach that.[77]

Dr. Michael Webster, a trainer himself [78], while acknowledging that the CPKN online course – which he has taken – provides good information[79], told the Inquiry there is more to improving the learning experience than simply moving the content of the course into a classroom setting:

> …[the course] provides a lot of information that [police officers] sit down in a passive fashion and they read. The component of the training that I think that that training is designed for is the active learning part, and the active learning part is a part where you're taught the skills, you try them on, you get some feedback and you make some corrections, and leave the training situation with some skills that you have confidence in. They're more likely to generalize now from the classroom to the real world because we've actually done it actively. That's the piece that's missing.[80]

Corrections Training

Correctional officers come into contact with persons with a mental illness "[on] almost a daily basis" and it is beneficial for them to acquire as many tools as possible to manage this challenge.[81] Equipping correctional officers to be able to recognize when a prisoner is experiencing a mental health crisis is vitally important because they may be dealing with a situation where the prisoner will not act rationally or be compliant.[82] Correctional officers monitoring prisoners in cells need to be able to identify, on the basis of how the prisoner is presenting, when health care or medical intervention should be called in.[83]

Mental health training takes place in the orientation package for correctional

officers. Sheriffs are looking to develop a comparable orientation programme.[84] Recently the CPKN on-line course was added to the Corrections curriculum.[85] "[That is]…essentially our training in terms of mental health, although we touch on [it] in other courses in dealing with individuals who might be in some type of emotional distress."[86]

As of February 23, 2010, twenty-five percent of correctional officers having contact with prisoners at the five adult institutions had taken the CPKN on-line course.[87]

Corrections is continuing to monitor training across the country including what is made available to Corrections Canada staff and plans to look at other mental health training options. "…so we haven't closed the door, I guess, to other training."[88] More training in relation to dealing with prisoners experiencing mental health issues would likely be welcomed by front-line correctional officers[89] and the CPKN course content would be enhanced in a more interactive format. For example, Corrections Canada's two-day course for staff, while apparently covering much the same material as offered through the CPKN on-line course, provides classroom instruction of small groups with the opportunity for participants to discuss the information and analyze case studies.[90] More training, while not a panacea, provides opportunities to work with the concepts and acquire strategies of best practice.[91]

Corrections – Crisis Intervention Training

Correctional officers also receive training in crisis intervention training.[92] "Conflict Crisis Intervention"[93] is aimed at enhancing skills in verbal tactics with a strong focus on using verbalizations to defuse a crisis. [The course] takes [correctional officers] through a verbal continuum allowing them to participate in role plays to enable them to better deal with situations with people in crisis."[94] "Verbal Crisis Intervention"[95] is an amplified programme, "…kind of a continuation from [Conflict Crisis Intervention.]"[96] A four-day course, it affords the opportunity to engage in role plays using different verbal tactics and verbal judo techniques, building confidence and enhancing existing skills.[97] It is recommended that correctional officers take the course within 36 months of their hiring date.[98] Staff are required to have taken Crisis Intervention Training before they are permitted to take the more advanced courses.[99]

As of February 23, 2010, sixty-seven percent of correctional officers having contact with prisoners had taken Verbal Crisis Intervention, with Crisis Intervention Training having been completed by eighty-seven percent.[100]

In the "Verbal Crisis" course, there is no specific reference to persons with a mental illness: the word "PIC" is used – people in crisis.[101] Correctional officers are taught to recognize indicators of intended self-harm, overdose or excess drug consumption, bizarre behaviour, hallucinations etc.[102]

Department of Justice – De-escalation Techniques

In the training of correctional and sheriffs' officers, use of force training now includes instruction in the importance of using communication skills tactically to defuse and resolve a situation without resorting to the use of force.[103] Much of the communications training is focused on dealing with confrontational situations, although "…a lot of it [is directed at trying] to resolve [the conflict] before it turns into physical combat."[104] An emphasis is placed on active listening and avoiding trigger words

> …that may set people [up] to be more aggressive rather than more responsive…we try to encourage verbals right up to the use of force being absolutely necessary even if we think verbals are not getting through.[105]

The training encourages the exploitation of opportunities to de-escalate the situation prior to the application or escalation of force.[106] Officers are trained to use calm, professional, respectful language and demonstrate empathy. Active listening operates to reduce anxiety and bring the prisoner to a calmer, more rational state where less force will achieve control.[107] In addition to the Department of Justice Training, according to Mr. Kennedy, Corrections provides extensive training in communications skills to its officers.[108] The DOJ training has not been offered previously to correctional officers.[109]

Department of Justice – Excited Delirium

Rolled out in December 2009[110], the provincial Department of Justice now provides correctional and sheriffs' officers with "an extensive amount of training that… educates officers with regard to excited delirium or autonomic hyperarousal syndrome."[111] Both terms are used in the training "…because we recognize in Nova Scotia [that] autonomic hyperarousal syndrome is a growing syndrome title. But excited delirium is one that is more familiar to the officers…[112]

The Department of Justice's new 3-day Team Intervention training programme covers this issue using scenarios and lectures and a DVD prepared by the Ontario Ministry of Justice,[113] that deals with signs and symptoms of excited delirium, as well as different restraint systems and control of subjects. An exam tests recognition of the symptoms of excited delirium.[114]

In the Ontario Ministry of Justice DVD, the police trainers make the statement that "it is very difficult to identify excited delirium during an altercation" and that it is most likely to be identified afterwards.[115] Tellingly, a psychiatrist interviewed for the DVD observes: "If you know what you are looking for, you have a better chance of recognizing it…" The featured police officer trainer makes the same statement, adding, "and knowing how to respond."[116]

Corrections – Excited Delirium

The basic security course[117] offered at the CNSCF and revised on September 24, 2007, also contains content on excited delirium. "…we do recognize we need to place more emphasis on…excited delirium, so we've added it to the orientation programme for new [correctional] staff."[118] The correctional officers involved with Mr. Hyde on November 22, 2007 had all taken the course prior to the inclusion of the excited delirium component. The evidence before the Inquiry did not establish if or when correctional officers who had taken the earlier version of the course would be given a refresher.[119]

The excited delirium content of the Corrections training seems to have been added in response to Mr. Hyde's case.[120]

Putting A "Face" on Mental Illness

The Mental Health Commission of Canada has recognized that mental health systems need to draw from the experiences of persons living with mental illness:

> …it will be essential to ensure that people with a lived experience of men-

tal health problems and illnesses actively participate in all aspects of the design, implementation and evaluation of a comprehensive, person-centred mental health system.[121]

The training of those working in the justice system such as the police and correctional officers must be informed by the same principle. As with any strategy designed to overcome stigma, police, correctional officers and sheriffs need to experience, in their training, direct contact with people living with mental health issues.[122] Such exposure will help to dispel stereotypes, deepen understanding and build confidence.

Persons with mental illness participate in the HRPS training programme to provide officers with a "face" for the issue and reduce the stigma associated with having a mental illness.[123] The reference in the HRPS CIT training syllabus of "first voice presentations" presumably indicates this inclusion of persons living with mental illness in CIT training.[124] Also important is the involvement in training of community organizations, such as the Canadian Mental Health Association, to provide officers with an understanding of the resources that can be accessed in the community and the options for referrals.[125]

Mental Health Training – Reflecting on Other Factors

A recent report, "Police Interactions with Persons with a Mental Illness: Police Learning in the Environment of Contemporary Policing" prepared for the Mental Health and the Law Advisory Committee of the Mental Health Commission of Canada[126], has concluded that the specific content of training programmes addressing the issue of mental illness while crucial, "is not the only determinant of successful learning." Other factors that have "a direct impact on the learning outcome" require attention.

- Selection of appropriate "trainers", including those who are both subject matter experts and who are operationally credible;
- Inclusion of local mental health professionals, for the purposes of providing reliable information as well as to assist in forming local connections with mental health agencies;
- Integration of PMI and their families into the training in order to provide direct first-hand experience with this population;
- Use of a variety of forms of learning media including participatory strategies;
- Focus on cognitive determinants of behaviour including attitudes, exercise of discretion and stigma;
- Adaptability of the curriculum to reflect the population receiving training (e.g. new officers versus specialized teams versus dispatch personnel) as well as local community needs.[127]

These factors are relevant whether the training is directed at police, corrections officers or sheriffs as is the trenchant observation by the authors of the report: education alone is not adequate for transforming interactions between state authorities and persons with mental illness. "…a systems approach is necessary to achieve desired sustainable shifts of attitudes and thus shifts of occupational and organizational culture."[128] Coleman and Cotton propose that training curricula designed to prepare police personnel for interactions with persons with a mental

illness "should include more than fleeting attention to an explanation of why it is that police interactions are important, and, indeed, are an integral element of contemporary policing."[129]

Notes

1 "Police Interactions with Persons with a Mental Illness: Police Learning in the Environment of Contemporary Policing" prepared for the Mental Health and the Law Advisory Committee of the Mental Health Commission of Canada by Terry G. Coleman, PhD(C) and Dr. Dorothy Cotton, May 2010, page 75

2 "Police Interactions with Persons with a Mental Illness: Police Learning in the Environment of Contemporary Policing" prepared for the Mental Health and the Law Advisory Committee of the Mental Health Commission of Canada by Terry G. Coleman, PhD(C) and Dr. Dorothy Cotton, May 2010, page 75

3 Testimony of Supt. William Moore, page 4052

4 Testimony of Sgt. Dean Stienberg, page 7097

5 Testimony of Sgt. Dean Stienberg, page 7152

6 Memorandum dated June 9, 2010 by Staff Sgt. Lindsay Hernden of the HRPS Training Division in response to a request for information on HRPS training, and included with Exhibit 290 "Halifax Regional Police Officer Safety/Use of Force & Related Training Material"

7 "Police Interactions with Persons with a Mental Illness: Police Learning in the Environment of Contemporary Policing" prepared for the Mental Health and the Law Advisory Committee of the Mental Health Commission of Canada by Terry G. Coleman, PhD(C) and Dr. Dorothy Cotton, May 2010, page 11

8 Exhibit 168, updated: October 2, 2008. This document is also found in Exhibit 107 – Binder containing Overview of Mental Health training materials from the Halifax Regional Police.

9 Exhibit 168, pages 2 and 3

10 HRPS cadet training is a 38 week programme that includes 3 months on-the-job experience. (Testimony of Sgt. Dean Stienberg, page 6989)

11 Testimony of Sgt. Dean Stienberg, page 7007

12 Testimony of Sgt. Dean Stienberg, page 7007

13 Testimony of Sgt. Dean Stienberg, pages 6992–6993

14 Testimony of Sgt. Dean Stienberg, page 7039

15 Testimony of Sgt. Dean Stienberg, page 7008

16 Testimony of Sgt. Dean Stienberg, page 6997

17 Testimony of Sgt. Dean Stienberg, page 7022

18 Testimony of Sgt. Dean Stienberg, pages 7035, 7077

19 Testimony of Sgt. Dean Stienberg, pages 7030, 7217

20 Attended by Sgt. Dean Stienberg in November 2009 in Nevada. (Testimony of Sgt. Dean Stienberg, page 7000) Sgt. Stienberg is a sergeant in the Training Section for the HRPS who oversees the training and the development of the training and is actively involved in the delivery of training. (Testimony of Sgt. Dean Stienberg, page 6985)

21 Testimony of Sgt. Dean Stienberg, page 7004

22 Testimony of Sgt. Dean Stienberg, page 7005

23 Testimony of Sgt. Dean Stienberg, pages 7224–7225

24 Testimony of Sgt. Dean Stienberg, page 7165

25 See, Part III, Chapters 35 and 38

26 See, Part IV, Chapter 41, Excited Delirium

27 Testimony of Supt. William Moore, pages 4016–4017

28 Testimony of Sgt. Dean Stienberg, page 7121

29 See, for example, Testimony of Cst. Gyles Gillis, pages 243, 302–303; Cst. John Haislip, page 2680

30 CIT training is based on an American model, the Memphis Model. (Testimony of Susan Hare, page 3674; Testimony of Sgt. Dean Stienberg, page 7009) Coleman and Cotton in "Police Interactions with Persons with a Mental Illness: Police Learning in the Environment of Contemporary Policing" prepared for the Mental Health and the Law Advisory Committee of the Mental Health Commission of Canada (May 2010) recommend the **TEMPO** (Training and Education about Mental Health for Police Organizations) learning model, a multi-module learning model, based on the **Learning Spectrum**. See further, Coleman and Cotton, pages 61–67. HRPS mental health training seems to bear some resemblance to TEMPO although Coleman and Cotton do not discuss this.

31 Testimony of Sgt. Dean Stienberg, page 7010

32 Testimony of Supt. William Moore, pages 4053–4054. At the time of Susan Hare's testimony before the Inquiry in August 2009, there had been three CIT training sessions conducted with 15–20 people in each sessions, not all of whom were HRPS officers. (Testimony of Susan Hare, page 3689)

33 Exhibit 168, page 2

34 Testimony of Supt. William Moore, page 4012. A watch is 75 officers so Supt. Moore envisions a third of a watch being CIT trained.

35 Testimony of Supt. William Moore, page 4013

36 At the very least, there is an issue of resources. (Testimony of Supt. William Moore, page 4180) Sgt. Dean Stienberg made the same point in his evidence: "I don't believe… it would be something that we would be able to do, to put every officer through 40 hours of training. I think we have to try and make an assessment on a go forward basis as to how many of these officers we actually do need trained to ensure that we've got adequate numbers on the street." (Testimony of Sgt. Dean Stienberg, page 7011)

37 Testimony of Supt. William Moore, pages 4011–4012

38 Testimony of Sgt. Dean Stienberg, pages 7122–7123

39 Testimony of Supt. William Moore, pages 4054–4055

40 Testimony of Susan Hare, pages 3897–3898

41 Testimony of Supt. William Moore, pages 4180–4181

42 Testimony of Supt. William Moore, page 4180

43 Testimony of Dr. Michael Webster, pages 11005–11006

44 Testimony of Dr. Michael Webster, page 10940

45 Testimony of Susan Hare, pages 3715–3716

46 Testimony of Susan Hare, page 3880

47 Testimony of John McKay, page 7909

48 Testimony of John McKay, page 7908. John McKay noted that crisis intervention techniques do not always work to defuse a situation (Testimony of John McKay, page 7954) but agreed that police officers need to try the techniques, if they know them, to see if they will produce positive results. (Testimony of John McKay, page 7955)

49 Testimony of Dr. Stephen Hucker, page 10030

50 Exhibit 265, Dr. Stephen Hucker's Report, dated May 28, 2009, page 10

51 Testimony of Dr. Stephen Hucker, page 10030

52 "Police Interactions with Persons with a Mental Illness: Police Learning in the Environment of Contemporary Policing" prepared for the Mental Health and the Law Advisory Committee of the Mental Health Commission of Canada by Terry G. Cole-

man, PhD(C) and Dr. Dorothy Cotton, May 2010, page 41, referring to Watson, A.C., M.S.Morabito, J. Draine & V. Ottati, *Improving police response to persons with mental illness: A multi-level conceptualization of CIT*, International Journal of Law and Psychiatry, 2008, Vol. 31, 359–368.

53 Testimony of Dr. Stephen Hucker, page 10069; see also, "Police Interactions with Persons with a Mental Illness: Police Learning in the Environment of Contemporary Policing" prepared for the Mental Health and the Law Advisory Committee of the Mental Health Commission of Canada by Terry G. Coleman, PhD(C) and Dr. Dorothy Cotton, May 2010, pages 54–56

54 Testimony of John McKay, pages 7904–7905

55 Testimony of John McKay, page 7912

56 Testimony of Dr. Stephen Hucker, page 10068; Testimony of Dr. Michael Webster, page 11014

57 Testimony of Dr. Michael Webster, page 11013

58 Testimony of John McKay, page 8051

59 Testimony of Dr. Michael Webster, page 11014

60 Testimony of Dr. Michael Webster, page 11012

61 Testimony of Dr. Michael Webster, page 10935; See also, Testimony of John McKay, page 7953

62 Braidwood Commission, Part 9: Medical Risks, page 263

63 Braidwood Commission, Part 10: Recommendation 4, page 310

64 Testimony of Sgt. Dean Stienberg, page 7048

65 Exhibit 104

66 Testimony of Supt. William Moore, pages 4189–4190

67 Testimony of Cst. Gyles Gillis, pages 374–375. Question: And what did your training tell you to look for to see if someone was displaying a mental health issue or having a mental health issue? Answer: I don't specifically recall.

68 Testimony of Sgt. Dean Stienberg, page 7008

69 Exhibit 287 is the evaluation report dated January 30, 2009 for the CPKN "Recognition of Emotionally Disturbed Persons" Pilot. The evaluation responses did not come only from the HRPS or DOJ Correctional Service officers who took the course. A high level of approval is indicated at page 13: "Overall, 89% of survey respondents indicated they would recommend this course to others and an overwhelming 95% stated that online learning worked well for them." However, as I discuss, the evidence at the Inquiry, including from trainers (Supt. William Moore and Dr. Michael Webster) was that dynamic skills training is a necessary component of the successful learning experience.

70 Testimony of D/S James Crook, page 5136

71 Testimony of D/S James Crook, page 5235

72 Testimony of D/S James Crook, page 5235

73 Testimony of S/Cst. Gregory MacCormick, page 2101

74 Testimony of S/Cst. Gregory MacCormick, page 2100

75 Testimony of John McKay, page 7911

76 Testimony of Supt. William Moore, pages 4190–4191

77 Testimony of Supt. William Moore, pages 4191–4192. See also, Testimony of Supt. Moore, pages 4181–4182

78 Dr. Webster is a trainer in the Vancouver Police Department Crisis Intervention training. Course content for the VPD programme includes "practical application through role-play." Exhibit 272

79 Testimony of Dr. Michael Webster, page 11002

80 Testimony of Dr. Michael Webster, pages 11002–11003

81 Testimony of Sean Kelly, page 7539; Testimony of D/Supt. Tracey Dominix, pages 7481, referring to the CPKN on-line course: "…I found it beneficial…it gives outlines from good signs and symptoms that you can be aware of. It gives you how you may approach individuals that may be mentally ill." Testimony of C/O Christopher Digout, page 6073, referring to the CPKN course as helpful.

82 Testimony of Correctional Officer Cameron Lamond, pages 6174–6175

83 Testimony of Sean Kelly, page 7561

84 Testimony of Roy Kennedy, page 10563

85 Testimony of Deputy Superintendent Tracey Dominix, page 7480; Testimony of Sean Kelly, page 7563: "…the latter part of the Summer [of 2009.]"

86 Testimony of Sean Kelly, Director of Correctional Services for the provincial Department of Justice, page 7535

87 Exhibit 280, email from Tim Arsenault, Manager Policy and Programs (Training Coordinator) to Sean Kelly

88 Testimony of Sean Kelly, page 7536

89 Testimony of D/Supt. Tracey Dominix, page 7485; Testimony of Sean Kelly, page 7538. And see, for example: Testimony of C/O Bradley Morris, pages 5879–5880; C/O Christopher Digout, page 6070; C/O Cameron Lamond, pages 6116–6117; C/O Algernon Smith, page 6229; Supt. Ian Prall, page 6277; C/O Peter Lloyd, page 6372; C/O John Currie, page 6470; Captain Todd Henwood, page 6538; Captain Paul Whitman, page 6667; C/O Michael Oliver, page 8416, 8428; C/O Earnest MacRae, page 8439;

90 Testimony of Sean Kelly, pages 7536–7537

91 Testimony of Sean Kelly, page 7538

92 Testimony of D/Supt. Tracey Dominix, page 7475, referring to Exhibit 116 "Verbal Crisis Intervention" and Exhibit 117 "Conflict Crisis Intervention", both classroom setting courses that D/Supt. Dominix has taught. (Testimony of Tracey Dominix, page 7475) D/Supt. Dominix works at the Central Nova Scotia Correctional Facility as a "training contact", making sure staff are attending courses on a regular basis and taking the courses and refreshers as required.

93 Exhibit 117, Department of Justice – Correctional Services "Conflict Crisis Intervention"

94 Testimony of D/Supt. Tracey Dominix, pages 7476–7477

95 Exhibit 116, Department of Justice – Correctional Services "Verbal Crisis Intervention"

96 Testimony of D/Supt. Tracey Dominix, page 7477

97 Testimony of D/Supt. Tracey Dominix, page 7477

98 Testimony of D/Supt. Tracey Dominix, page 7483

99 Testimony of Sean Kelly, page 7545

100 Exhibit 280, email from Tim Arsenault, Manager Policy and Programs (Training Coordinator) to Sean Kelly

101 Testimony of D/Supt. Tracey Dominix, page 7477

102 Testimony of D/Supt. Tracey Dominix, page 7524

103 Testimony of Roy Kennedy, pages10509; 10547

104 Testimony of Roy Kennedy, page 10553

105 Testimony of Roy Kennedy, page 10549

106 Testimony of Roy Kennedy, page 10547

107 Testimony of Roy Kennedy, pages 10549–10550

108 Testimony of Roy Kennedy, page 10553

109 Testimony of Roy Kennedy, page 10550

110 Testimony of Roy Kennedy, page 10512

111 Testimony of Roy Kennedy, pages 10515–10516

112 Testimony of Roy Kennedy, page 10516

113 Testimony of Roy Kennedy, page 10505. The DVD was entered as Exhibit 275.

114 Testimony of Roy Kennedy, pages 10507–10508

115 Exhibit 275: This DVD is the same as Exhibit 190, provided by the HRPS to the Inquiry.

116 Exhibit 275

117 Exhibit 118, Department of Justice – Correctional Services "Basic Skills Level and Documentation"

118 Testimony of Sean Kelly, pages 7534–7535

119 Testimony of D/Supt. Tracey Dominix, page 7492

120 Testimony of Sean Kelly, page 7539. Question: "Now has (sic) there been any…changes in the training regime or contemplated changes in your training program as a result of the incident involving Mr. Hyde?" Answer: "And as I mentioned earlier, excited delirium has now been added to the orientation training…" And, also: Question: "…I'm wondering how you reached the decision to include additional training in this?" Answer: "Obviously, you know, because of the situation with Mr. Hyde we have a situation where excited delirium was felt to be contributing to his demise, and so it was felt that having that level of training would be appropriate in response, I guess, to Mr. Hyde's death." (Testimony of Sean Kelly, pages 7575–7576)

121 The Mental Health Commission of Canada, "A Framework for A Mental Health Strategy for Canada: Toward Recovery and Well-Being", page 17

122 Referring to the relevant literature, this point is made by Terry Coleman and Dr. Dorothy Cotton in "Police Interactions with Persons with a Mental Illness: Police Learning in the Environment of Contemporary Policing" prepared for the Mental Health and the Law Advisory Committee of the Mental Health Commission of Canada, May 2010, page 49

123 Testimony of Supt. William Moore, pages 4147–4148

124 Exhibit 273, Halifax Regional Police CIT Training Syllabus

125 Testimony of Supt. William Moore, page 4148

126 Terry G. Coleman, PhD(C) and Dr. Dorothy Cotton, May 2010

127 "Police Interactions with Persons with a Mental Illness: Police Learning in the Environment of Contemporary Policing" prepared for the Mental Health and the Law Advisory Committee of the Mental Health Commission of Canada by Terry G. Coleman, PhD(C) and Dr. Dorothy Cotton, May 2010, page 7

128 "Police Interactions with Persons with a Mental Illness: Police Learning in the Environment of Contemporary Policing" prepared for the Mental Health and the Law Advisory Committee of the Mental Health Commission of Canada by Terry G. Coleman, PhD(C) and Dr. Dorothy Cotton, May 2010, page 47

129 "Police Interactions with Persons with a Mental Illness: Police Learning in the Environment of Contemporary Policing" prepared for the Mental Health and the Law Advisory Committee of the Mental Health Commission of Canada by Terry G. Coleman, PhD(C) and Dr. Dorothy Cotton, May 2010, page 53

The *Involuntary Psychiatric Treatment Act*

The *Involuntary Psychiatric Treatment Act*[1] was the subject of considerable attention at the Inquiry hearings with witnesses questioned quite extensively by various counsel about its provisions. It is no reflection on the painstaking efforts of skilled counsel that I do not intend to examine the legislation in great detail. It was not invoked in Mr. Hyde's case and therefore I do not have an evidentiary basis for determining what role it might have played in the events of November 21 and 22, 2007. It is possible that the trauma experienced by Mr. Hyde on November 21 in Booking, the tragedy of his death on November 22 and all the stressful intervening events might not have occurred had Mr. Hyde been apprehended by police on November 21 under IPTA and taken to an emergency department instead of being transported to police cells. However there is no way of knowing that because we do not know what decisions would have been made at the hospital.[2] I do not know if the medical examination under IPTA (which does not refer to a psychiatric examination in the first instance[3]) would have been followed by Mr. Hyde simply being returned to the police officers who are required under the legislation to retain custody of the person "until the medical examination is completed."[4] I cannot assume that Mr. Hyde would have been recommended for an involuntary psychiatric assessment or admitted as an involuntary patient.[5]

Acknowledging how difficult it is to make decisions about whether to invoke the involuntary committal option[6], Dr. Stephen Hucker identified several "junctures" where the civil commitment route could have been followed in Mr. Hyde's case: a mental health worker and trained police officer [from the MMHCT] may have been able to de-escalate the situation and Mr. Hyde taken for a mental health assessment; the police officers who attended at Albro Lake Road could have apprehended Mr. Hyde and taken him to hospital; Mr. Hyde could have been admitted at the QEII for a medical examination; and Mr. Hyde could have been sent from either the courthouse or the CNSCF to be assessed pursuant to the applicable civil commitment legislation (i.e. IPTA).[7]

I have decided to confine my focus to four IPTA issues that I have identified as relevant to the facts of Mr. Hyde's case:

1) Awareness and education of police officers about IPTA;
2) The interplay between IPTA and the HRPS Intimate Partner Violence Policy;
3) A recognition that an apprehension under IPTA is not without coercive implications for a person with a mental illness who comes to the attention of the police; and
4) The significance of Mr. Hyde's fear of being taken off to hospital.

Awareness and Education

The *Involuntary Psychiatric Treatment Act* (IPTA) provides police officers with the option of taking a person into custody for the purpose of immediately getting them to a hospital for a medical examination.[8] The legislation requires the officer to have "reasonable and probable grounds to believe" that the person "apparently has a mental disorder" and "will not consent to undergo medical examination."[9] In addition there must be reasonable and probable grounds for the officer to believe that the person, "as a result of the mental disorder" is a threat[10] to him/herself or others, or is likely to suffer serious physical impairment of serious mental deterioration or both, or is committing or about to commit a criminal offence.[11]

The prior experience with IPTA apprehensions of all the police officers who testified had involved individuals who were suicidal,[12] although Cst. Jardine understood that IPTA permitted the apprehension of someone who was "…going through a severe [behavioural] episode and has to be taken in [to hospital.]"[13] The officers who were dispatched to Albro Lake Road did not think they had the grounds for an IPTA apprehension.[14] Cst. Gillis did not view Mr. Hyde as presenting with a mental disorder and considered that his behaviour might be the result of drug intoxication.[15] Cst. Jardine did not form the view that Mr. Hyde had a mental health issue until after he had spend some time observing his behaviour at the QEII Emergency Department following the altercation at HRPS Booking.[16] At Albro Lake Road he did not think that Mr. Hyde was "going through an episode" that would trigger intervention via IPTA.[17] Cst. Edwards was advised that Mr. Hyde was arrestable for assault.[18] He testified that he had no reason to believe that Mr. Hyde was "…suffering from any mental health issue at the time."[19]

The *Involuntary Psychiatric Treatment Act* came into effect on July 3, 2007.[20] Supt. William Moore sent out an email on June 29, 2007 to all HRPS officers providing them with the "Involuntary Psychiatric Treatment Act – Fact Sheet for Law Enforcement."[21] The testimony of the police officers who responded to the dispatch concerning Mr. Hyde indicates their understanding that they needed reasonable and probable grounds to believe Mr. Hyde had a mental disorder but could not rely on information from Ms. Ellet to undertake an IPTA apprehension.[22]

The police officers were incorrect. They could have formulated the required reasonable and probable grounds under section 14 of IPTA based on what Ms. Ellet told them about Mr. Hyde's mental condition. HRPS police officers are trained to do an investigation and not rely solely on what they have personally witnessed. [23]

It was the opinion of both forensic psychiatrists who testified at the Inquiry as experts that Mr. Hyde would have satisfied the criteria under IPTA for civil commitment.[24] He was experiencing a psychiatric emergency[25] and, as a result of his schizophrenia, was "[suffering] serious mental deterioration…"[26] "At no point did the psychiatric emergency end"[27], and Mr. Hyde was still "certifiably mentally ill" when he was admitted to the QEII Emergency Department.[28] Based on Mr. Hyde's history, Dr. Hucker considered him certifiable as an involuntary patient even once he had received the dose of olanzapine that settled him.[29]

It is significant to note that Cst. Gillis thought that Mr. Hyde might need a psychiatric assessment, one he expected could be obtained through the courts. He believed the correct approach was to arrest Mr. Hyde for the assault of Ms. Ellet and have a judge determine if he should be sent for a psychiatric assessment.[30] I have the impression Cst. Gillis saw this as essentially the same as an IPTA assessment. Even as senior a police officer as Supt. Moore indicated he was not familiar with

the type of assessment that is ordered pursuant to the *Criminal Code* or the difference between a forensic psychiatric assessment and an assessment done through the hospital.[31] He testified that he assumed these assessments were the same.[32]

Supt. Moore did observe however that pre-charge and even "charge" diversion could be developed as options to ensure that persons with a mental illness get the therapeutic assistance they need which may not be available to them through the criminal justice process.[33] He recognized the vulnerability of a person like Mr. Hyde in the criminal justice system[34] and the need to minimize the criminalization of persons with mental illness who come into conflict with the law.[35]

In Chapter 56 I discuss the evidence the Inquiry heard about the differences between a "forensic" psychiatric assessment and a "civil" psychiatric assessment, information that should be included in police training on mental health issues.

IPTA and the HRPS Intimate Partner Violence Policy

The Inquiry heard about tensions between the Intimate Partner Violence Policy and IPTA.[36] Intimate partner violence is a "high-end" crime and police officers have been trained to treat it seriously, with the effect that they tend to proceed with the criminal process rather than IPTA in cases where there is an issue of mental illness.[37]

The HRPS Intimate Partner Violence policy is intended to support a "pro-charge" approach "at the lowest level we're aware of in the cycle of violence…the purpose is to have police intervention to get [the victim] into a system[38] before it escalates into something worse."[39] Even a low-end assault triggers the policy and its pro-charge approach.[40] The policy provides for the victim having very little input into the decision of whether charges are laid or not.[41] The paramount concern for a police officer responding to a call involving intimate partner violence is the safety of the victim.[42] This was true for the officers who were dispatched to Albro Lake Road.[43] They acted appropriately in arresting Mr. Hyde in circumstances where they had reasonable grounds to believe Ms. Ellet had been assaulted.

IPTA is primarily used by police officers in cases of risk of suicide or nuisance offences where the criminal aspect is seen as secondary to the mental health concern.[44] Although there are no policy or legal obstacles to invoking IPTA where a serious criminal offence is being alleged, there are practical issues.[45] One of these practical issues is that the HRPS policy on intimate partner violence affords very little discretion to police officers dealing with domestic violence charges irrespective of whether there is a mental health issue or not.

An IPTA apprehension has implications for the arraignment of an accused who is charged with a criminal offence and the issue of his/her bail. The least restrictive form of release available is an officer-in-charge undertaking with conditions.[46] If a higher level of release is required, for example, release involving a surety, a judge has to be involved in the person's release from custody[47] likely by attending to arraign the person in hospital.[48] Any release would then take effect once the IPTA process had run its course.[49] If the person subject to IPTA is remanded, there is no secure facility for them in HRM other than the ECFH which is an option only if an order is made for a court-ordered assessment.[50]

The option exists of course for charging the person later, with the priority being to get the person into hospital.[51] Even though Supt. Moore expressed some uncertainty about whether an involuntary patient could be arraigned, a determination under sections 17 and 18 of IPTA that a person does not have the capacity

to make admission and treatment decisions is not a determination that there is a fitness issue under the *Criminal Code*.

Police will make a recommendation that the Crown seek a psychiatric assessment where IPTA hasn't been triggered and they want to make sure the psychiatric assessment happens through the court process.[52] This approach raises again the issue of misapprehending the two assessment processes as being the same.

The Coercive Aspects of IPTA

An apprehension by police pursuant to IPTA may result in a committal to hospital as an involuntary patient if the determination is made by a psychiatrist that there is incapacity with respect to admission and treatment decisions.[53] A person can be detained for 72 hours while this decision is being made.[54] Authorized periods of detention as an involuntary patient then can be quite lengthy.[55] Decisions on treatment are given over to a substitute decision-maker.[56] Even release to the community may involve the person being subject to a community treatment order[57] with the continued involvement of a substitute decision-maker.[58] Community treatment orders can have a considerable shelf-life: there are no limits to the number of renewals that can be made "where the community treatment order has demonstrated efficacy…"[59]

Dr. Theriault described community treatment orders under IPTA as "leveraged care in the community…a mechanism by which the person can reside in the community but be required to follow certain provisions as laid out in [the order]."[60] He acknowledged that "the perspectives on community treatment orders [varies] quite widely":

> …depending on your perspective, a community treatment order can be seen as a significant infringement on the rights of people to…live their lives as they wish to in the community without undue intervention. On the other side, there's an argument that community treatment orders, in fact, allow people to live their lives in the community without even more egregious intervention…[61]

Community treatment orders are only available if a person lacks capacity to make medical treatment decisions.[62] The evidence does not indicate that Mr. Hyde lacked capacity in November 2007 or at the time of his discharge from the Nova Scotia Hospital in May 2007 (when CTO's were not available in any event).

Mr. Hyde's Past Experience of Involuntary Committal to Hospital and His State of Mind on November 21, 2007

We know that Mr. Hyde lashed out at Ms. Ellet because he was angry about her call to the MMHCT.[63] With his history and experience[64] he would have been aware that an outside intervention could once again result in him being taken to hospital or arrested. His aggression toward Ms. Ellet on the night of November 21 was a replay of his reaction a few months earlier. MMHCT notes from late April 2007 recorded Ms. Ellet describing Mr. Hyde as becoming extremely angry at any mention of "medication, doctor or hospital…"[65] In November 2007 he was once again highly anxious and paranoid and on a collision course with the hard edges of the criminal justice system.

Notes

1 *2005, c. 42* ("IPTA")

2 Testimony of Susan Hare, page 3951

3 *Involuntary Psychiatric Treatment Act*, section 15(1): "Where a person is taken in custody for a medical examination pursuant to Sections 13 or 14, the person may be detained for up to twenty-four hours in an appropriate place in order for a medical examination to take place."

4 *Involuntary Psychiatric Treatment Act*, section 16(2)

5 *Involuntary Psychiatric Treatment Act*, sections 16(3), 17. To admit a person as an involuntary patient, the psychiatrist conducting the involuntary psychiatric assessment must be satisfied that the person, as a result of the mental disorder, does not have the capacity to make admission and treatment decisions. See, also: Testimony of Dr. Scott Theriault, page 9596

6 Testimony of Dr. Stephen Hucker, pages 10169–10170

7 Testimony of Dr. Stephen Hucker, pages 10170, 10174; Exhibit 265, Dr. Hucker's Report dated May 28, 2009

8 *Involuntary Psychiatric Treatment Act,* section 14

9 The *Involuntary Psychiatric Treatment Act,* sections 14 (a) and (b). Section 14 also requires under (c) that the police officer have reasonable and probable grounds to believe that "it is not feasible in the circumstances to make application to a judge for an order for a medical examination pursuant to Section 13."

10 The actual wording of section 14(d)(i) is " as a result of the mental disorder, is threatening or attempting to cause serious harm to himself or herself or has recently done so, has recently caused serious harm to himself or herself, is seriously harming or is threatening serious harm towards another person or has recently done so."

11 *Involuntary Psychiatric Treatment Act,* section 14 (d) (i), (ii) and (iii)

12 Testimony of Cst. Gyles Gillis, pages 244, 296; Testimony of Cst. Bradley Jardine, page 546; Testimony of Cst. Jonathan Edwards, page 867

13 Testimony of Cst. Bradley Jardine, pages 744–745

14 Testimony of Cst. Gyles Gillis, pages 216, 232 , 244, 295, 337, 379; Testimony of Cst. Bradley Jardine, pages 542–543

15 Testimony of Cst. Gyles Gillis, page 379

16 Testimony of Cst. Bradley Jardine, pages 557–558

17 Testimony of Cst. Bradley Jardine, page 545

18 Testimony of Cst. Jonathan Edwards, page 874

19 Testimony of Cst. Jonathan Edwards, page 886

20 *Involuntary Psychiatric Treatment Act,* section *92;* Testimony of Dr. Scott Theriault, page 9701

21 Exhibit 285, Email from Elizabeth Buckle [counsel to HRPS] dealing with how information concerning the new *Involuntary Psychiatric Treatment Act* was conveyed to members of the HRPS.

22 Testimony of Cst. Gyles Gillis, pages 216–217; Testimony of Cst. Bradley Jardine, pages 532, 545: "…we can only go on what we see…"

23 Testimony of Sgt. Dean Stienberg, page 7210

24 Testimony of Dr. Joseph Noone, page 9182; Testimony of Dr. Stephen Hucker, page 10067

25 Testimony of Dr. Joseph Noone, page 9131; Testimony of Dr. Stephen Hucker, page 10082

26 *Involuntary Psychiatric Treatment Act*, section 14(d)(ii); Testimony of Dr. Joseph Noone, page 9132: "…he was suffering a relapse of his mental disorder."

27 Testimony of Dr. Joseph Noone, page 9181

28 Testimony of Dr. Joseph Noone, page 9134

29 Testimony of Dr. Stephen Hucker, page 10155

30 Testimony of Cst. Gyles Gillis, pages 233, 235

31 Testimony of Supt. William Moore, page 4101

32 Testimony of Supt. William Moore, page 4101

33 Testimony of Supt. William Moore, page 4069 referring to the fact that the Crown can decline to follow the police recommendation that a forensic assessment be sought.

34 Testimony of Supt. William Moore, page 4070

35 Testimony of Supt. William Moore, page 4029

36 Testimony of Supt. William Moore, pages 4003–4005; 4030–4032

37 Testimony of Supt. William Moore, page 4103

38 Supt. William Moore testified that the objective is to get release conditions in place on the accused and secure assistance for the complainant through Victims' Services. (Testimony of Supt. William Moore, page 4169)

39 Testimony of Supt. William Moore, page 4169

40 Testimony of Supt. William Moore, page 4170

41 Testimony of Supt. William Moore, pages 4172–4173

42 Testimony of Supt. William Moore, page 4172

43 Testimony of Cst. Bradley Jardine, page 544

44 Supt. William Moore agreed with this statement. (Testimony of Supt. Moore, page 4155)

45 Testimony of Supt. William Moore, page 4156

46 Testimony of Supt. William Moore, pages 4159–4160

47 Testimony of Supt. William Moore, page 4161

48 Testimony of Supt. William Moore, page 4162; Supt. Moore noted that accused persons who have been physically injured get arraigned in hospital. (Testimony of Supt. William Moore, page 4007) Staff Sgt. Sean Auld testified that had Mr. Hyde remained in hospital there would have been a 24-hour window for arraigning him, either through a tele-bail hearing through the Justice of the Peace Centre or by a judge attending at the hospital for the arraignment. (Testimony of Staff Sgt. Sean Auld, pages 3273–3274) See also, Testimony of Staff Sgt. Donald Fox, page 5411

49 Testimony of Supt. William Moore, page 4164

50 Testimony of Supt. William Moore, page 4167

51 Testimony of Dr. Joseph Noone, page 9208; Testimony of Dr. Stephen Hucker, page 10028; see also, Exhibit 265, Dr. Hucker's Report dated May 28, 2009, page 9: "Irrespective of the fact that he was in police custody, it would have been possible to place Mr. Hyde on a certificate for a psychiatric assessment [at the ER] and divert him into the mental health system. He could have been returned to custody and criminal procedures could have followed after his discharge."

52 Testimony of Supt. William Moore, pages 4032–4033; 4067

53 *Involuntary Psychiatric Treatment Act*, sections 17 and 18; Testimony of Dr. Scott Theriault, page 9596

54 *Involuntary Psychiatric Treatment Act*, section 9(3); Testimony of Susan Hare, page 3955

55 *Involuntary Psychiatric Treatment Act*, section 22

56 *Involuntary Psychiatric Treatment Act*, section 38 and 39

57 *Involuntary Psychiatric Treatment Act*, section 47

58 *Involuntary Psychiatric Treatment Act*, section 47(3)(b)

59 *Involuntary Psychiatric Treatment Act*, sections 52(1) and (2)

60 Testimony of Dr. Scott Theriault, page 9704

61 Testimony of Dr. Scott Theriault, page 9705; Dr. Joseph Noone made this point as well. (Testimony of Dr. Joseph Noone, pages 9261–9262)

62 *Involuntary Psychiatric Treatment Act*, section 47(3)(a)(iii)

63 Testimony of Karen Ellet, page 125

64 See, Part II, Chapters 2 and 3

65 Exhibit 79F, Tab J, page 9, MMHCT records

Educating Emergency Department Doctors

Assumptions about what would happen to Mr. Hyde when he was returned to police custody played a significant role in the decision to discharge him from the QEII Emergency Department without his having received a psychiatric assessment. Both ER doctors treating Mr. Hyde, first Dr. Curry and then Dr. MacIntyre, assessed him as needing an urgent psychiatric consultation.[1] Dr. Curry would not have supported Mr. Hyde being released from the hospital if he had known that he would not get to court until late in the afternoon.[2] He believed Mr. Hyde would get the essential psychiatric assessment either through the court process or by being returned to the ER.[3] Dr. MacIntyre's decision-making would have been different had she understood that Mr. Hyde would not be returned to the hospital for a psychiatric assessment if one was not ordered by the court.[4] She would have kept Mr. Hyde in the hospital and ordered an in-house assessment.[5] And Dr. MacIntyre did not know that the assessment she assumed Mr. Hyde would receive through the courts was not the assessment he needed to assist in the treatment of this most recent recurrence of his mental illness. She believed that a forensic psychiatric assessment was a full substitute for an in-hospital assessment through the QEII.[6] It was her expectation that Mr. Hyde would be given appropriate care through a forensic psychiatric assessment.[7] She was sufficiently convinced of this that she did not discharge Mr. Hyde with any medication[8], even though he had been stabilized with a shot of olanzapine that would gradually wear off.

Forensic Hospital versus "Civil" Hospital Based Psychiatric Assessments

Had Mr. Hyde been sent for a court-ordered *Criminal Code* psychiatric assessment, he would not have been seen by a psychiatrist on November 21 at the ECFH. His late afternoon court appearance would have had him arriving at the CNSCF/ECFH[9] site after the ECFH staff psychiatrists had left for the day at 4:30 – 5 p.m.[10] The normal time frame for producing the assessment report for the court is 30 days[11], so there would have been no rush to see Mr. Hyde. Presumably he would have spent the night of November 21 at the CNSCF and then securely housed in the MIOU[12] and seen by a psychiatrist the next day.

Furthermore, Mr. Hyde may well not have received any treatment at the ECFH for his psychosis: in the context of a *Criminal Code* assessment, the decision whether to treat "…depends on the situation at hand…[the ECFH psychiatrist] might for the purposes of fulfilling [his/her] primary mandate, decide not to treat or delay treatment or wait until the process is resolved before you would initiate treatment."[13]

An accused person with a psychotic illness but no agitation sent to the ECFH for a court-ordered assessment might not be treated if the psychiatrist tasked with providing the opinion on fitness and criminal responsibility decided that it was important to understand the person's thinking process without the mediating effect of medication.[14] Altering an accused's mental state through treatment might prevent the assessing psychiatrist from getting "…a clear picture of what it was at the time of the alleged offence…"[15]

As Dr. Scott Theriault, the clinical director for the ECFH[16] explained:

> …to even use the term "patients" is a bit of a misnomer…our primary role is to answer the questions put to us by the Court…whether in fact, in our opinion, the person is fit to stand trial or criminally responsible…[17][In the context of a Criminal Code assessment] we're acting as an agent for the Court, not as an agent for the individual…our primary purpose is to give the Court an opinion as to fitness or criminal responsibility, and issues of treatment are not its primary purpose…[18]

This contrasts starkly with the physician/patient relationship in the "civil" mental health system:

> …in the civil system, your relationship to the person is as a treatment provider. So your primary interest is the individual, their health, your relationship with that person around their health and their capacity to make decisions about their health care.[19]

Furthermore, treatment of an accused undergoing a "forensic" assessment would not involve any systematic or formal psychotherapy.[20] Treatment at the ECFH is "largely pharmacological in nature"[21] with the psychiatric service otherwise providing some support around problem-solving and the person's immediate distress.[22]

Emergency Physicians – Knowledge and Training

That Drs. Curry and MacIntyre did not know how the criminal justice system operates in cases where an accused person has a mental illness is not surprising. Dr. MacIntyre also did not properly understand the purpose of the HIT Form.[23]

In Nova Scotia, doctors' training is delivered through a peer-to-peer mentoring education process.[24] Doctors receive their education first in the undergraduate medical programme, then in residency placements, and through continuing medical education.[25] Education about forensic psychiatric assessments is not offered by Dalhousie Medical School beyond general instruction that such assessments are done, by psychiatrists, in certain circumstances.[26] There is no training offered by Capital District Health to ER physicians on forensic psychiatric assessments.[27] ER physicians do receive training about IPTA.[28]

Both Dr. Hucker and Dr. Scott Theriault prepared charts detailing the processes that are invoked when a person with a mental illness is moved through the criminal or the civil assessment systems.[29]

Dr. Michael Howlett was qualified by the Inquiry to give expert opinion evidence as an emergency room doctor with expertise in emergency medicine around the emergency care provided to Mr. Hyde on November 21, 2007 at the QEII Health Sciences Centre Emergency Department.[30] It was his assumption that an accused

person sent to the ECFH for a court-ordered psychiatric assessment will be provided with "some form of care relating to their psychiatric condition."[31] He did not research the issue of what training ER physicians receive with respect to the comparative treatment regimes of "forensic" versus "civil" psychiatric assessments.[32] Dr. Howlett told the Inquiry he did not see any value in providing training to ER physicians on the differences between *Criminal Code*-ordered psychiatric assessments and assessments obtained pursuant to IPTA:

> No, [more education would not be useful for ER physicians] because it doesn't solve a thing. It doesn't help us access care for patients. It just tells us what's happening currently. And what's happening currently is not sufficient. So, if you want to fix the problems, don't give us more education, put in place systems of care that address the problems.[33]

He subsequently seemed to moderate this stance somewhat, qualifying it by saying that education alone, while "useful" doesn't solve the "patient care problem" when what is needed are "options for care delivery."[34]

For Dr. Howlett, suitable "options for care delivery" for Mr. Hyde included a "forensic" psychiatric assessment. Even though Mr. Hyde was not violent or aggressive[35] while being treated and assessed at the QEII Emergency Department, Dr. Howlett referenced the issue of safety: "What I'm really trying to say is we need some sort of secure psychiatric assessment option for these types of patients."[36]

The Stigmatization of "Forensic" Patients

How Dr. Howlett saw the options resonates with an assumption about dangerousness that the forensic psychiatric experts, Drs. Joseph Noone and Stephen Hucker, identified as a feature of the stigmatization of forensic patients. In Dr. Howlett's view:

> …In Nova Scotia, access to a forensic unit may better serve a patient who is involved with the legal system rather than a short stay on a psychiatric unit with greater safety for both the patient and staff. I believe that Dr. MacIntyre acted in the patient's best interest to take advantage of the unusual opportunity to access forensic psychiatry. Although emergent consultation with psychiatry at the hospital is a reasonable option, in this case, it is also reasonable to attempt to obtain access to a formal psychiatric evaluation in terms of both this patient's medical condition and criminal prosecution.[37]

Dr. Noone commented on the stigma that follows the "forensic" patient into the ER: "…people are kind of afraid of them just because of their history without [that] necessarily being the situation."[38] Dr. Hucker emphasized that health care professionals typically do not understand the "forensic" system and are apt to believe that "…forensic is where you send these people…"[39] Dr. Hucker suggested that this Inquiry should recommend an enhancement of the "…education of hospital medical and nursing staff with respect to police involvement and psychiatric services."[40] As Dr. Hucker explained the issue:

> …many people, when they hear about somebody involved with the Courts, they immediately say "ah, forensic," and forensic is where you send mentally ill, badly-behaved people to be dealt with. And I think it becomes con-

fusing even for people who are sitting on committees, as I've done, trying to work out how to improve services ... is that that they think anybody who has had a police record is forensic. Anybody who has been in corrections is forensic. Anybody who acts up under police custody is forensic. And you try to explain "forensic" is related, in this instance, to the Courts, and if the judge doesn't send the person for a forensic assessment, it's left to…the Defence ... or the Crown Attorney to recommend this. And it's not something which staff at a hospital can say "Well, he should go to forensic." That's not how it works…the decision of the disposition that gets a person into the forensic mental health system, is a judicial one.

So thinking that the person should end up in forensic is not something somebody in an emergency room has any control of…and it does suggest that people think aggression and violence and mental illness is forensic. And I think, a misunderstanding, and I think it's partly the reason why in many jurisdictions…if a mentally ill person presents in an emergency room and is suicidal, then getting admitted is not going to be difficult. If you get taken to the emergency room and you're violent, they're much more likely to be told "charge him," because people don't want to manage violent, psychotic individuals. Harm to themselves they seem to be able to cope with, and it's partly because over the years mental health staff's expertise, except in specialized settings, has become less. So dealing with violence is something which many mental health professionals try to steer away from. So it becomes very convenient to say, oh, forensic is where you send these people.

…

I think [that it is] important that people get their heads around what the differentiation is and how the systems interact and don't interact. So I think it's important for that knowledge to be transmitted and where necessary for clear statements or guidelines to be developed as to what to expect.[41]

…

Furthermore, teaching health care professionals that "…they don't have to be afraid of their [psychotic] patients" leads to improvements for staff and patients.[42]

There is no evidence before this Inquiry that Mr. Hyde was discharged because the Emergency Department medical personnel wanted to off-load him. However Dr. Curry misunderstood the court-ordered assessment in much the way that Dr. Hucker described:

Question: Can you explain to the Inquiry what's your understanding of how those assessments work?

Answer: My understanding would be that if somebody…has a psychiatric issue that has to be addressed…and there's also a criminal element involved or something…that…is a potential for violence…essentially, they should more likely…get a forensic assessment and [the determination made] whether they need to be hospitalized in a forensic unit versus a regular ward.[43]

Enhancing Knowledge: Enhancing Outcomes

Emergency physicians cannot assume that an accused person will be sent for a court-ordered psychiatric assessment.[44] Based on the evidence heard at the Inquiry, it is clear that had Drs. Curry and MacIntyre been equipped with a more robust understanding of the workings of the *Criminal Code* psychiatric assessment process versus the hospital psychiatric assessment process, and the limitations of the HIT Form, Mr. Hyde would not have been discharged from hospital back into police custody. Furthermore, as noted by Dr. Hucker, the ability to improve services is compromised by a failure to properly understand each system and how they operate in relation to a person with a mental illness who is in conflict with the law.

Notes

1 Testimony of Dr. Stephen Curry, pages 4549, 4557; Testimony of Dr. Janet MacIntyre, page 4811

2 Testimony of Dr. Stephen Curry, pages 4561, 4562

3 Testimony of Dr. Stephen Curry, page 4544

4 Testimony of Dr. Janet MacIntyre, page 4868

5 Testimony of Dr. Janet MacIntyre, page 4766

6 Testimony of Dr. Janet MacIntyre, page 4776

7 Testimony of Dr. Janet MacIntyre, page 4776

8 Testimony of Dr. Janet MacIntyre, page 4757

9 The two facilities are co-located.

10 Testimony of Dr. Scott Theriault, page 9635: "…we would all be there…for the regular work week, 8:30 to 4:30, five o'clock every day."

11 Testimony of Dr. Scott Theriault, page 9557

12 Testimony of Dr. Scott Theriault, pages 9572–9573

13 Testimony of Dr. Scott Theriault, page 9614

14 Testimony of Dr. Scott Theriault, page 9556; Testimony of Dr. Stephen Hucker, page 10173: "I cannot assess a person who is medicated."

15 Testimony of Dr. Scott Theriault, page 9595. Dr. Theriault explained that it would be more likely that an accused, admitted to the ECFH for a court-ordered assessment who was "quite tortured" by their delusional beliefs, would be treated to alleviate their acute distress where it would be inhumane not to do so. (Testimony of Dr. Scott Theriault, pages 9555, 9649)

16 Dr. Theriault is also clinical director for speciality programmes for the Capital District Mental Health Programme and an associate professor of psychiatry at Dalhousie University, Department of Psychiatry.

17 Testimony of Dr. Scott Theriault, page 9554

18 Testimony of Dr. Scott Theriault, pages 9594–9595

19 Testimony of Dr. Scott Theriault, page 9613

20 Testimony of Dr. Scott Theriault, page 9666

21 Testimony of Dr. Scott Theriault, page 9666

22 Testimony of Dr. Scott Theriault, pages 9666–9667

23 See Part IV, Chapter 51, The Health Information Transfer Form (Understanding the HIT Form's Purpose and Function and Acting on Its Content)

24 Testimony of Dr. Michael Howlett, page 10338

25 Testimony of Dr. Michael Howlett, pages 10339–10340

26 Dr. Michael Howlett, page 10257

27 Testimony of Susan Hare, page 3701

28 Testimony of Dr. Michael Howlett, page 10258; Testimony of Susan Hare, page 3679

29 Dr. Hucker's chart is Appendix 1 to Exhibit 265, his report. Dr. Theriault's chart was entered as Exhibit 254 (2 pages).

30 Dr. Howlett's curriculum vitae was entered as Exhibit 267. Examination re: qualifications, Transcript pages 10206–10225. His report, dated November 25, 2009 was entered as Exhibit 268.

31 Testimony of Dr. Michael Howlett, page 10279

32 Testimony of Dr. Michael Howlett, page 10279

33 Testimony of Dr. Michael Howlett, page 10291

34 Testimony of Dr. Michael Howlett, page 10292

35 The fact that Mr. Hyde made a couple of attempts to kick Dr. Curry during his examination does not justify labeling him as either violent or aggressive. He was otherwise compliant and docile while at the ER.

36 Testimony of Dr. Michael Howlett, page 10291

37 Testimony of Dr. Michael Howlett, page 10234; Exhibit 268, Dr. Howlett's Report, dated November 25, 2009, page 4

38 Testimony of Dr. Joseph Noone, page 9172

39 Testimony of Dr. Stephen Hucker, page 10032

40 Exhibit 265, Dr. Hucker's Report, page 10; Testimony of Dr. Hucker, pages 10030–10033

41 Testimony of Dr. Stephen Hucker, pages 10031–10033

42 Testimony of Dr. Jacqueline Kinley, page 9844–9845. Although Dr. Kinley was referring to nursing staff, physicians would also benefit from training that is aimed at reducing the stigma associated with patients with mental illness who are subject to the criminal justice process. It is a matter of learning to "look beyond the behaviour and to connect with the patient…" (Testimony of Dr. Jacqueline Kinley, page 9845)

43 Testimony of Dr. Stephen Curry, pages 4450–4451

44 Testimony of Dr. Joseph Noone, page 9292

Living With a Mental Illness in the Community

By November 2007, nothing much stood between Mr. Hyde and the final, tragic relapse of his illness. His prescriptions had expired and his mental health supports in the community consisted of a family doctor, who was sympathetic but under the mistaken impression that Mr. Hyde was relying primarily on another general practitioner. Mr. Hyde was not. As far as mental health services were concerned, Mr. Hyde was very much on his own.

As I have noted in Part II, Chapter 2, Mr. Hyde had experience with Connections Clubhouse and the Nova Scotia Hospital SCOT Team although his involvement with both had ended unhappily in late 2004/early 2005. It does appear that he re-connected with Connections Clubhouse because Ms. Ellet recalls that he enjoyed going there.[1] She thought it was only a social venue. She appreciated that the Mobile Mental Health Crisis Team was a resource and had accessed the Team's services earlier in 2007 although it does not appear Mr. Hyde did. She was unaware of any other help in the community.[2]

It is apparent that the standard responses to Mr. Hyde's illness throughout its long history were ones he found particularly objectionable: medication and involuntary hospitalization.

Anti-Psychotic Medication and Compliance

Dr. Hucker identified medication as the "mainstay" treatment for psychosis.[3] It certainly was in Mr. Hyde's case. And Mr. Hyde had long-standing, clearly articulated complaints about the medications prescribed to manage his schizophrenia.[4] On its final day of evidence, the Inquiry watched an amateur video of Mr. Hyde, made several years before his death, in which the very first subject he discussed was olanzapine and the need for medications that "don't make you fat, with better side effects."[5] Even while recovering in hospital from his collapse in HRPS Booking, he was describing the negative effects of his medication to the police officers guarding him.[6]

There was nothing unique about Mr. Hyde's problems with non-compliance [7]. Poor compliance by persons with a mental illness "is associated with an increased rate of relapse"[8] often leading to hospitalization, as experienced by Mr. Hyde:

> …it's a common problem to have somebody who responds to medication that their symptoms come under control, then they get returned to the community, and then they relapse again because they either lack insight, or because they don't like the side effects, or because the regime is too complicated to follow and they miss a dose or two and then they start missing

lots of them. And then the cycle starts again.

…

The problem more often is that the person relapses again, and then they start getting into hospital again, and they get treated and they improve. And that's the continuing cycle, the "revolving door", as it's been called. So that's really the practical problem. And that's the case with people who don't do anything illegal and they don't have problems with substance abuse or anti-social problems, but that's just part of the cyclical nature of the treatment of this illness.[9]

Mr. Hyde's aversion to his medications was not irrational. He experienced real and unpleasant side-effects, weight gain and sexual dysfunction. The "novel anti-psychotics"[10] which include olanzapine[11] , very commonly result in weight gain and produce "sexual side effects."[12] Medications used to treat psychosis "can have long-term effects, some of which may not be known at this point…[and] side effects that can be quite serious."[13] Dr. Hucker acknowledged that the side effects of some of these medications can be "horrible" and said he sympathized with Mr. Hyde's reaction.[14]

Non-compliance with a medication regime exposes the tensions between personal agency and autonomy which includes the right to make health care decisions, and concerns about the debilitating effects of severe mental illness. Unless the person is subject to the coercive power of the forensic system, they cannot be forced to take anti-psychotics.[15] Dr. Hucker talked about how the mental health systems secures compliance largely through "a process of coercion and persuasion and cajoling…"[16] Under the *Involuntary Psychiatric Treatment Act*, where a person has capacity to consent to treatment, there is

…very little we [the health care system] can do except some very creative and proactive engaging with the individual to support them to make decisions that we think are better for their health and hopefully that they think are good for their health as well.

So there's a fair bit of…engaging, coaching, mentoring, supporting individuals around what treatment options make the best sense for them so that they can live a full and satisfying life in the community.[17]

…

…it's an incredibly difficult illness to live with, and I would also suggest that the…medical treatment options, have significant numbers of side effects that aren't pleasant to live with. So people are making choices based on…not necessarily great options.

I do think with more resources in the community and people seeing the possibility of living healthier, happier lives that aren't layered in poverty and lack of access to services certainly would…give them thought that they may be able to do more and might be more inclined to stay on medication based on the fact that they now have access to more services and resources and can live a more satisfying life.[18]

The Inquiry also heard that medication non-compliance is not unique to persons with mental illness. Health services broadly speaking, with an approximate rate of 40 percent non-compliance in the general population, have had to identify ways to help people take their medication as prescribed.[19]

Other Treatment Modalities

The evidence before the Inquiry indicates that Mr. Hyde was managed on a regime of medications that held his psychotic symptoms at bay. Once off those medications he decompensated, a pattern that in the past had led on many occasions to his hospitalization. The evidence as a whole suggests that it is unhelpful to simply see the issue as one of poor compliance: it is necessary to examine the possibility that the emphasis on medication in the treatment of Mr. Hyde's illness did not allow for the development of other approaches to care on a sustained and robust basis when he was in the community.

The Inquiry heard evidence that medications alone are not enough to enable a person with a chronic mental illness to maintain good health in the community.

> Symptoms are problematic but they are not the problem. The problem is inside the person. So if you don't actually get inside the person and work with them and figure them out and understand who they are and what drives them, the symptoms are not going to go away…people take their pills and they are great, they go off their pills, their psychosis comes back. What a surprise, you know…[20]

The role of the therapeutic relationship was also emphasized by Dr. Stephen Hucker:

> …there's a whole process of interacting with patients, and trying to get them to come to terms with their problems and work out other ways of dealing with it.[21]

Medications stabilize a person experiencing psychotic symptoms associated with schizophrenia[22] but intensive psychotherapy can be employed to build up resilience and teach self-regulation[23] even in someone who has had a twenty-year history of chronic schizophrenia.[24]

Optimum treatment however is not just focused on symptoms:

> …The symptoms are problematic, but the problem lies in the core of the way that the person manages their thoughts, and manages their feelings, and interacts with others. And so that's what we target [with intensive group psychotherapy]. We target those core drivers of their difficulty…[25]

There are differing viewpoints on the extent of the role of medication in managing the mental health challenges of a person living with a serious mental illness. Weaning off medication is an approach favoured by Dr. Jacqueline Kinley, Director of the CDHA intensive treatment programme.[26] Dr. Hucker acknowledged the importance of psychotherapy but testified that "the need to combine therapies is the standard model these days."[27] He identified the value of psychotherapy as a treatment modality, coupled with reliance on medication:

> I think the vast majority of psychiatrists would say that medications are the mainstay of treatment for schizophrenia but it's not the whole answer. Psychotherapy, depending on how you characterize that, because it can cover a number of techniques, but cognitive behaviour therapy where you try to get the person to think about their moods and feelings before they act on something. That's a kind of principle that's widely used in psychiatry.

> And helping the person understand their illness and their need for medications. These are all psychological techniques that are in the best kind of programs, are all fully integrated with the medication.[28]

Mr. Hyde was provided with therapies other than medication, during his hospital admissions and as an out-patient when he received "…interventions from other members of staff…geared towards better understanding of his illness."[29] The problem was that these interventions were "always intermittent."[30] In any event, there is no evidence that Mr. Hyde ever had the benefit of intensive group psychotherapy indicated by Dr. Kinley as having achieved success in the treatment and support of people living with severe, challenging mental health problems.[31]

Intensive case management that is focused on ensuring that a medication regime is being followed lacks the therapeutic capacity "to build an alliance with patients in a deep way to understand how to work with their thoughts and feelings" and does not provide adequate support to persons living with mental illness in the community:

> …that's a good attempt but it's not going to help somebody who's out on their own with few supports, who needs more than medication and somebody to check and make sure they're home.[32]

Dr. Kinley's service tries "to build a community of support" for its patients "that's really going to be able to hold them in their healing and support them. Nuture them." [33] Steven Lurie echoed the theme of building relationships to help people stay engaged with services.[34]

There seemed to be universal agreement amongst witnesses engaged in the delivery of services to persons with mental illness that hospital care will remain necessary but that reliance on hospital resources and emergency departments can be reduced by offering better and more accessible resources in the community.[35]

Family Doctors and Psychiatric Care

Mr. Hyde's family doctor, Dr. Singh, seems to have enjoyed a positive, sympathetic relationship with Mr. Hyde and was supportive of him. However he did not realize that he was, in fact, Mr. Hyde's primary health care provider, and that Mr. Hyde needed more intensive supports than Dr. Singh was in a position to provide. Dr. Singh felt comfortable managing Mr. Hyde's illness and had the benefit of previous experience working with psychiatric patients as a family doctor in Scotland.[36] His principle complaint was lack of readier access to psychiatrists for his patients. Referrals that led to a patient obtaining the services of the SCOT team were a way to get a patient connected to the SCOT team psychiatrist.[37] He was critical of the circuitous referral route of patients in need of urgent psychiatric care, first to the Dartmouth General Hospital and then, after a lengthy wait in the ER, to the Nova Scotia Hospital.[38] He also noted that a shortage of psychiatrists can mean patients waiting twelve months to see one.[39]

Certainly Mr. Hyde was someone who needed to be seen regularly by a supportive psychiatrist[40] who could have established a relationship with him such that his motivation to keep attending for appointments would have improved.[41] However, a fee-for-service system does not encourage private psychiatrists or psychologists to spend a lot of time with patients.[42] Patients with chronic and persistent mental illness who need considerable support present special challenges for private

practitioners as they require a significant commitment of time and energy.[43]

A heavy burden of care falls on the shoulders of family doctors of persons living with a severe, persistent mental illness.[44] Family doctors are the "cornerstone" in the mental health system, and psychiatrists, as Dr. Singh indicated, are not readily accessible and concentrated in HRM.[45] Dr. Hucker identified the expectation that family practitioners will be able to manage complex psychiatric illnesses with little or no supports:

> …often they lack psychiatric training other than the very basic that you get in medical school, where they're being told, Well, you're the primary care giver, so just keep giving them the tablets.[46]

Another problem with this approach should be obvious: medication therapy presents challenges and offers no solution for the wide range of complicated and interconnecting socio-economic problems experienced by persons living in the community with serious, chronic mental illnesses.

The typical model of care in Canada leaves the primary responsibility with the general practitioner; the psychiatrist only becoming involved when there is a crisis or some need for consultation. Dr. Hucker testified that family practitioners find it very frustrating to be trying to provide appropriate care to a patient with a chronic illness when enhanced professional skills are needed.[47] There is scope for family doctors developing better skills for use in their care for their patients with mental illnesses. For example, the Inquiry heard that Dr. Jacqueline Kinley is teaching psychotherapy to general practitioners in the Family Physician Program with the objective of better, and earlier, interventions to reduce the acute episodes that return people to hospital.[48] And Dr. Kinley pointed to the challenge of creating opportunities for family doctors "to be more present with their patients…"[49]

Family doctors would also benefit from improved communication with other GP's where there is a shared patient although in Dr. Singh's experience this does not happen, perhaps because of patient confidentiality obligations.[50] This difficulty could be readily addressed of course by obtaining consent from the patient.

The ability to refer patients to the Shared Care Programme of the CDHA, which operates clinics staffed by general practitioners, a psychiatrist and psychiatric nurse, was also attractive to Dr. Singh although he did not have any information about this service.[51]

Steven Lurie advocated strongly for improving the ability of family doctors to provide better health care to their patients with mental illness:

> …that's the place you have to start. You have to say what resources are going to be available to family physicians if somebody shows up with a mental health problem? What training is available? What kind of clinical support is available to family physicians? And that doesn't assume for a moment that the family physician does it all, but it assumes that the family physician will be able to connect and leverage the kind of supports they need from specialized mental health services.[52]

He also described the shared care model[53] of a psychiatric consultation system developed in Hamilton, Ontario which provides a general practitioner or general practice team with access to a psychiatric consultant to assist in the delivery of appropriate care.

> …[this] brings in on the treatment side the specialized knowledge that psychiatry can provide, but it allows family physicians and other allied health professionals to work with the person to meet their needs.[54]

Supporting Persons Living with Mental Illness in the Community

It was when Mr. Hyde was living in the community that he encountered difficulties coping with his mental illness.[55] Although people with serious mental illness are no longer abandoned in asylums as they used to be, abandonment is still an issue in mental health care delivery. Now it is abandonment in terms of not being able to get continuing care.[56] Supports and services in the community are essential to ensuring that people with mental illness can sustain themselves and their mental health outside of an institutional setting.[57] Extra supports in the community have been lacking and "… the stop-gap has been that we criminalize people…"[58]

Cst. Kathryn Willett, one of the police officers who transported Mr. Hyde to the Dartmouth Court House on November 21, observed that some of the people with a mental illness that she encounters in her work do not even have personal support systems in the community, like family or friends.[59] Cst. Willett's experience has led her to conclude there is a lack of resources in the community and mental health systems.[60] She spoke about unsuitable living conditions, poverty and lack of supports such as those provided by an ACT team. [61] She noted that people she has dealt with have told her they are unable to get the help they need for their mental illness.[62] Cst. Gyles Gillis, who dealt with Mr. Hyde at Albro Lake Road and spent time with him in the ER, commented on how more resources in the community for people with mental illness "would be a great help."[63] He understood that access to better resources could have made a difference in Mr. Hyde's life:

> I think even before that evening, I think the evidence that's presented so far there was ongoing issues of mental health, and I don't really know if there was just lack of support there, or Mr. Hyde obviously wasn't taking his medication for some time…and I don't know. If there was more resources there, that may have helped.[64]

A broad and comprehensive range of resources are needed to better support the well-being of persons living with mental illness in the community. Several witnesses were explicit about this:

> There needs to be more availability of reasonable supportive housing and [residences] for individuals to live in that are not transitional in nature, that support individuals living in their own home or in their own place [65]…[and]…Access to more resources and services around employment, education, around social engagement…" [66]
>
> …
>
> **…**supportive housing environments, supportive care environments so that people that are living independently can get some sort of supports in their home, increased efforts to increase employment opportunities for people with marginal work skills related to illness, financial systems that allow people to live in places where they're not subject to environments that have high drug rates or high criminal activity rates…[67]

Mr. Lurie connected the availability of opportunities to the issue of personal dignity by relating the comments of a friend who lived with schizophrenia and obtained work on a community research project: "That was the first time I didn't feel like a mental patient."[68]

Supporting people living with mental health in the community is therefore not just a matter of providing improved access to better equipped and trained family doctors and psychiatrists and access to medication. It is about people being able to live a meaningful life in the community:

> …people having choices about how they want to spend their time…having opportunities to connect with other people…having adequate and decent housing…having an adequate income…having a job…having access to a responsive service system. So that when they do have a difficulty, there is somebody at the end of the [telephone] line…or there is a team that they can see.[69]

Assertive Community Treatment Teams/ Intensive Care Management

Assertive community treatment teams (ACT) represent one type of resource for supporting persons living with mental illness in the community. They are "clinically indicated" for people who have a diagnosis of schizophrenia, the population that makes up the majority of ACT teams' clients.[70] ACT teams can "provide a comprehensive care system based on individual client needs."[71] An ACT team is multi-disciplinary with a psychiatrist, nursing staff, case management or community support workers, and can include an occupational therapist, employment specialist, and where appropriate, substance abuse counselors.[72] The concept is one of "bundling services for people living with serious mental illness in the community."[73] Members of the team can visit the client daily if necessary.[74] This permits the kind of "vigorous monitoring" in the community that a person with a severe, chronic mental illness should receive from the health care system.[75]

ACT teams can work with clients who are resistant to taking their medications to assist them in understanding the effects of their choices.[76] The essential feature of such teams is their ability to build and sustain a relationship with the client.[77] Where insight is an issue, as it often is for persons living with schizophrenia[78], relationship-building is critical.[79] The plan to be followed by the team must be focused on recovery and developed with the full participation of the client, reflecting what the client wants.[80]

Explaining to the Inquiry that the ACT team model "is probably one of the best researched examples of community care worldwide", Steven Lurie described its success:

> And what [the research] generally shows is that people with severe and persistent mental illness can live full productive lives in the community and can achieve dramatic reductions in hospitalizations through the intervention of the teams, and can achieve better outcomes in relation to housing and…employment.[81]

ACT clients often have "serious functional impairments affecting activities of daily living and an inability to meet basic survival needs."[82] They may also have a history of involvement in the criminal justice system or be at risk of involvement.[83]

The ACT team model achieves very good results with clients who are living with schizophrenia and are involved in the justice system.[84]

Another complimentary model of community support is intensive case management, which has been shown to achieve success through the development of a supportive, direct-service relationship between a mental health worker and the client. The trained mental health worker in consultation with the client will assess the client's needs and provide both direct support (e.g., cooking instruction, help finding employment) and connection to services. "…it's a combination of skills teaching, client-based advocacy and counseling."[85]

Citing the severity of his illness and the difficulty in getting him established on medications, Dr. Noone identified Mr. Hyde as someone who needed "an enhanced level of management in the community, which he described as "assertive case management."[86]

Both models of support – the ACT team model and intensive case management seem to be offered in the Capital Health District (Halifax Regional Municipality). The evidence established that Mr. Hyde was involved with an ACT team-like CDHA service, the SCOT team (Supported Community Outreach Team), in 2005.[87] The SCOT team is "a version of what we call an ACT team."[88]

The Capital District Health Authority SCOT Team "…is based on a model of supportive community treatment…the most intensive treatment team we have in the community…they provide fairly intensive services to individuals who have either fairly complex psychiatric needs or functional impairments in connection with their psychiatric needs."[89] I note that Dr. Jacqueline Kinley described the SCOT team as "more tracking than treating." [90] To assess whether the SCOT team offers what Steven Lurie described in his testimony as the most effective model, I would need to have heard evidence from the team itself which I did not.

The issue of medication compliance is one that the SCOT team deals with in providing services to clients.[91] The SCOT team also assists clients with their activities of daily living, navigating the health care system to get to appointments on time, and close monitoring of clients who are particularly vulnerable to decompensating because of their illness.[92] CDHA material describes the team's services as: "Based on the Assertive Community Treatment Model; multidisciplinary team approach; provides Intensive Case Management Services; 7 days a week service; individual assessment and flexible treatment and service planning; supportive counseling; direct assistance with medication and symptom management, medication monitoring and support, medical considerations; assistance obtaining and meeting basic needs; creating a supportive environment; direct teaching/management of life skills and development; assertive outreach and advocacy; rapid and flexible response to crises; partnership-education and support of family members and significant others…commitment to remain involved and supportive of the client over time." Steven Lurie indicated that Toronto, with a population of 2.5 million has 13 over-extended teams of this model which prompted him to suggest that the Halifax Regional Municipality with a population of 400,000 could use an additional team, "if not more."[93]

Intensive Case Management is also available in HRM. It was described to the Inquiry as a case-management service which is slightly less intense. "It might be once or twice a week versus daily…"[94] The case management team supports an individual to "access and navigate" the services they require to live as independently as possible in the community and they monitor and assess the individual to deter-

mine how the person is coping in terms of accessing services and managing their illness. The ultimate goal for the case manager and the client is support of the client to some stage of recovery and integration in the community.[95]

Asked about the mental health services offered in the Halifax Regional Municipality by the Capital District Health Authority, Steven Lurie responded by saying that "the salient question would be service volumes and wait lists." He went on to say:

> …this is not an unimpressive listing of services, but if they're full and you can't get in, or as we've seen in Ontario people are getting less service than they actually need, having a comprehensive list of services is a good starting point. But the question I would have is so is there a wait list for case management services? How many ACT teams do you have? What's the waiting time to get into ACT teams? What's the situation in relation to supportive housing? Are people able to access that? Because I think most mental health systems in Canada would say that in the last…10 to 15 years they have tried to develop this array of services but they would also say that the demand far exceeds the supply…[96]

This was Mr. Hyde's experience in 2004/2005 when it was several months before the SCOT team was able to add him to their case load. As Dr. Scott Theriault acknowledged about resources, "…that's not unusual in mental health services, generally, but all of the services have…a saturation point so they can only take on some many cases."[97]

Steven Lurie noting that seven out of ten people with mental illnesses in Ontario cannot get services, said: "And I can't imagine it's much better here in Nova Scotia."[98]

Accessing Services and Supports

Knowing what services are available and accessing them is a significant dimension of the problem for people looking for effective mental health care in the community.[99] It is also often a challenge for police officers who find they are the first point of contact for a person with a mental illness who needs help. Steven Lurie described the establishment in Toronto of a police access line staffed 24/7 that dispenses advice about available services. Clients can be connected directly to an access-line worker and entry to a crisis prevention programme can be facilitated.[100] Police officers who have used the telephone access line had found it to be very effective.[101]

Another relevant factor is whether there is a sufficient variety of services from which persons with mental illness can make a choice.[102] An ACT team or intensive case management may not suit some people who would rather engage with a peer-support programme.[103] Much more has to be available than just "the local hospital or nothing, or a case management program where you can wait two years to get in."[104]

Commenting on the services offered by the Capital District Health Authority, Steven Lurie observed:

> …you need much more of what you've handed me [the description of services from the CDHA website], and you need different ways of providing the services. For example, Mr. Hyde might not have gone to the clubhouse, but he might have gone to a peer run drop-in centre. He might have got-

ten involved in a community economic development service run by survivors.[105]

Mr. Lurie explained the difference between the Connections Clubhouse service offered through the CDHA and a peer-support programme, describing the Clubhouse model as collaboration between people living with mental illness and professional staff to create a supportive community. Mr. Hyde had enjoyed participating in the local Connections Clubhouse which offered him a place to get meals and socialize.[106] The Clubhouse "can be a very important base for people who have a broad range of service needs but may not need an ACT team."[107]

Peer support and "wellness rehabilitation action planning initiatives" offer services that may resonate with people less inclined to use more traditional support options:

> …if you can create a peer-led initiative where somebody knows what their triggers are, knows how to manage their symptoms, knows where to go [for] help, and also know that…because part of the crisis planning that's built into wellness rehabilitation action plans is the understanding that… I'm your friend or your relative and you don't appear to be using the supports you need but you appear to be getting into trouble, then I might have some responsibility to try and get you into care.[108]

Peer support can also be effectively built into an ACT team to offer the lived experience of mental illness and as a positive role model.[109] The Mental Health Commission of Canada has a study team looking into the issue of how peer support can be embedded into the mental health system in order to create

> …lots of opportunities for people not only to interact with…caring clinicians who can help them with their treatment or caring service providers who can provide the range of community services, but people who have actually been there, done that, have lived with mental illness and who can provide a role model and can provide support to people in their own context.[110]

The challenge of people not accessing available services in the community, perhaps because of past negative experiences, frustrations or disappointments can be addressed through "case finding", in other words, by way of outreach services that include a role for peer-support.[111]

Criminalization

It is important to appreciate that the incidence of violence amongst people with mental illness is relatively rare.[112] In the case of schizophrenia, which is not typically characterized by violence, it is substance abuse or anti-personality disorder – neither of which were issues for Mr. Hyde – that compound the disorder to create violence.[113] However the testimony of front-line police officers, and other evidence before the Inquiry made it clear that people having problems with their mental health in the community often find themselves "drawn into the justice system."[114]

Witnesses to the Inquiry made a direct link between the inadequacy of mental health services in the community and through the civil system and the criminalization of persons with mental illness.[115] It was Steven Lurie's view that:

> …we have failed in this country to provide an adequate array of mental health services that will both keep people out of the justice system and, when they get involved with the justice system, will respond adequately to their needs…and that will take a number of things. It will take increased funding, it will take a wider array of services and supports being available, and it will take…increased collaboration between the justice system and the mental health system to improve outcomes for people who are living with mental illness.[116]

For persons living with schizophrenia, "the critical issues are access to a full range of comprehensive support services, which tend to be lacking in many jurisdictions worldwide."[117] Steven Lurie referred to a "care deficit…[the failure] to invest sufficient resources in providing comprehensive services in the community to people who are living with mental illness."[118] Access to services in the community such as safe, affordable and supportive housing has been shown to dramatically reduce involvement in the justice system, psychiatric hospitalization and emergency department visits.[119]

The Inquiry also heard that reliance on coercion to gain treatment compliance from persons with mental illness is less likely to have a positive response from service users.[120] Personal autonomy is infringed by a coercive system for securing compliance: where the forensic system is engaged, the available services are accessed through criminalization. As Dr. Theriault explained:

> …in order to avail yourself of all that the forensic system has to offer…unfortunately, the ticket into the system…is through the courts which means through the criminal process.[121]

Steven Lurie identified mechanisms for diverting people away from the criminal justice system, through "pre-charge diversion and police crisis teams." As an alternative to the criminal process, case management and community support services can be engaged to provide "ongoing care or linkage to more specialized services so they don't get reinvolved."[122] In the words of a senior HRPS officer, minimizing criminalization "really is beneficial to all."[123]

Notes

1 Testimony of Karen Ellet, pages 188–189

2 Testimony of Karen Ellet, page 154

3 Testimony of Dr. Stephen Hucker, page 10085

4 See, Part II, Chapters 2 and 3

5 Exhibit 284

6 Testimony of Cst. Gyles Gillis, pages 257, 435

7 Exhibit 266, Letter from Dr. Stephen Hucker dated January 12, 2010 (supplemental report), page 1

8 Exhibit 266, Letter from Dr. Stephen Hucker dated January 12, 2010 (supplemental report), page 1

9 Testimony of Dr. Stephen Hucker, pages 10098–10099

10 Testimony of Dr. Joseph Noone, page 9306

11 Testimony of Dr. Joseph Noone, page 9307

12 Testimony of Dr. Joseph Noone, pages 9306–9307

13 Testimony of Dr. Stephen Hucker, page 10062. Dr. Noone also discusses this in his testimony at pages 9306–9307

14 Testimony of Dr. Stephen Hucker, pages 10065, 10066

15 Testimony of Dr. Scott Theriault, pages 9631–9632. Dr. Theriault noted that community treatment orders under the *Involuntary Psychiatric Treatment Act* operate as a "leverage system of care with different parameters [than the forensic process.]" (Testimony of Dr. Scott Theriault, page 9632)

16 Testimony of Dr. Stephen Hucker, page 10010

17 Testimony of Susan Hare, page 3738

18 Testimony of Susan Hare, page 3739

19 Testimony of Steven Lurie, page 10725

20 Testimony of Dr. Jacqueline Kinley, page 9864

21 Testimony of Dr. Stephen Hucker, page 10085

22 Testimony of Dr. Jacqueline Kinley, page 9853; and,"…in our programme…[medications are]…front-end treatments" (Testimony of Dr. Jacqueline Kinley, page 9830)

23 Testimony of Dr. Jacqueline Kinley, pages 9896–9897 describing how persons with mental illness who are "disregulated" can be regulated by their interaction with other people in a safe and supportive environment "instead of taking a pill…"

24 Testimony of Dr. Jacqueline Kinley, page 9852. When asked if she would accept in her intensive six-week integrated group psychotherapy programme a person with a twenty-year history with chronic schizophrenia (the questioner obviously contemplating Mr. Hyde), Dr. Kinley responded: "Absolutely."

25 Testimony of Dr. Jacqueline Kinley, page 9829

26 Testimony of Dr. Jacqueline Kinley, page 9853

27 Testimony of Dr. Stephen Hucker, page 10058

28 Testimony of Dr. Stephen Hucker, pages 10057–10058

29 Testimony of Dr. Stephen Hucker, page 10086

30 Testimony of Dr. Stephen Hucker, page 10086

31 Testimony of Dr. Jacqueline Kinley, pages 9831, 9832–9836 "All of our patients are able to get better…The challenge is they have to be willing…to do it." (Testimony of Dr. Jacqueline Kinley, page 9836) see also, pages 9881, 9884

32 Testimony of Dr. Jacqueline Kinley, page 9863

33 Testimony of Dr. Jacqueline Kinley, page 9861; see also, page 9859: "There's a concept of a therapeutic community which basically just speaks to the fact that if you set up an environment that is understanding, supportive, facilitative…people flourish. People do exceedingly well…"

34 Testimony of Steven Lurie, page 10770

35 See, for example, Testimony of Steven Lurie, pages 10773–10774, page 10613

36 Testimony of Dr. Sarban Singh, page 10421

37 Testimony of Dr. Sarban Singh, page 10422

38 Testimony of Dr. Sarban Singh, pages 10422–10423. Dr. Singh noted that in Scotland he could refer directly to the psychiatric hospital. (Testimony of Dr. Sarban Singh, page 10434)

39 Testimony of Dr. Sarban Singh, page 10433. Dr. Hucker testified that psychiatry does not appeal to most medical students and very few pursue the speciality. (Testimony of Dr. Stephen Hucker, page 10106)

40 Testimony of Dr. Stephen Hucker, page 10087. "He should have been followed regularly by a psychiatrist."

41 Dr. Hucker noted that Mr. Hyde had seen psychiatrists for periods of time. "The prob-

lem is when somebody decides they don't want to see the psychiatrist any more…you can only do so much."

42 Testimony of Dr. Jacqueline Kinley, page 9860

43 Testimony of Dr. Jacqueline Kinley, page 9860

44 Steven Lurie testified that 60% of Ontarians enter the mental health system through their family physician. "And most family physicians are reasonably hard pressed to deal effectively with mental illness, especially serious and persistent mental illness." (Testimony of Steven Lurie, page 10597)

45 Testimony of Dr. Scott Theriault, page 9717

46 Testimony of Dr. Stephen Hucker, page 10103

47 Testimony of Dr. Stephen Hucker, pages 10104–10105

48 Testimony of Dr. Jacqueline Kinley, pages 9874–9875

49 Testimony of Dr. Jacqueline Kinley, page 9891

50 Testimony of Dr. Sarban Singh, page 10461

51 Testimony of Dr. Sarban Singh, page 10462: The CDHA Community Mental Health interdisciplinary teams are, described on the CDHA website as teams that include clinicians and learners from nursing, psychology, occupational therapy, social work, psychiatry, and other health care professions. It is the position of the CDHA that "subject to ongoing resource limitations….continued promotion and advancement of this "shared care" model is a desireable basis for delivering psychiatric care in the community." (Final written submissions of CDHA, paragraph 94)

52 Testimony of Steven Lurie, page 10765

53 Testimony of Steven Lurie, pages 10713–10714

54 Testimony of Steven Lurie, page 10598

55 Testimony of Dr. Stephen Hucker, page 10087

56 Testimony of Dr. Stephen Hucker, page 10101; see also, Testimony of Dr. Jacqueline Kinley, page 9831: "…the challenge for us is when we discharge patients [from hospital] to make sure that the mental health system actually supports them."

57 Testimony of Dr. Stephen Hucker, page 10162; Testimony of Steven Lurie, page 10594: Mr. Lurie explained that even 100 years ago when society relied heavily on institutionalization to manage people with mental illness, a third of the patients in these institutions in Ontario stayed for three months or less. This illustrates that issues of providing appropriate community-based care are not new.

58 Testimony of Dr. Stephen Hucker, page 10180

59 Testimony of Cst. Kathryn Willett, page 3147

60 Testimony of Cst. Kathryn Willett, pages 3148–3149

61 Testimony of Cst. Kathryn Willett, pages 3152–3153

62 Testimony of Cst. Kathryn Willett, page 3157; see also, page 3055

63 Testimony of Cst. Gyles Gillis, page 390

64 Testimony of Cst. Gyles Gillis, page 391

65 Testimony of Susan Hare, page 3942

66 Testimony of Susan Hare, page 3946

67 Testimony of Dr. Scott Theriault, pages 9700–9701

68 Testimony of Steven Lurie, page 10763

69 Testimony of Steven Lurie, page 10596

70 Testimony of Steven Lurie, pages 10626–10627; see also, Testimony of Steven Lurie, page 10723, referring to the comparative ACT study in the materials he referenced during his testimony at the Inquiry: "International Comparative ACT Study Process and Data: How ACT teams compare in Toronto, Birmingham, Nashville and Auckland", The

71 Testimony of Steven Lurie, page 10724

72 Testimony of Steven Lurie, page 10620

73 Testimony of Steven Lurie, page 10620

74 Testimony of Steven Lurie, page10725

75 Testimony of Dr. Joseph Noone, pages 9241–9242

76 Testimony of Steven Lurie, page 10776

77 Testimony of Steven Lurie, page 10725

78 Testimony of Dr. Scott Theriault, pages 9715–0716

79 Testimony of Steven Lurie, pages 10725–10726

80 Testimony of Steven Lurie, page 10776

81 Testimony of Steven Lurie, pages 10620–10621. For example, ACT teams in Birmingham, England have been very effective at keeping people out of hospital and out of conflict with the law. (Testimony of Steven Lurie, page 10626) See also, Testimony of Steven Lurie, pages 10635–10637 referring to the 2006/07 Ontario ACT Data Outcome Monitoring Report, Ontario Technical Advisory Panel, Ministry of Health and Long-Term Care, February 2008 on the significant reduction in hospital days for ACT clients. Mr. Lurie pointed to the data showing an 85% reduction in ACT clients living in hospital and 62% less homelessness for these clients.

82 Testimony of Steven Lurie, page 10621

83 Testimony of Steven Lurie, page 10621

84 Testimony of Steven Lurie, page 10640

85 Testimony of Steven Lurie, pages 10719; see also, pages 10608–10609

86 Testimony of Dr. Joseph Noone, page 9206

87 See Part II, Chapter 3

88 Testimony of Dr. Scott Theriault, page 9623

89 Testimony of Susan Hare, page 3682

90 Testimony of Dr. Jacqueline Kinley, page 9892

91 Testimony of Susan Hare, page 3889

92 Testimony of Susan Hare, page 3889

93 Testimony of Steven Lurie, pages 10755–10756

94 Testimony of Susan Hare, page 3682

95 Testimony of Susan Hare, page 3683

96 Testimony of Steven Lurie, page 10754

97 Testimony of Dr. Scott Theriault, page 9623

98 Testimony of Steven Lurie, page 10762

99 Testimony of Steven Lurie, page 10727; Testimony of Dr. Stephen Hucker, page 10051

100 Testimony of Steven Lurie, page 10738

101 Testimony of Steven Lurie, page 10739

102 Testimony of Steven Lurie, page 10729

103 Testimony of Steven Lurie, page 10729

104 Testimony of Steven Lurie, page 10729

105 Testimony of Steven Lurie, pages 10762–10763

106 Testimony of Karen Ellet, page 189

107 Testimony of Steven Lurie, page 10758

108 Testimony of Steven Lurie, page 10771; Dr. Jacqueline Kinley also spoke about the

benefits of peer-support programmes. (Testimony of Dr. Jacqueline Kinley, page 9877) See, further, Testimony of Dr. Jacqueline Kinley, page 9862: "…patients can heal each other."

109 Testimony of Steven Lurie, page 10778. See Mr. Lurie's discussion of peer support specialists at pages 10653–10654

110 Testimony of Steven Lurie, page 10653

111 Testimony of Steven Lurie, page 10760; [Mental health services] need to be very proactive with the public, indicating how you can connect with mental health services, what services are available, where to go if you need help." (Testimony of Steven Lurie, page 10731)

112 Testimony of Steven Lurie, page 10662

113 Testimony of Dr. Stephen Hucker, page 10003; see also, *Winko v. British Columbia (Forensic Psychiatric Institute)*, [1999] S.C.J. No. 31, paragraphs 35–37

114 Testimony of Steven Lurie, pages 10661–10662

115 Testimony of Dr. Stephen Hucker, page 10063; Testimony of Steven Lurie, page 10692

116 Testimony of Steven Lurie, page 10692

117 Testimony of Steven Lurie, page 10590

118 Testimony of Steven Lurie, page 10593

119 Testimony of Steven Lurie, page 10612

120 Testimony of Dr. Stephen Hucker, page 10063; Testimony of Dr. Joseph Noone, page 9304; Testimony of Steven Lurie, page 10770: "As many jurisdictions and as the user movement worldwide is saying, we need to rely less on force and compulsion in terms of treatment…"

121 Testimony of Dr. Scott Theriault, page 9632

122 Testimony of Steven Lurie, page 10707

123 Testimony of Supt. William Moore, page 4029

Part V

Major Findings

PART V

Major Findings

These findings are a snapshot of the landscape through which the Inquiry travelled. I have identified them as the findings most relevant to the recommendations I make in Part VII of this Report. However, an understanding of what emerged from the evidence and what the Report has to say can be acquired only by reading the entire Report, notwithstanding the demands such an undertaking places on the reader.

These findings have been organized according to the events described in Part II, Factual Narrative, and Part III, Cause and Manner of Death. The evidentiary authority for the findings can be located in these earlier chapters. Findings that are grounded in the discussion of matters arising from the Inquiry's work (Part IV) are noted accordingly.

Howard Hyde's Mental Illness[1]

Howard Hyde had a long history of chronic and persistent mental illness. He had been diagnosed with schizophrenia and exhibited symptoms of paranoia, psychosis, agitation, disordered thoughts and a lack of insight when he was ill.

Mr. Hyde was very social, outgoing, friendly and popular, when well. He was intelligent and musically talented and had a wide range of interests.

Mr. Hyde had a history of non-compliance with the medications prescribed to manage his schizophrenia. He complained over the years about the side-effects of his medication. He had many contacts with the psychiatric health care system and was fearful of being hospitalized. He did not want to be treated against his will.

Mr. Hyde was keenly aware of the stigma associated with having a diagnosis of schizophrenia and understood that stigma was amplified by his involvement in the forensic system from 2002 - 2004.

Mr. Hyde's experience in January 2005 of being "tasered" by police had a profound effect on him. He never overcame his fear of the police as a result of this incident or the trauma of being "tasered."

Mr. Hyde's Mental Illness in November 2007[2]

By November 2007, Mr. Hyde had a history of being fearful that he would be deprived of his liberty, hospitalized and treated against his will.

It is most likely that Mr. Hyde stopped taking olanzapine by July 2007 and therefore by November 21, 2007 had been off this medication for approximately five months.

The medication he had more recently been taking was lorazepam, with that prescription running out in early November 2007.

By November 2007 the only support Mr. Hyde was receiving in the community was from his family doctor, Dr. Sarban Singh whom he saw infrequently. More extensive community and health care supports were essential for Mr. Hyde given the nature and severity of his illness.

By November 21, 2007, Mr. Hyde was experiencing a severe onset of his psychotic symptoms and was anxious, agitated, fearful and paranoid.

November 21, 2007 – At Albro Lake Road[3]

Ms. Ellet told 911 that Mr. Hyde would respond violently to any intervention and had a twenty-year history of behaviour similar to what he was exhibiting. She identified that he had mental health issues and had not been compliant with his medications.

The attending police officers, Csts. Gillis and Jardine, dealt appropriately with Ms. Ellet and were professional and responsive. They were told by Ms. Ellet that Mr. Hyde was "schizophrenic." When Cst. Edwards encountered Mr. Hyde in the parking lot and inquired over the radio whether he was "arrestable", he was told by Cst. Jardine that he was "very mentally unstable, so heads up."

The police officers acted appropriately in arresting Mr. Hyde for assaulting Ms. Ellet and taking him into custody.

Mr. Hyde was passive and cooperative with the police officers. They did not appreciate that he was experiencing a serious mental health crisis. Although the officers believed they did not have grounds to apprehend Mr. Hyde under the *Involuntary Psychiatric Treatment Act*, (IPTA) they could have done so on the basis of information provided by Ms. Ellet.[4]

There is no evidence that what Ms. Ellet told 911 was communicated to the police officers who attended at Albro Lake Road. If the information was conveyed to them, they also could have used it as a basis for apprehending Mr. Hyde under IPTA.

Mr. Hyde was experiencing a psychiatric emergency at Albro Lake Road. At no point did the psychiatric emergency end.[5]

Cst. Jardine was told by Ms. Ellet that Mr. Hyde had been "tasered" in the past. He was also told that Mr. Hyde was "paranoid of police". Csts. Gillis and Jardine did not communicate the information they had received about Mr. Hyde – that he had a diagnosis of schizophrenia, was off his medication and had been previously "tasered" – to Cst. Edwards who was in the process of transporting Mr. Hyde to Booking. It would have been relevant for the police officers in Booking to have known about Mr. Hyde's mental health issues in the context of dealing with him.

It would have been useful for the police officers in HRPS Booking to have had information that would have enabled them to reasonably infer that Mr. Hyde might be anxious in an encounter with police.

Although the police officers who responded to Albro Lake Road were appropriately

concerned with Ms. Ellet's safety, they would have benefitted from a much better understanding of the provisions of IPTA and their powers under IPTA.

It could have been better if Mr. Hyde had been transported to hospital for psychiatric care rather than taken to HRPS Booking. It is not possible to say it would have been better for this to have happened because, as subsequent events showed, doctors at the Emergency Department may have viewed a court-ordered psychiatric assessment as appropriate in view of Mr. Hyde's arrest. Even if the police had transported Mr. Hyde to the ER, he may not have been admitted for a psychiatric assessment and ended up in HRPS Booking in any event.

Clearer HRPS policy guidance on what can trigger the option of an IPTA apprehension by police would have been helpful to the police officers dealing with Mr. Hyde at Albro Lake Road.

The officers did not contact the MMHCT to assist in assessing and dealing with Mr. Hyde.

There was nothing to preclude the officers at Albro Lake Road on November 21 asking the Mobile Mental Health Crisis Team to attend.[6]

The MMHCT could have conducted a follow-up of Mr. Hyde while he was in police custody or at the QEII ER to determine if his mental health issues were being appropriately attended to but the Team assumed Mr. Hyde's illness would addressed through the criminal justice process.

There is no evidence that the MMHCT followed up on November 21 to see what had happened to Mr. Hyde.[7]

Training in dealing with persons with mental illness, the role and function of the MMHCT, police powers under IPTA, and crisis intervention techniques could have assisted Csts. Gillis, Jardine and Edwards in their interactions with Mr. Hyde and the decisions they made.

Transport to HRPS Booking, Arrival at Booking and the LiveScan Room[8]

There was an opportunity for Cst. Edwards to develop a rapport with Mr. Hyde and build a working alliance on the trip from Albro Lake Road to HRPS Booking.

Mr. Hyde was experiencing anxiety at HRPS Booking even before being led into the LiveScan room. He was in fact, "acutely anxious and stressed."[9]

There was an opportunity for Cst. Edwards to have tried to establish a rapport with Mr. Hyde in Booking before going into the LiveScan room.

It is reasonable to infer from the evidence that Mr. Hyde's memories of previous encounters with police and hospitalizations were contributing to him feeling anxious and vulnerable in HRPS Booking.

Although he did not complain, Mr. Hyde was unsuitably dressed in Booking wearing shorts, with no shirt and bare feet in the latter part of November.

Mr. Hyde paced and talked to himself in the HRPS Booking holding cell.

Cst. Edwards and S/Cst. Gregory MacCormick were not told by Csts. Gillis and Jardine what they had learned from Ms. Ellet, that Mr. Hyde had a diagnosis of schizophrenia and had stopped taking his medications.

Mr. Hyde was compliant with the officers in the LiveScan room until the lace-cutting tool was produced. The large, hinged blade was closed. S/Cst. MacCormick intended to use the small, fixed blade to cut the lace in Mr. Hyde's shorts before he was placed in cells.

S/Cst. MacCormick's unfortunate choice of words: "We'll have to cut one of those balls off" and Mr. Hyde's extreme anxiety and psychosis combined to create a state of terror in Mr. Hyde. He tried to get away from what he believed was a threatening situation.

S/Cst. MacCormick uttered the words: "We'll have to cut one of those balls off" innocently, with no appreciation of the effect they would have on Mr. Hyde.[10]

Mr. Hyde did not threaten or assault the police officers in the LiveScan room. Already paranoid about the police, and terrified, he simply tried to escape.

It is highly unlikely that S/Cst. MacCormick uttered words to Mr. Hyde in the LiveScan room that included something about a "fucking dance." It is likely that the words about a "fucking dance" were: "You are going to have me do the fucking dance." The most reasonable inference is that Mr. Hyde said those words, reflecting his perception that S/Cst. MacCormick was going to harm him.

There were opportunities to have established a rapport with Mr. Hyde in the LiveScan room and to have defused his anxieties about being in police custody.

Training in dealing with people with mental illness, the role and function of the MMHCT, and crisis intervention techniques could have assisted S/Cst. MacCormick and Cst. Edwards in dealing with Mr. Hyde in Booking.

The MMHCT could have been called to Booking on November 21 to assess Mr. Hyde.[11]

The Altercation in Booking/Use of the CEW[12]

When Mr. Hyde was wrestled to the floor by the Booking counter he repeatedly told the officers he was sorry. His saying this is audible on the unenhanced audio from the Booking surveillance footage.

By saying he was sorry, Mr. Hyde was trying to de-escalate the situation behind the Booking counter.[13]

It took Csts. Edwards and Mitchell one second to get Mr. Hyde to the floor by the Booking counter. S/Cst. MacCormick was not involved in trying to restrain him.

Csts. Edwards and Mitchell had been unable to control Mr. Hyde whom they found to be incredibly strong. He actively resisted having his hands cuffed behind his back.

The officers were focused on controlling Mr. Hyde so that he would not escape from the Booking area into the street [actually a parking lot] or get hold of items in Booking that could have been used as weapons.

During his struggle with the officers, Mr. Hyde did not try to reach for anything that could have been used by him as a weapon.

Mr. Hyde did not assault any of the police officers in Booking. Any physical contact with the officers was related to Mr. Hyde's terrified attempts to get away from the officers or ward off the CEW.

Twelve seconds after Mr. Hyde burst from the LiveScan room with the police officers grappling with him to prevent his escape, S/Cst. MacCormick was looking for a CEW in the area of the Booking counter. Eighteen seconds after Mr. Hyde was brought to the floor, S/Cst. MacCormick warned Csts. Edwards and Mitchell that he was going to deploy the weapon.

When S/Cst. MacCormick deployed the CEW, Csts. Edwards and Mitchell moved off Mr. Hyde, which permitted him to get to his feet.

Mr. Hyde experienced extreme pain and distress from being shocked by the CEW. Contrary to S/Cst. MacCormick's expectations, the CEW failed to incapacitate him. Mr. Hyde tried to fend off the weapon, and when this failed, he turned and scrambled over the Booking counter, running down the adjacent hallway to get away. It was only once he had been shocked several times with the CEW that Mr. Hyde tried to escape by going over the Booking counter.

The time from S/Cst. MacCormick's casual mention in the LiveScan room of having to "cut one of those balls off" and Mr. Hyde scrambling over the Booking counter was one minute.

The use of the CEW against Mr. Hyde escalated the situation and made it worse, prompting Mr. Hyde to clamber over the Booking counter.[14]

At no time in Booking was Mr. Hyde in a state of excited delirium.[15]

S/Cst. MacCormick was trained in the use of the CEW. He had no training in identifying or dealing with persons with a mental illness. He would not have known that someone like Mr. Hyde might fail to respond to direction or that the application of pain to a person with a mental illness would only serve to aggravate an already fraught situation. In Mr. Hyde's case it subjected an acutely anxious man to excruciating pain. "With mentally ill patients [pain] generally does worsen the situation."[16]

Although the use of the CEW on Mr. Hyde was in accordance with the training S/Cst. MacCormick had received and complied with existing use of force guidelines and HRPS policies, it was ill-advised.[17]

Despite the evidence of S/Cst. MacCormick and Cst. Edwards that knowing Mr. Hyde had been traumatized by a previous police tasering would have made no difference to how they dealt with him, I find that training in dealing with people experiencing an emotional disturbance and crisis intervention techniques likely would have influenced how the officers interacted with Mr. Hyde in Booking. Such

training would have helped the officers understand Mr. Hyde's behaviour and his comments from the time he entered the Booking area.

Training in crisis intervention techniques and dealing with persons experiencing an emotional disturbance could have better equipped the officers and led to a different outcome in Booking.[18]

The HRPS Booking Hallway and Mr. Hyde's Collapse[19]

Mr. Hyde tried to escape down the Booking hallway but turned before he reached the door to face the officers pursuing him. He continued to plead that he was "sorry" and "innocent."

Neither the video nor the audio evidence from the Booking hallway indicate that Mr. Hyde was being combative.

Mr. Hyde was shocked again by S/Cst. MacCormick and reacted in pain and distress.

Csts. Edward and Mitchell got Mr. Hyde to the floor of the Booking hallway in approximately four seconds. Mr. Hyde continued to struggle and resist being restrained. He did not intentionally assault any officers.

Mr. Hyde was restrained in a prone position on the floor in the Booking hallway with the assistance of police officers who arrived as back up. He still showed considerable strength by snapping a plastic zip tie that was placed around his ankles. He momentarily displaced from his legs S/Cst. MacCormick and Cst. Buchanan who had just applied the zip tie.

Immediately after this occurred, Mr. Hyde became unconscious. He appears to have stopped breathing. He had an obvious cyanosed appearance. S/Cst. MacCormick tried but could not locate a pulse.

The police officers engaged in restraining Mr. Hyde in the Booking hallway knew about the dangers of putting weight on the back of a person lying in a prone position, especially a person with a large abdomen like Mr. Hyde.

There is no evidence to indicate that significant pressure was placed on Mr. Hyde's prone body although various officers did physically restrain him, including one officer placing his foot on Mr. Hyde's back for 37 seconds in case he tried to roll over.

Cst. Michael Carter unhesitatingly began mouth-to-mouth resuscitation on Mr. Hyde without the benefit of a mask. This was highly professional. Cst. Carter's efforts were successful in reviving Mr. Hyde.

The struggles with Mr. Hyde although brief were intense. Excepting the ill-advised deployment of the CEW, the police officers' use of force at HRPS Booking was reasonable and proportionate and within training and use of force guidelines.

Attendance of EHS at Booking, Transport to the QEII Emergency and Admission[20]

During the period when Mr. Hyde lost consciousness, he lost control of his bladder.

When the paramedics arrived at HRPS Booking, Mr. Hyde was agitated. He was hyperventilating and had a fast heart rate.

Mr. Hyde's elevated heart rate of 170 – 210 beats per minute indicated supra-ventricular tachycardia (SVT). Upon arrival at hospital, Mr. Hyde's heart rate was about 120.

Mr. Hyde continued to be agitated during the ambulance ride and was not making much sense.

Admission to the QEII Emergency and Initial Assessment and Treatment[21]

When admitted to the QEII Emergency Department, Mr. Hyde was "certifiably mentally ill."[22]

A 10 mg dose of olanzapine was ordered by the ER physician, Dr. Curry, to provide Mr. Hyde with some rapid relief for his psychosis. Mr. Hyde settled well.

No one thought to seek Mr. Hyde's consent for the administration of the olanzapine. There was nothing that would have precluded asking for Mr. Hyde's consent and it would have been appropriate to do so. Mr. Hyde was very cooperative when permission was sought by the nurses to draw blood and take a blood pressure reading.[23]

The pressures of a busy Emergency Department limited what Dr. Curry had time to do. He did not speak to any of the paramedics (although the nursing staff did) and did not see their report which indicated that Mr. Hyde had had an irregular heartbeat. Dr. Curry assessed Mr. Hyde on the basis of his presentation when he examined him. A review of the blood screenings did not lead him to conclude that any additional tests of further blood work was needed.

The EKG results indicated that Mr. Hyde was not experiencing an acute cardiac event as a result of having been shocked with the CEW.

During Dr. Curry's shift, Mr. Hyde's heart rate slowed to an acceptable level. His vital signs were good.

Assessment at the QEII Emergency of Mr. Hyde's Psychiatric Condition and Needs[24]

Dr. Curry knew that Mr. Hyde had a diagnosis of schizophrenia, had been off his prescribed medication and had been "tasered" at HRPS Booking.

In Dr. Curry's opinion it was imperative for Mr. Hyde to have his psychiatric illness treated and "absolutely necessary" for him to receive a psychiatric assessment.

Dr. Curry did not contact the psychiatric resident on call to come in and assess Mr.

Hyde because he concluded there was no need to disturb either the resident or Mr. Hyde, who was resting, in the middle of the night, when Mr. Hyde could be assessed in the morning after a night of being stabilized.

A psychiatric consultation was requested for Mr. Hyde by someone in the ER although not by either of the two ER physicians on duty, Drs. Curry and MacIntyre. A psychiatric liaison nurse was scheduled to come on duty at 09:00, November 21.

There is no evidence to explain why neither Dr. Curry nor Dr. MacIntyre ordered a psychiatric consult for Mr. Hyde. It is reasonable to infer they did not do so because they believed he would be sent for a psychiatric assessment by the court when he appeared for arraignment.

Dr. Curry was under the impression that Mr. Hyde would be arraigned during a brief court appearance early in the morning and in all likelihood would be sent for a court-ordered psychiatric assessment. Dr. Curry was convinced that if this did not happen, Mr. Hyde would be returned to the ER for a hospital psychiatric assessment.

Dr. Curry did not involuntarily commit Mr. Hyde under the IPTA because he did not want the police to leave the hospital where they were maintaining custody over him.

When Dr. MacIntyre came on duty, Dr. Curry informed her about Mr. Hyde's altercation with the police in HRPS Booking, that he had been "tasered" and had collapsed apparently with no pulse, that he had a history of schizophrenia, was off his medications, appeared to be experiencing an acute psychosis and had received 10 mgs. of olanzapine.

Dr. Curry's discussion with Dr. MacIntyre at shift-change about Mr. Hyde being discharged from hospital to go to court was premised on Mr. Hyde being well enough to attend for a brief court appearance early in the morning and then getting appropriate psychiatric treatment.

Dr. Curry believed this would balance Mr. Hyde's needs with the priorities of the police and the criminal justice system.

Dr. Curry and Dr. MacIntyre discussed Mr. Hyde's need for a psychiatric assessment, to be obtained either through the court or by being returned to the ER. Both doctors assumed that if Mr. Hyde was not sent for a court-ordered psychiatric assessment, he would be returned to the ER.

Dr. Curry and Dr. MacIntyre did not discuss sending any medication with Mr. Hyde in the event he was discharged to attend court.

Dr. MacIntyre observed Mr. Hyde during the time he remained at the ER but did not speak to him directly. The reports from the nurses caring for him were good and he appeared to be settled.

Mr. Hyde had breakfast in the ER. He was not aggressive or agitated while in the ER.

The Issue of Mr. Hyde Going to Court[25]

The police wanted Mr. Hyde to be arraigned in court on the morning of November 21, if possible. About an hour after Mr. Hyde's arrival at the ER, a police officer approached Dr. Curry to ask whether he could be returned to Booking. At that time Mr. Hyde was not ready to be discharged from the hospital. Dr. Curry had no intention of discharging Mr. Hyde during his shift which ended at 04:00.

As a consequence of her contact with Cst. Haislip, Dr. MacIntyre felt a sense of urgency that Mr. Hyde attend court in the morning.

Cst. Haislip was told by S/Sgt. Fox that Mr. Hyde had been brought to the ER for physical not psychiatric issues. S/Sgt. Fox instructed Cst. Haislip that if Mr. Hyde was medically stable and medically cleared, the police had a duty to get him to court. I accept Cst. Haislip's testimony and find it was this communication from Cst. Haislip's superior that, through Cst. Haislip, imparted the message to Dr. MacIntyre that the police were hoping to get Mr. Hyde returned to their custody for court that morning. Cst. Haislip told Dr. MacIntyre that the police had a duty to get Mr. Hyde to court within 24 hours of his arrest.

Dr. MacIntyre believed that it was very probable that Mr. Hyde would be sent for a court-ordered assessment. She relied on Cst. Haislip's opinion that it was highly likely this would happen and understood that he had confirmed this with a supervising officer.

Cst. Haislip spoke with and was assured by S/Sgt. Fox that Mr. Hyde could be returned to the ER from court provided the HIT Form was filled out accordingly. S/Sgt. Fox appears to have been under the mistaken impression that Mr. Hyde could be taken back to the ER if he wasn't sent for a court-ordered assessment.

Cst. Haislip knew the police would have no authority over Mr. Hyde once he was transferred out of police custody but he assumed a peace officer could return him to the hospital. He relied on S/Sgt. Fox's assurance that Mr. Hyde could be returned to the ER. He did not tell Dr. MacIntyre that the police would not have the authority to bring him back once he would no longer be in police custody.

Cst. Haislip was confused by Dr. MacIntyre's HIT Form direction but he did not reflect his confusion in his notes. He was confident that Mr. Hyde would get a psychiatric assessment which he believed would be done at the CNSCF once Mr. Hyde arrived there. Cst. Haislip was not aware that there are no psychiatrists at the CNSCF.

It was Dr. MacIntyre's opinion that Mr. Hyde needed appropriate psychiatric care, either in a hospital or a forensic psychiatric unit, rather than a jail. Dr. MacIntyre believed: a court-ordered assessment would achieve her goal of having Mr. Hyde receive the psychiatric care he required; a forensic psychiatric assessment was a full substitute for an in-hospital psychiatric assessment through the QEII in terms of the care and treatment Mr. Hyde would receive; and that Mr. Hyde would be placed in a psychiatric facility with trained professionals without much delay, assessed and given appropriate care for his psychiatric illness.

The evidence indicates that front-line and senior police officers also believe a *Crim-*

inal Code forensic psychiatric assessment and an in-hospital assessment are the same.[26]

Dr. MacIntyre did not think Mr. Hyde would be safe in jail without being under psychiatric care.

Like Dr. Curry, Dr. MacIntyre wanted to try and satisfy co-existing objectives: Mr. Hyde's need for psychiatric assessment and care and the police's interest in getting him to court.

Dr. MacIntyre would not have discharged Mr. Hyde from hospital if she had known that the police would be unable to return him to the ER if he was not sent for a court-ordered assessment. Had she known that the police lacked the authority to return him after his court appearance, she would have kept him at the hospital and ordered an in-house assessment.

Dr. MacIntyre would not have discharged Mr. Hyde from hospital if she had known that the police were intending to take him to Booking rather than directly to court.

Because Dr. MacIntyre believed Mr. Hyde would be making an immediate and brief appearance in court, and would then be in the care of a psychiatrist either due to being sent for a forensic psychiatric assessment or being returned to the ER, she did not discharge Mr. Hyde with any further psychiatric medication. She thought it was more appropriate for his psychiatric team to determine what medication he should receive.

Mr. Hyde did not need a forensic psychiatric assessment pursuant to section 672.12 of the *Criminal Code*. He needed a psychiatric assessment, as would have been available through the QEII Emergency Department, for the purpose of determining how to address his current mental health issues.[27]

Had Mr. Hyde remained at the ER, the psychiatric consult request would have resulted in him being seen by the psychiatric liaison nurse on the morning of November 21.[28]

The Health Information Transfer (HIT) Form[29]

Dr. MacIntyre insisted upon completing a Health Information Transfer Form before discharging Mr. Hyde into police custody.

The Form provided to her was faxed from HRPS Booking and was an out-dated version of the Form from 2001. The Form had been revised in 2006.

While it would have been preferable for the most recent version of the HIT Form to have been available to Dr. MacIntyre, nothing turns on the fact that she was provided with, and completed, the 2001 form.

When Dr. MacIntyre reassessed Mr. Hyde at 09:20 on November 21 she concluded that he was medically stable both physically and mentally but still had ongoing psychiatric issues – schizophrenia and psychosis - that required assessment and treatment. She believed she was discharging him to a safe environment where he would receive the psychiatric care he needed.

Dr. MacIntyre did not indicate on the HIT Form that Mr. Hyde had received a 10 mg. dose of olanzapine at 02:50 on November 21. I think it is most likely that in a busy ER dealing with a situation where there was police involvement and a pending court appearance, Dr. MacIntyre simply forgot to note the olanzapine injection that had been administered before she came on duty.[30]

With her direction on the HIT Form - **"Patient discharged in police custody for court appearance. If patient not sent for forensic psychiatric assessment police are to return patient to Emergency Department."** – Dr. MacIntyre was trying to maintain control over what happened to Mr. Hyde in the event he was not sent for a court-ordered assessment.

Dr. MacIntyre did not indicate on the HIT Form a time when the psychiatric assessment should be done. She assumed Mr. Hyde would be returned to the ER in a timely manner if he was not sent for a court-ordered assessment.

Dr. MacIntyre believed it was the police who would be responsible for returning Mr. Hyde to the ER if he was not sent for a court-ordered assessment.

Dr. Michael Howlett, qualified by the Inquiry as an expert in emergency medicine, held the same erroneous view.[31]

The police should have informed Dr. MacIntyre as soon as it was determined that they lacked the authority to return Mr. Hyde once he left their custody.[32]

Dr. MacIntyre did not properly understand the purpose of the HIT Form.

The HIT Form is not "a form of doctor's orders." It cannot trump an order from the court remanding a prisoner to a correctional facility.[33]

There is no evidence that the police receive any training in relation to the HIT Form.[34]

Dr. MacIntyre believed that the information on Mr. Hyde's HIT Form indicating he had schizophrenia and psychosis would be communicated by the police to the Crown. Dr. Curry also believed that the court would be informed about Mr. Hyde's psychiatric issues.

Dr. MacIntyre did not provide any specific instructions to the ER charge nurse about what was to take place should Mr. Hyde be returned to the ER.

Cst. Hillier, Cst. Haislip's partner at the hospital, was tasked with making the Versadex report entry for their shift and did not indicate anything about Dr. MacIntyre's HIT Form direction. It is highly probable that Cst. Hillier knew from Cst. Haislip what was on the HIT Form.

Police Contact with Mr. Hyde at the QEII Emergency[35]

While guarding Mr. Hyde at the hospital during the early morning hours of November 21, Csts. Gillis and Jardine engaged in conversation with him and tried to comfort and reassure him.

Mr. Hyde told the officers that what had happened in Booking (the presentation of

the lace-cutting tool and being shocked by the CEW) had terrified him.

Mr. Hyde was not at all violent or disruptive at the hospital.

Neither Cst. Gillis nor Cst. Jardine made any entries in the Versadex system about Mr. Hyde receiving an injection of olanzapine or needing to be seen by a mental health professional or that he could alternate between being lucid and being incoherent. Such information could have been helpful to people in the justice system who dealt with Mr. Hyde later on.

Back in HRPS Booking [36]

Mr. Hyde was friendly and cooperative on his return to Booking from the hospital. He was fingerprinted and photographed without incident.

About an hour after his return to Booking at 09:30, Mr. Hyde started to become more agitated and vocal. The injection of olanzapine given at 02:50 at the ER was wearing off by this time.

S/Cst. Fraser assumed Mr. Hyde had had some that was losing its effect. He assumed the doctor responsible for Mr. Hyde being medicated at the hospital would have known it would wear off and would have provided medication to accompany Mr. Hyde if she felt it was required. He did not know that Dr. MacIntyre had not discharged Mr. Hyde with any medication because she believed he would be receiving psychiatric care in a timely fashion once he went to court that morning.

Mr. Hyde was agitated about what had happened to him in Booking the previous night. S/Cst. Fraser reassured him that there was a new shift on duty in Booking and talked to him about his impending court appearance. He was successful in calming Mr. Hyde down.

The MMHCT could have been called to assess Mr. Hyde in Booking.[37]

The Significance of Mr. Hyde Being Discharged from Hospital

The discharge of Mr. Hyde from the ER, medically clearing him to be processed by the criminal justice system indicated to the police, sheriffs and correctional officers who dealt with him that there were no urgent health issues to be addressed, notwithstanding Dr. MacIntyre's direction on the HIT Form.

S/Cst. Dan Fraser in Booking on the morning of November 21 assumed that, having been discharged from the ER with a HIT Form, Mr. Hyde was "safe to go to cells and safe to go to court."[38]

HRPS Booking and the HIT Form Direction[39]

S/Cst. Fraser would not have accepted Mr. Hyde into custody at Booking had he thought there were any outstanding urgent health issues. In that event, Mr. Hyde would have been returned to the hospital.

S/Cst. Fraser assumed that Mr. Hyde would either be sent for a court-ordered as-

sessment or returned to the QEII in accordance with Dr. MacIntyre's HIT Form direction. He knew the police would not have the authority to return Mr. Hyde to the hospital once he was no longer in police custody and assumed that the sheriffs' department or corrections would do so.

Mr. Hyde's Transport to Court[40]

Cst. Willett read the information on the HIT Form, including Dr. MacIntyre's direction but knew she did not have the authority to transport Mr. Hyde back to the ER if he was not in police custody.

She saw no grounds in Mr. Hyde's behaviour to invoke the IPTA. Although a little agitated, Mr. Hyde was was cooperative and followed directions well. Cst. Willett had been informed about the altercation in Booking the previous night and was vigilant for any indications that Mr. Hyde was unraveling again.

Cst. Willett was not told that Cst. Haislip and S/Cst. Fraser understood that Dr. MacIntyre expected someone in the justice system, not necessarily the police, to return Mr. Hyde to the hospital if the court did not send him for a forensic psychiatric assessment.

Cst. Willett did not understand why Mr. Hyde had been discharged from the hospital if he still needed a psychiatric assessment. She found the HIT Form to be "almost contradictory"; clearing Mr. Hyde medically but requiring him back for a psychiatric assessment.

Cst. Willett expected Mr. Hyde would be remanded into custody.

At the Dartmouth Courthouse Cells[41]

When they transported Mr. Hyde into the custody of the Dartmouth sheriffs on the afternoon of November 21, Cst. Willett, and her partner Cst. David Smith, took care to pass on the information they had about him to Deputy Sheriff Shirley Day – that he had been "tasered", his heart had stopped and he had been taken to hospital.

D/S Day made an immediate attempt to connect with Mr. Hyde and establish a rapport. Mr. Hyde's behaviour indicated that he was nervous and overwhelmed.

D/S Day looked over Mr. Hyde's HIT Form. In light of what the transporting officers had said, she was concerned that Mr. Hyde might have heart problems. She wanted to know what medications he might be on.

Mr. Hyde told D/S Day that he was not taking his medication which she thought might be for a cardiac condition.

There was nothing on the HIT Form to tell D/S Day that Mr. Hyde had been given a dose of olanzapine 24 hours earlier.

D/S Day assigned D/S Crook, who was known to be very compassionate with prisoners, to talk with Mr. Hyde alone in a cell. Mr. Hyde was scared and confused. His distracted and disjointed thinking made it difficult for D/S Crook to connect with him.

Notwithstanding Mr. Hyde's significant mental health issues, Deputy Sheriffs Shirley Day and James Crook were able to manage his anxiety and maintain his equilibrium. Using an approach that was calming and reassuring, these officers helped Mr. Hyde deal with the stress of his court appearance and the news that he would not be released on bail and would spend the night in custody.[42]

However, had the officers needed some assistance with Mr. Hyde, they would not have known to contact the Mobile Mental Health Crisis Team, whose services were available to them.[43]

D/S Day properly maintained the confidentiality of Mr. Hyde's health information in the HIT Form. She told duty counsel, Peter Planetta, that Mr. Hyde had mental health issues and had not been taking his medication. She was concerned about Mr. Hyde's wellbeing and wanted him dealt with sooner rather than later in the court's afternoon docket.

In accordance with her obligation to safeguard the confidentiality of Mr. Hyde's HIT Form information, D/S Day did not inform the Crown of the contents of the Form.

D/S Day acted appropriately in dealing with the confidential contents of Mr. Hyde's HIT Form.

The sheriffs' officers who testified at the Inquiry showed a strong understanding of the HIT Form, its purpose and function.[44]

D/S Day knew that Sheriffs' Services did not have the authority to transport Mr. Hyde back to the ER if he was released from custody. She did not consider calling the hospital to get clarification of Dr. MacIntyre's HIT Form directive.

D/S Day knew the HIT Form would accompany Mr. Hyde to the CSNCF and would be reviewed there before the CNSCF would take over custody of Mr. Hyde from Sheriffs' Services.

During his time in the Dartmouth courthouse cells, Mr. Hyde did not present in a manner that caused the Dartmouth sheriffs to consider having him transported to the ER.

Mr. Hyde's Arraignment and the Issue of Bail[45]

Mr. Hyde was arraigned in the late afternoon of November 21 on charges of assaulting Ms. Ellet, resisting Csts. Edwards and Mitchell and S/Cst. MacCormick, and escaping lawful custody.

The position of Crown counsel, Cheryl Byard, on the issue of bail was that Mr. Hyde could be released on a recognizance with a surety pledging $1500 of personal property. Ms. Byard did not want Mr. Hyde being able to go back to Albro Lake Road. She was concerned about Ms. Ellet's safety.

As no surety could be arranged on November 21, the issue of Mr. Hyde's bail had to be adjourned to the next morning on the basis of a consent remand.

The requirement for a surety potentially represented a significant barrier to Mr.

Hyde's release, although the court, by way of a bail hearing may have set less onerous conditions.[46]

Ms. Byard knew from the Crown file that Mr. Hyde had a diagnosis of schizophrenia. She gave no consideration to asking the court for a forensic psychiatric assessment of Mr. Hyde. She did not see any basis for doing so. There was nothing that red-flagged Mr. Hyde's mental health issues for Ms. Byard.

The fact of the hospital discharging Mr. Hyde for court was significant to Ms. Byard.

Had Ms. Byard seen Dr. MacIntyre's notation on the HIT Form or the references to "schizophrenia/psychosis", "aggression toward others", and "potential for self-harm" she still would not have sought a forensic psychiatric assessment or called upon the doctor to come and testify in support of obtaining one because the Form did not recommend such an assessment. However she would have asked the police to clarify with the doctor why she was recommending that Mr. Hyde should be returned to the hospital when he had been medically cleared.

Mr. Planetta did not have instructions to seek a court-ordered assessment. He would only seek one if he had instructions to do so. When representing Mr. Hyde on November 21 he acted in accordance with his instructions.

The notations on Mr. Hyde's HIT Form, even if the Crown and/or Mr. Planetta had seen them, would not have stirred their concerns about Mr. Hyde being remanded to the CNSCF. Mr. Planetta would have been influenced by the fact that Mr. Hyde had been medically cleared by the hospital.

Admission to the CNSCF[47]

The CNSCF Admitting officer, Correctional Officer Christopher Dixon learned from D/S Crook that Mr. Hyde had a mental illness, was off his medication, had been in a significant struggle with police and had been medically cleared after a visit to the hospital. He passed this information on to Health Care.

C/O Dixon made a deliberate assessment of Mr. Hyde's state of mind by speaking to him when he got out of the Sheriffs' van. He thought Mr. Hyde seemed fine. Even so, in light of what D/S Crook had told him, he had already decided that Mr. Hyde should be placed in one of the Health Segregation cells overnight. This would mean Mr. Hyde would be the subject of more regular checks through the night by correctional staff.

The Health Segregation cells are nothing more than jail cells.

C/O Dixon did not have the authority to send a prisoner directly to the Mentally Ill Offender Unit (MIOU) located in the co-located East Coast Forensic Hospital.

Mr. Hyde was given a bag lunch on his admission to the CNSCF. This was around 17:00. There is no evidence Mr. Hyde had anything to eat in the previous ten hours.

Mr. Hyde exhibited "bizarre" behaviour during his twenty minute Admissions interview but was mostly lucid and compliant.

Mr. Hyde's Health Assessment admission interview took five minutes. Sandra

McLeod, the acting admissions nurse, saw no signs of psychosis. Mr. Hyde was cooperative and answered her questions appropriately.

The triage-length Health Assessment interview did not ascertain how ill Mr. Hyde was. Mr. Hyde was in fact, very ill: he was "very tenuously maintained" on a low, depreciating, dose of olanzapine.[48]

Nurse McLeod obtained information from Mr. Hyde that he had been prescribed olanzapine and she called his pharmacy for verification. From this call she learned that Mr. Hyde's last olanzapine prescription had been a thirty-day prescription ordered on June 26, 2007.

Records from the QEII containing the information that Mr. Hyde had received a 10 mg dose of olanzapine in the ER did not arrive at the CNSCF until Nurse McLeod had gone off shift.

Nurse McLeod was not concerned that Mr. Hyde needed medication. She could not have obtained medication for Mr. Hyde without a prescription.

Nurse McLeod reviewed Mr. Hyde's HIT Form. She had never before seen anything like Dr. MacIntyre's direction. The direction did not constitute a doctor's order.

Nurse McLeod called the MIOU to see if they were expecting Mr. Hyde for the purposes of a forensic assessment, which they weren't.

Nurse McLeod had Maureen Walford, a member of the OHU clerical staff, call the QEII ER to confirm that Mr. Hyde had been medically cleared.

When Ms. Walford read Dr. MacIntyre's HIT Form direction to the ER charge nurse, Glenda Keyes, Nurse Keyes advised that Mr. Hyde did not need to return to the ER. Ms. Walford emphasized that Mr. Hyde was in a jail and not receiving any psychiatric services. She was told: "He doesn't have to be returned."

Nurse Keyes did not inform Ms. Walford that Mr. Hyde had been given a 10 mg. dose of olanzapine at the ER.

There is no evidence that Nurse Keyes knew what was on the HIT Form. It can be inferred from the evidence that Dr. MacIntyre did not inform Nurse Keyes of her opinion that Mr. Hyde would not be safe in jail and urgently needed psychiatric assessment and care.[49]

Nurse McLeod had no authority to send Mr. Hyde back to the ER where she had assessed him as not being acutely ill.

She did not consider Mr. Hyde to be "unfit for detention" and was prepared to contact the on-call physician the next morning about a referral to a psychiatrist if Mr. Hyde returned to the CNSCF from court.

Nurse McLeod told Mr. Hyde that if he needed to speak to a nurse through the night he could tell the correctional staff.

Before she went off shift, Nurse McLeod spoke with Ken Murray, the PRAXES employee on duty for the night telling him that Mr. Hyde had a history of schizophrenia and had been "tasered."

Nurse McLeod provided no instructions to any of the correctional officers about what to look for in the case of a prisoner with psychosis. She had some experience from working at the ECFH with persons diagnosed with schizophrenia who were not taking their medication and knew there could be mood and behavioural changes including increased aggression and violence, confusion and delusions.

Karen Ellet called the CNSCF around 20:00 to tell them how ill Mr. Hyde was and that she thought he should be getting proper medical treatment for his psychosis. There is no evidence that whatever information she passed on to the correctional employee she spoke to was ever communicated to anyone at the institution. It should have been.

Overnight in the Health Segregation Cell (November 21/22)[50]

None of the correctional officers who monitored Mr. Hyde through the night of November 21/22 had any training in relation to mental health issues.

The correctional officers were not informed that Mr. Hyde was in a Health Segregation cell because he had mental health issues.

Being given a glass of juice at approximately 19:30/20:00 was the only face-to-face contact Mr. Hyde had with anyone until 07:40 on November 22 when he was handed a bag breakfast.

Mr. Hyde was observed pacing and yelling in his cell throughout the night. He barely slept at all.

With the exception of C/O Stephen Kayongo, the extent of Mr. Hyde's relentless pacing through the night of November 21/22 was either not fully appreciated by health care and correctional staff or it was simply not seen as requiring an urgent, or indeed any, response.[51]

Generally speaking, pacing and shouting are such commonplace behaviours in the correctional setting that they have become normalized and staff habituated to them. Although they can indicate a psychotic episode, correctional officers regard them as very common behaviours and not a cue for a mental health crisis.[52]

Correctional officer Stephen Kayongo was sufficiently concerned by his observations of Mr. Hyde's behaviour that he spoke to his captain and the PRAXES employee, Ken Murray. His concerns developed early on: he spoke with Mr. Murray by 20:00 – 20:15.

Mr. Murray knew that Mr. Hyde had a diagnosis of schizophrenia.

Mr. Murray spoke very briefly with Mr. Hyde through the door of the cell. He could have asked to speak with Mr. Hyde in the cell with C/O Kayongo providing security.

Mr. Murray formed the impression that Mr. Hyde was "very apprehensive and scared."

Mr. Murray determined that Mr. Hyde was not in need of emergency medical assistance based on: (1) his own assessment; (2) the fact that Mr. Hyde had been

medically cleared by a doctor for release from hospital; and (3) the fact that Mr. Hyde had been assessed by a Health Care nurse at the time of his admission to the CNSCF.

Mr. Murray believed that Mr. Hyde's mental health issues would be dealt with the next day.

The "assessment" Mr. Hyde received from PRAXES in response to C/O Kayongo's concerns was wholly inadequate. There is no in-house training for PRAXES employees on dealing with prisoners with mental illnesses.[53]

All of the correctional officers tasked with monitoring Mr. Hyde's cell were diligent about doing so. In addition to C/O Kayongo, on subsequent shifts, Correctional Officers Morris and Digout also observed Mr. Hyde behaving in a peculiar way.

However monitoring Mr. Hyde closely with no clear understanding of what was being observed was not what he needed so much as human contact and appropriate, compassionate intervention by a properly trained health care professional.[54]

The evidence does not support a finding that Mr. Hyde activated the intercom in his cell during the night.

It is highly likely, in my opinion, that if a properly trained health care professional had met with Mr. Hyde during the night he spent in the Health Segregation cell, the severity of his illness would have been apparent. Proper consideration could then have been given to whether Mr. Hyde was well enough to attend court in the morning and most importantly, whether he should be receiving psychiatric care on an urgent basis. The evidence indicates the urgency of that need would have been obvious.[55]

Going to Court – The Morning Escort of Howard Hyde (November 22, 2007)[56]

The correctional officers escorting Mr. Hyde on the morning of November 22, Peter Lloyd and Renee Jones, did not know that Mr. Hyde had been displaying signs of mental illness through the night. They did not know he had a serious mental illness and was off his medications.

It would have been helpful to the officers to have had information concerning the symptoms of mental illness they should be aware of in Mr. Hyde's case such as paranoia, anxiety, agitation, and disordered thinking.

C/O Jones would have tried to communicate with Mr. Hyde and establish a rapport had she known about his mental health issues and the "tasering".

C/O's Lloyd and Jones had no training in mental health issues or crisis intervention techniques.

When Mr. Hyde balked at the top of the long hallway to Admissions and would not proceed, C/O Lloyd recognized atypical anxieties and tried to reassure and encourage him.

C/O Lloyd saw it as his responsibility to get Mr. Hyde to Admissions for transport

to court that morning, notwithstanding his strange behaviour at the top of the long hallway.

When called back to the top of the long hallway by C/O Lloyd, C/O Jones viewed her role as assisting C/O Lloyd get Mr. Hyde to court. Despite their joint encouragement Mr. Hyde would not budge. He was afraid.

C/O Lloyd and C/O Jones tried to "herd" Mr. Hyde into the long hallway. Mr. Hyde abruptly veered away from them to avoid being taken down the hallway.

Mr. Hyde was "physically uncooperative" or "actively resistant" at this point.[57]

The video surveillance evidence indicated that C/O Lloyd spent 37 seconds trying to direct Mr. Hyde down the hallway to Admissions before turning to get C/O Jones to help. Five seconds after C/O Jones re-appears to assist C/O Lloyd, the officers attempted to "herd" Mr. Hyde down the hall. He veered sharply away from them and attempted to get away. He was motivated to do so by fear of the long hallway.

Crisis intervention techniques, including those that employ alternative strategies for dealing with prisoners experiencing an emotional disturbance, and a de-escalation of Mr. Hyde's fears could have avoided a physical altercation with him.[58]

The Struggle at the Top of the Long Hallway[59]

Once Mr. Hyde tried to escape from them, C/O's Lloyd and Jones had no choice but to restrain him and prevent him from getting away. They could not risk him being on the loose in the institution.

Mr. Hyde put up a strenuous struggle with C/O Lloyd and Jones. He was very strong and vigorously resisted being restrained.

It took C/O's Lloyd and Jones four seconds to bring Mr. Hyde to the floor. The force used by C/O's Lloyd and Jones was sufficient to achieve their objectives of preventing him from getting away.

Other correctional officers who intervened helped to get Mr. Hyde handcuffed in a matter of a few seconds. It took one minute from the time Mr. Hyde's legs were restrained to standing him up for the escort down the hallway.

Once brought to his feet, Mr. Hyde was shouting out statements that made no sense. He was rambling.

The High-Profile Escort of Mr. Hyde to Search Cell #2[60]

Mr. Hyde did not struggle during the high-profile escort.

He was very vocal, making loud, "nonsensical" statements. He repeated a theme he had emphasized with the police the previous day: "I'm an innocent man, you can't do this to me."

C/O Lloyd recognized that Mr. Hyde was delusional and tried to orient him to time and place, telling him where he was being taken.

Other correctional officers, including the most senior one on the scene, then Sgt.

(now Captain) Todd Henwood, noticed Mr. Hyde's bizarre utterances. Cpt. Henwood thought Mr. Hyde might have a mental illness.

Had Cpt. Henwood known about Mr. Hyde having a diagnosis of schizophrenia, the fact he was not taking his medication and the symptoms of mental illness he had shown through the night, he would have established more contact with Mr. Hyde and tried to "defuse" the situation.

Neither Cpt. Henwood nor the other correctional officers who responded to the struggle at the top of the long hallway had any training in mental health issues or crisis intervention techniques.

The Struggle in Search Cell #2 and Mr. Hyde's Collapse[61]

Even though Mr. Hyde's anxieties erupted again at the door of Search Cell #2, the escorting correctional officers were able to forcibly hustle Mr. Hyde into the cell in a matter of seconds.

There was a struggle in the cell with Mr. Hyde "hollering [and] shouting" and vigorously resisting the officers' efforts to restrain him.

Mr. Hyde was "proned out" on the floor of the search cell by four correctional officers in six seconds. He continued to yell that he was innocent and shouldn't be going to court.

Mr. Hyde was very strong and did not seem to tire but he was unable to overpower the officers. The techniques used to control him were standard use of force procedures established through policy.

The struggle with Mr. Hyde inside the search cell lasted approximately two and a half minutes.

It required "very minimum force" to keep Mr. Hyde down on the floor once his legs were restrained and he was in a fully proned position.

The goal in the search cell was to restrain Mr. Hyde and get him ready to be transported to court.

Cpt. Henwood tried to calm Mr. Hyde down by talking to him. He asked Mr. Hyde if he was going to calm down.

Mr. Hyde said he would.

Mr. Hyde went limp and became cyanosed within seconds of agreeing to comply. He lost control of his bladder.

Cpt. Henwood started to remove Mr. Hyde's handcuffs because he could see Mr. Hyde was in trouble.

Mr. Hyde had stopped breathing.

It is unlikely that Cpt. Henwood found a pulse when he tried to check for one.

Nursing staff from the OHU arrived in the cell just over a minute after Mr. Hyde's

handcuffs were removed. They could not find a pulse. They started CPR. By this time Mr. Hyde had been in the search cell for less than six minutes.

There was no unreasonable delay in initiating CPR.

The correctional officers' use of force at the top of the long hallway and in search cell #2 was reasonable and proportionate and within training and use of force guidelines.

EHS and the Dartmouth General Hospital[62]

Nursing staff performed CPR on Mr. Hyde for about 10 minutes before EHS arrived.

Mr. Hyde did not regain consciousness or take a breath.

The nurses had a defibrillator but Mr. Hyde had no shock-able heart rhythm.

EHS connected Mr. Hyde to a cardiac monitor. He was asystole, no cardiac rhythm.

Mr. Hyde remained aystole.

The CNSCF nursing staff and EHS did everything they could to revive Mr. Hyde.

An ultrasound of Mr. Hyde's heart at the Dartmouth General Hospital showed no cardiac movement at all. Mr. Hyde was pronounced dead at the hospital at 08:42 on November 22, 2007.

Cause of Death[63]

The cause of Mr. Hyde's death was not "excited delirium due to paranoid schizophrenia."

At no time during November 21 or 22 was Mr. Hyde in a state of "excited delirium."

Mr. Hyde's death was not caused by: blunt force injuries, coronary artherosclerosis, the Conducted Energy Weapon or positional asphyxia.

Mr. Hyde's rib fractures identified at autopsy were caused by the chest compressions applied in CPR.

Mr. Hyde died because of physiological changes in his body brought on by an intense struggle involving restraint.

Manner of Death[64]

The manner of Mr. Hyde's death was accidental.

Notes

1 Part II, Chapter 2, Howard Hyde's Mental Health History – Before 2007; Chapter 3, Howard Hyde's Mental Health – 2007; and Chapter 4, Dr. Sarban Singh's Involvement with Mr. Hyde

2 Part II, Chapter 3, Howard Hyde's Mental Health – 2007

3 Part II, Chapter 5, Albro Lake Road – November 21, 2007

4 See also, Part IV, Chapter 55, *Involuntary Psychiatric Treatment Act*

5 Part IV, Chapter 55, *Involuntary Psychiatric Treatment Act*

6 Part IV, Chapter 45, Mobile Mental Health Crisis Team

7 Part IV, Chapter 45, Mobile Mental Health Crisis Team

8 Part II, Chapter 6, Transport to Halifax Regional Police Booking, and Chapter 7, Halifax Regional Police Service Booking – Arrival and the LiveScan Room

9 Part IV, Chapter 41, Excited Delirium

10 Part IV, Chapter 42, Use of Force

11 Part IV, Chapter 45, Mobile Mental Health Crisis Team

12 Part II, Chapter 8, The Altercation in Booking/Use of Conducted Energy Weapon

13 Part IV, Chapter 42, Use of Force

14 Part IV, Chapter 42, Use of Force

15 Part IV, Chapter 41, Excited Delirium

16 Part IV, Chapter 44, Conducted Energy Weapons

17 Part IV, Chapter 42, Use of Force; Testimony of Dr. Joseph Noone, page 9174

18 Part IV, Chapter 42, Use of Force

19 Part II, Chapter 9, The HRPS Booking Hallway and Mr. Hyde's Collapse

20 Part II, Chapter 10, Attendance of Emergency Health Services (EHS) at Booking, and Chapter 11, Transport to the QEII Emergency Department, Transfer of Care and Admission

21 Part II, Chapter 12, Nursing care at the QEII – November 21, 2007, 02:30 hours 07:00 hours, and Chapter 13, Attendance by Dr. Stephen Curry

22 Part IV, Chapter 55, *Involuntary Psychiatric Treatment Act*

23 See also, Part IV, Chapter 46, Mental Health Services at the QEII Emergency

24 Part II, Chapter 13, Attendance by Dr. Stephen Curry, and Chapter 14, Attendance by Dr. Janet MacIntyre

25 Part II, Chapter 17, The HIT Form and Mr. Hyde's Discharge from the QEII Emergency Department

26 Part IV, Chapter 55, *Involuntary Psychiatric Treatment Act*

27 Part IV, Chapter 48, Mental Health Services: The Courts

28 See also, Part IV, Chapter 46, Mental Health Services at the QEII Emergency

29 Part II, Chapter 17, The HIT Form and Mr. Hyde's Discharge from the QEII Emergency Department

30 Part IV, Chapter 51, The Health Information Transfer Form

31 Part IV, Chapter 51, The Health Information Transfer Form

32 Part IV, Chapter 52, Communication, Information-Sharing, and Confidentiality

33 Part IV, Chapter 51, The Health Information Transfer Form

34 Part IV, Chapter 51, The Health Information Transfer Form

35 Part II, Chapter 16, HRPS Officers at the Emergency Department

36 Part II, Chapter 18, Back at HRPS Booking

37 Part IV, Chapter 45, Mobile Mental Health Crisis Team

38 Part II, Chapter 18, Back at HRPS Booking

39 Part II, Chapter 18, Back at HRPS Booking

40 Part II, Chapter 19, HRPS Booking and Transport to the Dartmouth Courthouse

41 Part II, Chapter 20, Dartmouth Courthouse Cells

42 Part IV, Chapter 48, Mental Health Services: The Courts

43 See also, Part IV, Chapter 48, Mental Health Services: The Courts

44 See also, Part IV, Chapter 51, The Health Information Transfer Form

45 Part II, Chapter 21, Howard Hyde's Arraignment and the Issue of Bail (Dartmouth Provincial Court)

46 Part IV, Chapter 49, Release from Custody: Temporary Supportive Housing

47 Part II, Chapter 22, Admission to the CNSCF

48 Part IV, Chapter 50, Mental Health Services: The Central Nova Scotia Correctional Facility

49 Part IV, Chapter 52, Communication, Information-Sharing, and Confidentiality

50 Part II, Chapter 23, Overnight in Health Segregation Cell # 11

51 Part IV, Chapter 50, Mental Health Services: The Central Nova Scotia Correctional Facility

52 Part IV, Chapter 50, Mental Health Services: The Central Nova Scotia Correctional Facility

53 Part IV, Chapter 50, Mental Health Services: The Central Nova Scotia Correctional Facility

54 Part IV, Chapter 50, Mental Health Services: The Central Nova Scotia Correctional Facility

55 Part IV, Chapter 50, Mental Health Services: The Central Nova Scotia Correctional Facility

56 Part II, Chapter 24, Going to Court – The Morning Escort of Howard Hyde (November 22, 2007)

57 Part IV, Chapter 42, Use of Force, note 20

58 Part IV, Chapter 42, Use of Force

59 Part II, Chapter 25, The Struggle at the Top of the Long Hallway

60 Part II, Chapter 26, The High-Profile Escort of Mr. Hyde to Search Cell # 2

61 Part II, Chapter 27, The Struggle and Mr. Hyde's Collapse in Search Cell # 2

62 Part II, Chapter 29, The Attendance of Paramedics to the CNSCF and the Transport to the Dartmouth General Hospital

63 Part III, Chapter 38 (see also, Part III, Chapters 31 – 37, Cause and Manner of Death)

64 Part III, Chapter 38, My Findings on Cause and Manner of Death

Part VI

Changes Since November 2007

PART VI

Changes Since November 2007

It has been encouraging to read in the Attorney General's final submissions that,

> As a result of Mr. Hyde's experience, ensuring front-line responders have the tools to respond appropriately to the mentally ill accused and the mentally ill offender has been made a priority by the Department of Justice.[1]

The Attorney General notes that both Corrections and Sheriff Services have implemented the Canadian Police Knowledge Network's training package on Recognizing Emotionally Disturbed Persons, which I have referred to in Part IV, Chapter 54, Mental Health and Crisis Intervention Training. As I noted in Part IV, Chapter 43, Use of Restraint, the Department of Justice has also implemented a best practice in its Use of Force training that limits the amount of time a prisoner is restrained in a prone position. The new goal is 3 minutes or less.

Other changes since November 2007 are described in Part IV, Chapter 44, CEW deployment policy changes. Additional changes to training, including with respect to prone restraint, are documented in Part IV, Chapters 43 and Chapter 54.

And although the Attorney General also points to curriculum inclusions to address autonomic hyperarousal or excited delirium as it has more typically been called, the findings I have made from the evidence at this Inquiry on the issue of excited delirium do not support this emphasis in the training of justice system officers.

Legislation

In the Attorney General's submissions, it is noted that there have also been legislated changes with the Province recently passing Bill 50, *An Act to Amend Chapter 37 of the Acts of 2005, the Correctional Services Act, and Chapter 31 of the Acts of 2004, the Police Act*. The amendments to the *Corrections Services Act* and the *Police Act* provide for the Minister of Justice approving and implementing "uniform training programs and guidelines" for employees (this would include correctional and sheriffs' services) and police officers "who work with individuals with mental disabilities.

Halifax Regional Police Service, the CNSCF and the QEII

Other changes have also occurred since November 2007 in the policing and correctional contexts, and at the QEII.

Changes to HRPS Booking

Since November 2007 there have been significant changes made to the Booking area at the Halifax police station. These are detailed in Exhibit 227, a memorandum from Staff Sergeant John Parkin to Superintendent Sykes dated June 25, 2009.

The changes emerged from earlier assessments of the cells area (which included the Booking section). A 2006 review of the facility, a report from Superintendent Falkenham to Deputy Chief Burbridge in August 2007, and a report by the Municipal Association of Police Personnel (MAPP)[2] to the Chief of Police in September 2007 included recommendations for improvements.

Relevant to Mr. Hyde's experiences in Booking are the following:

1) The LiveScan and fingerprint machine were moved to a room outside of the location of the Booking counter. This had been recommended in mid-2007. It avoids the need to bring prisoners to an area behind the Booking counter in the work area of the Booking staff.[3]
2) A clear Lexican barrier was installed along the Booking counter to act as an "environmental barrier" and protect staff from contact with prisoners brought into the Booking area.[4] It is no longer possible to leap, as Mr. Hyde did, over the counter.[5]
3) Additional cameras were installed to monitor the Booking counter area and audio coverage was expanded. These measures were necessitated by the installation at the Booking counter of the Lexican shield.[6]
4) A three-quarter wall was erected to separate the workstation for the matron [the position that S/Cst. Shannon Coombs occupied in November 2007] and the corridor to the new location for the LiveScan room.[7]
5) The workstations in the Booking area were reconfigured to bring all staff into a common work area, with one work station facing the Lexican screen.[8]
6) It would appear that weapons and other dangerous objects as depicted in Exhibit 67[9] are no longer stored in an open drawer in the Booking area.[10] S/Sgt. Parkin does not recall seeing anything like the number or types of items represented in Exhibit 67 when he inspected drawers in Booking in the spring or summer of 2008. He did not inspect the drawers in or prior to November 2007.[11]
7) A bail hearing room was constructed with a video link to the Justice of the Peace Centre in Dartmouth.[12]

The only door on the Booking level that leads to the outside is the door at the end of the hallway where Mr. Hyde collapsed. It is a primary exit to the outside from the south end of the building. This door is the most immediate access to the outside in the event of an emergency evacuation from the Booking area.[13] For this reason its locking mechanism, which prevents unauthorized access from the outside, can be released from the inside.[14]

There does not appear to have been any installation of audio monitoring of the hallway where Mr. Hyde collapsed [15] but there is now video surveillance in the LiveScan room.[16]

Changes at the Central Nova Scotia Correctional Centre

Since November 2007, changes have been made to Correctional Policies and Procedures to ensure that an admitting officer promptly consults with health care staff where a prisoner demonstrates signs of distress due to a mental illness.[17] This is effectively a formalization of what C/O Christopher Dixon did when Mr. Hyde arrived at the CNSCF in the late afternoon of November 21. The Attorney General indicates that section 14.3 of the Policy was also added to ensure that, if health care confirms the prisoner's distress is due to a mental illness, and emergency medical

attention is not advised as being required, the prisoner must be placed on a special watch.[18] Correctional Services Policy and Procedures, Special or Suicide Watch has been amended to require correctional staff to closely monitor a prisoner "who is identified or showing signs of being in distress as a result of a mental illness", and notify health care staff when a prisoner demonstrates signs of distress "as a result of a mental illness."[19] Correctional officers in facilities where health care staff is not immediately available are now mandated under the Policy to institute special watches and close monitoring and assessment by health care on the next scheduled visit.[20]

I will note that Mr. Hyde was observed by conscientious correctional officers throughout the nearly fourteen hours he spent in the Health Segregation cell on November 21/22, 2007 and health care, in the form of a PRAXES employee, was notified. Monitoring and a perfunctory exchange with a health care worker failed to address or alleviate the distress Mr. Hyde was experiencing that lead to tragedy early the next morning.

Correctional officers have also now been issued one-way airway valves for CPR.

Since Mr. Hyde's death the admission process for accused persons remanded late in the day for court-ordered assessments ensures that these accused persons are admitted directly to the East Coast Forensic Hospital and do not spend the night at the Central Nova Scotia Correctional Facility.[21] Of course, this is not a change that would have made any difference in Mr. Hyde's case as he was a straight remand, and was not sent by the court for a forensic assessment.

As for the experience of prisoners at the CNSCF, the Inquiry heard evidence that Corrections is looking at options for reducing light levels in the cells through the installation of individual light switches, offering prisoners better conditions for sleeping, while preserving the ability of correctional staff to see inside a cell using infrared cameras.[22]

Witnesses also testified to the practice at the CNSCF of indicating on a form affixed to the outside of the cell, the reason for each prisoner being housed in Health Segregation. Cheryl Champion testified that the information supplied in this manner to correctional officers working in Health Segregation is limited: "We would just say that…they had surgery, or they're there for mental health issues… without getting into too much detail."[23] Although it was Ms. Champion's evidence that posting such information began in the summer of 2009, Cpt. Todd Henwood testified that this "identification system" has "always been there...from when we left the Halifax County Correctional Centre."[24]

Cpt. Henwood, an experienced correctional officer, told the Inquiry in October 2009 that as far as "dealing with mentally ill offenders", nothing has changed at the CNSCF since November 2007.[25] And, unsurprisingly, the institution still has "people coming in…with mental illnesses that are remanded and not sent on assessment orders…"[26] which describes the status Mr. Hyde had at the CNSCF on November 21/22, 2007.

The QEII – Psychiatric Emergency Services

Changes to psychiatric emergency services at the QEII since November 2007 are described in Part IV, Chapter 46 and include the improvement that psychiatric nursing services are now available 24/7.

The Health Information Transfer Form

The Attorney General indicates that there has been a provisional change[27] to its Standard Operational and Administrative Policy and Procedure regarding the HIT form. Sheriffs are now permitted to provide the Crown Attorney with the HIT form in limited circumstances.[28] The Attorney General's submissions advise that Sheriff Services, and the Department of Justice, will be revisiting the issue of the provision of the HIT form to Crown Attorney's once my recommendations are received.[29]

In final submissions, counsel for the Attorney General indicated that with respect to the Health Information Transfer Form, the correct Form (developed in 2006) is now being used uniformly by various police agencies, Sheriffs' services and Corrections.[30]

The Mental Health Court

Another change since November 2007 is the Mental Health Court now operating in the Halifax Regional Municipality. The Attorney General describes the creation of a Mental Health Court as "a significant milestone for the Province in its attempts to deal effectively with the mentally ill accused."[31] The Attorney General's submissions refer to the Court providing "…individuals who suffer from a mental illness, who find themselves in violation of the criminal law, access to the mental health supports they need."[32]

As I discuss in Part IV, Chapter 48, Mental Health Services: The Courts, notes 4 and 5, the Mental Health Court would not have assisted Mr. Hyde. Furthermore, it will often be the absence or inaccessibility of services and supports that leads to an involvement with the criminal law.[33]

Notes

1 Final written submissions of the Attorney General of Nova Scotia, paragraph 207

2 MAPP is the union representing police officers in HRM. (Testimony of S/Sgt. John Parkin, page 7418)

3 Exhibit 227, page 2

4 Testimony of S/Sgt. John Parkin, pages 7421–7422

5 Testimony of S/Sgt. John Parkin, pages 7446–7447; Testimony of Cst. John Edwards, page 1018

6 Testimony of S/Sgt. John Parkin, pages 7422–7423, 7425

7 Testimony of S/Sgt. John Parkin, page 7423

8 Exhibit 227, page 3

9 Photographs taken by S/Cst. MacCormick and S/Cst. Skidmore of the weapons and potential weapons located in the Booking room.

10 Testimony of S/Sgt. John Parkin, pages 7426–7427

11 Testimony of S/Sgt. John Parkin, pages 7445–7446

12 Testimony of S/Sgt. John Parkin, page 7424

13 Testimony of S/Sgt. John Parkin, page 7427

14 Testimony of S/Sgt. John Parkin, page 7445

15 Testimony of S/Sgt. John Parkin, page 7440

16 Testimony of Cst. Jonathan Edwards, page 1019

17 Final written submissions of the Attorney General of Nova Scotia, paragraph 208, referring to Exhibit 81, Tab J, Correctional Services Policy & Procedures: Admission to a Correctional Facility, Health Assessment of Offenders, section 14.1

18 Final written submissions of the Attorney General of Nova Scotia, paragraph 208 referring to Exhibit 81, Tab J, Correctional Services Policy & Procedures: Admission to a Correctional Facility, Health Assessment of Offenders

19 Final written submissions of the Attorney General of Nova Scotia, paragraph 208 referring to Exhibit 81, Tab V, Correctional Services Policy and Procedures, Special or Suicide Watch sections 1.1.5, 3.1.4

20 Final written submissions of the Attorney General of Nova Scotia, paragraph 208 referring to Exhibit 81, Tab V, Correctional Services Policy and Procedures, Special or Suicide Watch , section 4.1

21 Testimony of Cpt. Todd Henwood, page 6642

22 Testimony of Sean Kelly, page 7531

23 Testimony of Cheryl Champion, R.N., pages 6815–6816. Other examples are drug withdrawal and wired jaws. (Testimony of Cheryl Champion, page 6818)

24 Testimony of Cpt. Todd Henwood, page 6649

25 Testimony of Cpt. Todd Henwood, page 6643

26 Testimony of Cpt. Todd Henwood, page 6650

27 Testimony of Sheriff Laurel Purcell, pages 5081–5082

28 Final written submissions of the Attorney General of Nova Scotia, paragraph 209, referring to Exhibit 169, section 14.18

29 Final written submissions of the Attorney General of Nova Scotia, paragraph 209

30 Final oral submissions of the Attorney General of Nova Scotia, page 11181

31 Final written submissions of the Attorney General of Nova Scotia, paragraph 211

32 Final written submissions of the Attorney General of Nova Scotia, paragraph 211

33 Part IV, Chapter 57, Living With a Mental Illness in the Community, note 115

Part VII

Recommendations

PART VII

Recommendations

For each recommendation, where applicable, in addition to the Commentary, the corresponding "subject matter" chapter in Part IV (Matters Arising from the Inquiry) should be carefully reviewed.

Recommendation #1

The Province should develop a provincial mental health strategy that ensures coordination of care, integration of services and supports, and monitors quality and outcomes in relation to mental health generally and mental health in the context of the criminal justice system. The Strategy should be informed by "best practices" and the Convention on the Rights of Persons with Disabilities.[1]

Commentary:

This recommendation is adapted from the spirit of various submissions, including those of the Canadian Mental Health Association.[2] The Auditor General has criticized the Department of Health for "inadequate oversight of the mental health system and no effective monitoring of compliance with mental health standards..." The present situation is unacceptable with "The Department…not fulfilling its legislative requirements under the Health Authorities Act to monitor and evaluate the quality of mental health services." The Auditor General does not mince words: "The lack of effective oversight significantly increases the risk of creating a disjointed system that fails the people who need it most."[3]

Acknowledging "absolutely" that there is a need and an opportunity to improve the delivery of mental health services in Nova Scotia, Capital District Health Authority indicated that it "fully" supports the "development and refinement" of a mental health strategy that "…needs to be interdisciplinary [and] must recognize there are many stakeholders…many of whom have been appearing before this Inquiry, but there are others."[4]

Recommendation #2

The Province should create a position in government of Director of Mental Health Strategy whose mandate will be to oversee and be accountable for the Province's mental health strategy. The position would also involve responsibility for monitoring the treatment of persons with mental illness by the various components of the justice system and oversight of mental health training for Department of Justice employees.

Commentary:

Inquiry Counsel and the Nova Scotia Government and General Employees Union

each proposed the appointment of a senior official to assume responsibility for mental health in the context of the administration of criminal justice.[5] The Nova Scotia Government and General Employees Union submitted that: "…there needs to be a senior position within government that brings the strands together and creates accountability for the way the justice system responds to persons living with mental illness."[6]

Recommendation #3

The Director of Mental Health Strategy should have recent, relevant experience in mental health policy generally and mental health policy in the context of criminal justice.

Recommendation #4

The Province should establish an inter-departmental (Justice and Health) Committee, to address mental health issues in the criminal justice system. The Committee should report to the Deputy Ministers for Health and Justice.

Commentary:

Inquiry Counsel and the Halifax Regional Police Service specifically indentified the need for a forum that could bring together interested parties for the purposes of more effective collaboration and service-delivery.[7]

Recommendation #5

The Director of Mental Health in Criminal Justice should chair the Justice and Health Committee. Membership on the Committee should not be limited to representatives from the Departments of Justice and Health and should include representation from the Capital District Health and a senior member of the Halifax Regional Police Service. The Department of Community Services should also be invited to participate. The Committee should also include a representative from each of the Schizophrenia Society of Nova Scotia and the Canadian Mental Health Association, to be selected by those organizations.

Commentary:

The Justice and Health Committee's interdisciplinary composition would enable the Departments of Justice and Health, Capital District Health, the Department of Community Services and the Halifax Regional Police working with community organizations to improve and formalize collaboration so that gaps in services for persons with mental illness can be quickly identified and addressed.

Recommendation #6

The Committee should be a new committee and not simply a re-establishment of the Joint Forensic Committee.

Commentary:

The only evidence I heard about the Joint Forensic Committee was historic, relating to the development of the Health Information Transfer Form. A new, revitalized committee should be constituted with a different mandate that includes an emphasis on the dignity and human rights of persons with mental illness in conflict with the law.

Recommendation #7

The Director of Mental Health Strategy and the Justice and Health Committee should carefully review the content of the Consensus Project[8] to identify what might be valuable in improving the Nova Scotia criminal justice system's response to persons with mental illness.

Recommendation #8

Through a collaboration of departmental representatives, (Department of Health, Department of Justice), Capital District Health, health professionals, police representatives, mental health "consumer" representatives and other appropriate participants, issues relating to service modalities and service delivery, access to services and suitability of services and supports should be assessed.

Commentary:

The Auditor General has already identified "excessive" wait times in respect of community supports programming[9], the likelihood of which was raised by Steven Lurie in his evidence.[10] The Nova Scotia Government and General Employees Union proposed that a study should be funded by The Department of Health on the utilization of the existing mental health treatment resources in institutional and community settings.[11] The purpose of this study, which the NSGEU suggested should be conducted by the Canadian Mental Health Association, would be to "identify those resources that are not fully utilized and develop strategies for their use to re-direct funding."[12]

Recommendation #9

The Province through its funding of mental health services, should support community-based mental health programmes and services and alternative treatment modalities to pharmacological and involuntary hospitalization models.

Commentary:

Although the Capital District Health Authority has submitted that Mr. Hyde's case was not one "of a lack of available and appropriate resources, but rather of an inability to ensure his continued accessing of these resources"[13], I do not agree that the difficulties Mr. Hyde encountered in managing his chronic mental illness were this simple. As I noted in Part IV, Chapter 57, Living With A Mental Illness in the Community: "…the standard responses to Mr. Hyde's illness throughout its long history were ones he found particularly objectionable: medication and involuntary hospitalization."[14] While the evidence of Dr. Jackie Kinley, Dr. Stephen Hucker and Dr. Joseph Noone indicated the necessary role that medications play in the treatment of chronic and persistent mental illness, the challenges of unpleasant side-effects and the potential for success with other treatments were also identified as relevant to the care of persons living with a severe mental illness. The Canadian Mental Health Association emphasized the need to provide mental health service users with treatment choices and to challenge the perspective that the medical model of care is the only viable approach. "When a system of care relies heavily on one model of treatment…a pharmacological model, it is understandable that a common understanding would be that if people only stayed on their medication, things would be all right."[15]

Susan Hare noted that ongoing research is needed on improved medical treatments because the side effects from a significant number of medications are "pretty severe."[16]

Recommendation #10

The Department of Justice should implement a diversion program, including pre-charge diversion, for accused persons with mental illness.[17]

Commentary:

The Consensus Project, Chapter 9 notes: "…The best interests of justice can sometimes be served by extending to the individual the opportunity to address issues that may have led to the commission of the alleged offense without prosecuting the individual…the decision of whether to offer the defendant the opportunity to participate in an pretrial diversion program is at the discretion of the prosecutor… When faced with a defendant with a mental illness, prosecutors should also look at the relationship between the defendant's mental condition, whether the defendant was receiving adequate community treatment, and behavior that led to the arrest."[18]

Recommendation #11

The Province should significantly increase funding for mental health services. This increase in funding should not be achieved through a reallocation of existing health care funding.[19]

Commentary:

In the section of his June 2010, A Review of Mental Health Services in Nova Scotia, the Auditor General observed how significantly mental health services are underfunded in Canada:

> …The Institute of Health Economics argued mental health is underfunded in its September 2008 report titled "*How Much Should We Spend on Mental Health*?" The Report stated mental illness accounts for more than 15% of the disease burden in developed countries like Canada but only 5.4% of total health expenditures. In Nova Scotia, according to provincial estimates documents, expenditures on mental health represented 3.4% of total health expenditures in 2008 – 09 and 3.3% in 2007 – 2008. These figures do not include costs for psychiatrists which are funded through MSI.

According to the Auditor General's Report, in 2003, the Department of Health (DOH) released "Standards for Mental Health Services in Nova Scotia". "These standards were developed based on professional best practices and expert consensus, and were intended to allow DOH to plan and evaluate mental health services in Nova Scotia."[20] DOH management has acknowledged that, at the time, the additional cost associated with implementing the standards was "approximately $20 million".[21] (In 2007 – 2008, the DOH estimated that the amount needed to comply with the mental health standards had risen to $23.5 million.[22])

The Auditor General has recommended that: "The Department of Health should prepare a long-range plan documenting steps needed to ensure all District Health Authorities and the IWK Health Centre can fully meet the Standards for Mental Health Services in Nova Scotia. This plan should include a timeframe for implementation and should identify funding requirements to fully implement the

standards." The Department of Health has responded to this recommendation by indicating that: "A mental health strategy will be developed beginning in the Fall 2010. This strategy will be accompanied by a business plan which will address the mental health standards."[23]

In its final oral submissions, the Canadian Mental Health Association offered a couple of examples to illustrate the failure to adequately invest in mental health services:

> …prior to the introduction of the *Involuntary Psychiatric Treatment Act*, it was argued that community treatment orders in this *Act* would force government to provide extra dollars to ensure that those community services would be in place so that community treatment orders could be implemented. We have not seen an expansion of community services to support these treatment orders. And now with the introduction of the Mental Health Court, there is a concern that…this will be a method to fast track individuals to clinical care and also into limited community services such as housing. Our point in providing this background is to say this request for additional dollars is long overdue.[24]

Recommendation #12

Increased funding for mental health services should be directed to: enhancing support for improved community-based mental health services, increased training for front-line police officers, sheriffs and correctional officers, supports for family physicians providing mental health services to patients, increasing and improving community awareness about and understanding of mental illness, in the general public and particular groups such as police officers, teachers, family physicians and members of the justice system, and campaigns to eliminate the stigmatization of persons living with mental illness.[25]

Commentary:

In its final submissions, the Canadian Mental Health Association drew a distinction between "community supports" and "clinical services that are based in the community", describing community supports as "all those necessary services that support community inclusion of persons with a mental illness: safe, affordable housing, opportunities for work or for continued education, social and recreational services, advocacy services, peer support services, education and information-sharing on the individual's illness and also…adequate income to meet their needs in the community. [26] Community services are provided by community agencies and are different from relocating clinical care teams in a community setting.

Support for "community outreach activities which focus on mental health" was also indicated by the Halifax Regional Police Service.[27]

Recommendation #13

The proportion of the mental health budget directed to the provision of treatment and support in community settings should be increased.[28]

Commentary:

This recommendation is adopted from the submissions of the Nova Scotia Government and General Employees Union, the Canadian Mental Health Association, and

Inquiry Counsel.[29] Currently, eighty-seven percent of the money spent on mental health in Nova Scotia goes to hospital-based services.[30] Redirecting resources to community mental health services would make the services more accessible to clients and would reduce the high costs associated with hospitalization.[31]

Susan Hare observed that financial constraints are a significant barrier to positive change in the delivery of mental health services and supports. Increased resources provides "…the opportunity to do things differently…[to] collaborate differently…[to work] more creatively in the community. [There are] different things you can do [in the delivery of services and supports] when you're not feeling the constraints of budget and workload."[32]

Recommendation #14

The Department of Health should explore alternate means of delivering mental health care and treatment in order to provide greater access to mental health services. Greater use could be made of nurse practitioners specializing in psychiatric issues, in community-based, mental health clinics. Individual psychiatrists could provide consultation services for family medicine practice groups.[33]

Commentary:

This recommendation speaks in part to the "shared care" model of mental health care discussed approvingly by Steven Lurie and supported by the Capital District Health Authority in its final submissions.[34] The Nova Scotia Government and General Employees Union noted that expanding the modes for delivery of mental health services could alleviate the impact of the shortage of psychiatrists in the community.[35]

Recommendation #15

The Department of Health, Mental Health Services Branch should recognize the value of Peer Support and through appropriate policy development, working in conjunction with existing Peer Support programs being delivered by CMHA, Self Help Connection and Healthy Minds Cooperative, proceed with broader implementation of more fully funded Peer Support Programs with paid Peer Support Workers.

Commentary:

This recommendation is adopted from the submissions of the Canadian Mental Health Association and draws from the evidence provided by Steven Lurie.[36] Peer support is also recognized by the Convention on the Rights of Persons with Disabilities: "State Parties shall take effective and appropriate measures, including through peer support, to enable persons with disabilities to attain and maintain maximum independence…"[37]

Recommendation #16

The Province should examine how mental health services for persons in conflict with the law can be enhanced outside of the Halifax Regional Municipality.

Commentary:

Although the events of November 21 and 22, 2007 occurred within the infrastructure of the health and justice systems of the Halifax Regional Municipality, Mr.

Hyde had a mental health history from when he lived in rural Nova Scotia, one that was characterized by a reliance on in-hospital treatment and little in the way of community mental health supports or services. Consideration of the rural context was urged by the Nova Scotia Government and General Employees Union: "[Justice and Health workers working in the area of mental health] in rural parts of Nova Scotia face very real challenges and different challenges [than their counterparts in HRM.]"[38] Although the NSGEU suggested the provision of on-call psychiatric assessment services for the persons held in custody at courts outside the Halifax Regional Municipality, this is unlikely to be feasible given the shortage of psychiatrists.[39] The NSGEU also suggested a review of security in hospital emergency departments be recommended for all health facilities.[40]

Dr. Curry proposed that all Health Authorities in Nova Scotia develop protocols for providing appropriate services to persons seeking emergency psychiatric care, such as improved physical surroundings at hospitals and clinics and availability of health professionals trained in psychiatric assessment and care.[41]

Although the Capital District Health Authority cautioned that "stepping outside, looking at other health authorities", about which there was little if any evidence to assist the Inquiry, may lead to recommendations that never gain any traction,[42] policy makers should not be deterred from mining the evidence and recommendations of this Report for ideas that could benefit rural Nova Scotians with mental illness.

The Consensus Project, Chapter 9 describes the potential for mobile mental health units holding "…clues for developing a model for options that can be used by courts to develop release alternatives in rural jurisdictions. These units are designed to respond rapidly to a person in a mental health crisis so that an arrest is avoided and the person is taken to an appropriate mental health facility. In rural areas, such mobile units may provide the courts with alternatives by bringing mental health treatment resources to those who need it. It may also be useful to make greater use of telemedicine, in which mental health professionals are available to conduct private telephone consultations with mental health patients from a remote location."[43]

Recommendation #17

Halifax Regional Police and health authorities (CDHA and IWK) should continue and expand their collaborative work, including better and more comprehensive education in the law enforcement community regarding the mandate and ability of the Mental Health Mobile Crisis Team to provide advice and conduct mobile visits at any stage of the justice system process. This should include exploration of additional models for police and mental health collaboration when responding and providing service to persons with mental illness.

Recommendation #18

The MMHCT and its supporting agencies should promote greater awareness among emergency department physicians and nursing staff, family physicians, justice system officials, family members, friends, community-based organizations and other social supports of people with a mental illness about the Team's ability to provide advice, including about community supports and resources, and to conduct mobile visits and assessments at any stage of the person's illness.

Commentary:

Recommendations 17 and 18 are adapted from proposed recommendations by the Capital District Health Authority.[44]

Some parties before the Inquiry submitted that the mandate of the MMHCT should be reviewed and the Team's hours expanded. I am satisfied from the evidence that the mandate of the Team is sufficiently broad to permit the Team to come out to a situation involving violence where the police have gone as first responders or to permit a Team response to HRPS Booking or courthouse cells. There is however "room and opportunity for greater education about the potential role and benefit" of the Team.[45]

The submissions of the CDHA indicated that the only way to expand the hours of the MMHCT beyond the "optimal period" of 13:00 – 01:00 hrs would be with additional funding for this purpose. The CDHA submitted that it is not in a position to increase MMHCT staffing within its existing budget and is not prepared to reallocate existing funding at the expense of currently funded programmes.[46] In my view raising awareness and making the best use of the Team's current availability should be the most immediate objective.

The Inquiry heard that the MMHCT was "looking at both the systemic impacts of [the] service and also getting some qualitative…and quantitative data around health outcomes…"[47] That study, "A Controlled Before-and-After Evaluation of a Mobile Crisis Partnership Between Mental Health and Police Services in Nova Scotia" [MMHCT Evaluation Study] has now been published.[48] It indicates approving responses from users[49] and MMHCT staff and Halifax Regional Police officers who "spoke positively about their ability to act as a team on-scene."[50] The Study commented on the various types of crisis team models and observed that: "Irrespective of the model, the core elements include police training, collaboration between police and mental health services, and an expanded role for law enforcement officers. Success is underpinned by 2 factors: the existence of a psychiatric service with a no-refusal policy for police referrals; and a broad acceptance by police that mental health response is a core element of the police role."[51]

Recommendation #19

The Mobile Mental Health Crisis Team should ensure it has protocols in place that direct follow-up of a contact with the Team in all cases to ensure that the person who has been the subject of the call is receiving appropriate services. A detailed record should be made of a follow-up or a case debriefing.

Commentary:

There was no follow-up of Mr. Hyde by the MMHCT on November 21. According to the evidence, it has been the MMHCT's practice where the person who has been the subject of a contact with the Team ends up arrested and held in custody for court, the Team will wait to see whether the court orders a *Criminal Code* assessment in which event there is no MMHCT follow up.[52] This should change so that the Team is able to determine what happened to the person and whether his/her needs are being appropriately addressed.

The evidence also indicates that there was no record made of the debriefing of Mr. Hyde's case.

Recommendation #20

The Province should invest in and/or identify supportive short-term housing units for persons with a mental illness who have been arrested and who would otherwise have no immediate housing options. Such housing would have to provide a safe environment for accused persons who are temporarily homeless and ready access to mental health and community support services.

Commentary:

Inquiry Counsel, the Nova Scotia Government and General Employees Union, the Halifax Regional Police Service and the Canadian Mental Health Association all made submissions on the need for safe, supportive crisis housing for temporarily homeless accused persons with a mental illness.[53] The Capital District Health Authority indicated it "liked" the concept.[54] Although the Attorney General submitted that 'safe beds' are outside the Inquiry's mandate "because there is no evidence that there's a critical mass of individuals who are not…able to access mental health supports outside of the court" and because the Crown may not have agreed to Mr. Hyde's release even to a "safe bed" if the organization running the facility would not be acting as a surety[55], the existence of supportive housing could have provided a viable option for Mr. Hyde's release on conditions and could assist other accused persons with a mental illness avoid the only other alternative, being temporarily housed on remand in jail.[56]

The Convention on the Rights of Persons with Disabilities emphasizes that the majority of persons with disabilities live in conditions of poverty and recognizes the "critical need to address the negative impact of poverty on persons with disabilities."[57]

Recommendation #21

The Province should ensure that robust supports are in place for persons discharged from involuntary treatment or correctional facilities, such supports to include, at a minimum, adequate housing, regular access to appropriate mental health services, community outreach and support and intensive community support as needed.[58]

Commentary:

The need for collaboration (see Recommendations 5 and 9 above) to identify "gaps in services", share concerns and work out difficulties in the delivery of services to persons with mental illness who come into contact with the justice system was identified by the Halifax Regional Police Service. "Gaps" may include delays (which in Mr. Hyde's case occurred when the SCOT Team was unable to absorb him as a client for several months in late 2003[59] (following his release from involuntary hospitalization) and can have a negative effect on persons living with a mental illness, potentially leading to the need for more intensive services in the future.[60]

Recommendation #22

In recognition of the role police officers play as mental health first responders, the Province should fund a police access line so that information about mental health services available through the health care system and in the community is readily available to all patrol and Booking officers in particular. The inventory of

services could be compiled through a collaboration of the Departments of Justice, Health, and Community Services and the Capital District Health Authority, the Mobile Mental Health Crisis Team, and the Schizophrenia Society and the Canadian Mental Health Association. The inventory of services should identify the nature of the service and appropriate contact information and be updated regularly so that the information being relied on by police officers coming into contact with persons with a mental illness is accurate and current.

Commentary:

This Recommendation is adapted from submissions made by the Nova Scotia Government and General Employees Union, Inquiry Counsel and the Halifax Regional Police Service.[61] Steven Lurie testified about the benefits offered by a staffed phone line accessible by police officers.[62]

Information about health care system and community services and supports could also be very useful to defence counsel representing a person with mental illness.[63]

Recommendation #23

The Committee referred to in Recommendation #4 should monitor the work of the Mental Health Commission of Canada to identify "best practices" for developing a provincial anti-stigma campaign. The Province should support local community initiatives and programmes that promote an anti-stigma, inclusive message or engage in a positive stigma-reduction activities.

Commentary:

The obligation to institute anti-stigma measures is a feature of the U.N. Convention of the Rights of Persons with Disabilities. The Convention's Preamble recognizes that "…disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others."[64] Article 8 of the Convention requires States Parties to "undertake to adopt immediate, effective and appropriate measures…to raise awareness throughout society…combat stereotypes, prejudices and harmful practices…foster respect for the rights and dignity of persons with disabilities…[and]…promote awareness of the capabilities and contributions of persons with disabilities."[65]

Meaningful opportunities in the community for persons living with mental illness can combat stigma and also reduce the chances of re-engagement with the justice and mental health systems because of "their active participation and their increased self-respect and the notion that they can make a difference."[66] The Canadian Mental Health Association also proposed that there should be "…utilization of locally available anti-stigma educational programs that have been evaluated for their effectiveness and comply with best practice guidelines in the training of all frontline workers: Mental Health First Aid, Changing Minds and Mental Health Works."[67]

Recommendation #24

The Province, Health Authorities, policing services and members of the health care and justice communities should immediately adopt respectful language that is appropriate in identifying persons with a mental illness: persons with a mental illness, persons living with a mental illness.

Recommendation #25

Persons detained in custody should not be described as "offenders" and should always be referred to as "prisoners." Provincial policies and legislation should be changed to reflect this as should any policies of policing authorities.

Recommendation #26

The Province and policing services should consistently refer to the M26 Taser or any conducted energy weaponry as Conducted Energy Weapons (CEW's).

Commentary:

Recommendations 24, 25 and 26 are grounded in the discussion found in Part IV, Chapter 39, Language. The use of the term "prisoner" is consistent with the United Nations Standard Minimum Rules for the Treatment of Prisoners and the American Bar Association's 2010 Criminal Justice Standards on the Treatment of Prisoners.[68]

Recommendation #27

The Province should not emphasize in its policies or training the phenomenon of "excited delirium."

Commentary:

Mr. Hyde's case is not an object lesson in excited delirium.[69] I was urged by counsel to make recommendations on training that were as "specific and clear as possible so that the parties will understand [and be able to implement] what they are being directed to do." The point was made that recommendations need to "reflect the evidence and findings and should recognize the fact that there are finite resources – not just money, but people's time - available for training."[70] In addition to the cautions I sounded in Part IV, Chapter 41 about excited delirium that has breathed life into this recommendation, valuable time and resources should be focused in directions that are justified on the evidence heard by this Inquiry.

Recommendation #28

The Province's prone restraint policy should be enhanced by adding a requirement that a designated member or members of the restraint "team" should be tasked with monitoring the breathing of the person being restrained.

Commentary:

This was suggested by counsel for Joanna and Dr. Hunter Blair in final oral submissions.[71]

Recommendation #29

Conducted energy weapons should not be applied to persons in a state of agitation due to an emotional or psychological disturbance except as a last resort once it has been determined that crisis intervention and de-escalation techniques have not been effective.

Commentary:

The fact that the CEW did not cause Mr. Hyde's death does not place it outside the mandate of this Inquiry. I have found on the evidence that use of the CEW on Mr. Hyde worsened the situation.[72]

This recommendation is drawn from submissions by Inquiry Counsel and the Nova Scotia Government and General Employees Union.[73]

The present policy of the Halifax Regional Police provides that a CEW may be an appropriate response to "an emotionally disturbed person who is perceived to be violent."[74] This actually seems to me to be a more relaxed threshold than the Province's present Governance Standard for CEW use which limits the deployment of a CEW to situations where the person "exhibits behaviour consistent with: aggressive or violent resistance or active threat, that may cause serious injury to the police officer, the subject or the public."[75]

As I noted in Part IV, Chapter 44, Conducted Energy Weapons, Dr. Joseph Noone recommended against use of CEW's with emotionally disturbed persons. He qualified this by saying there are "always times when it may be necessary" but cautioned that it should be "a last resort."[76] Halifax Regional Police submitted in final argument that current CEW training emphasizes that CEW's are to be deployed only when de-escalation techniques would not appear to be feasible.[77] Neither HRPS' Policy nor the Provincial Governance Standard indicate this and, in any event, it is my view that the standard should be, as I have recommended, more rigorous to avoid the application of a CEW to a person like Mr. Hyde.

I note that the recently announced new national guidelines for CEW's state: "Prior to using a CEW, officers should consider whether de-escalation techniques or other force options have not, or will not, be effective in [defusing] the situation.[78]

It was proposed by Joanna and Dr. Hunter Blair that there should be a recommendation for an absolute ban on the use of CEW's. I am not recommending this. Mr. Hyde's death was not caused by the application of the CEW. Furthermore, there may be circumstances where deployment of a CEW would avoid resort to the use of lethal force[79] (which is what CEW's were intended for in the first place, an alternative to lethal force.)

Recommendation #30

Halifax Regional Police Service should continue to document CEW usage including the mode of use (presentation, stun mode, probes), the reasons for the use of force and the de-escalation/crisis intervention techniques undertaken prior to deployment.

Commentary:

This recommendation is adapted from a recommendation proposed by the Halifax Regional Police Service.[80]

Recommendation #31

The Department of Justice should overhaul the manual it uses for CEW training[81] to significantly reduce if not eliminate the reliance on Taser International resource materials.

Commentary:

I raised this issue in Part IV, Chapter 44, Department of Justice – CEW Training.

Assistance may be available to the Department of Justice from the Halifax Regional Police who indicated to the Inquiry that they have moved away from Taser International's training and developed their own.[82]

Recommendation #32

The Capital District Health Authority should review its security arrangements for its Emergency Departments and in that review, consult with Emergency Department doctors and staff. If CDHA does not have trained Code White teams already, such teams should be trained and available in all Emergency Departments.

Commentary:

The evidence disclosed that Dr. Curry wanted the police officers who were at the hospital with Mr. Hyde, to stay. Dr. Curry's concerns were heightened because Mr. Hyde had been in an altercation with police so there was a potential he might become disruptive. He did not effect a civil commitment of Mr. Hyde in part because to do so would have meant the police officers would leave.[83] Although the CDHA made submissions that it has a policy dealing with "violent, potentially-disruptive patients" which involves calling a Code White and having a trained Code White hospital team attend[84], the Inquiry heard evidence that the QEII hospital (the hospital that admitted Mr. Hyde) does not have a Code White Team.[85] It is probable that Emergency Department doctors would be reassured by the presence of specially trained staff. The submissions of the NSGEU indicate that its clients have security concerns on their radar.[86] (It is to be remembered that it is not Mr. Hyde's conduct at the QEII Emergency Department that makes security a relevant issue for this Inquiry: it is the evidence about Dr. Curry's concerns to have the police remain on site.)

In its final submissions, the CDHA indicated it would have no difficulty conducting a review of its security arrangements for its Emergency Departments.[87]

Recommendation #33

The Public Prosecution Service and the psychiatrists working at the East Coast Forensic Hospital should maintain the arrangement of a psychiatrist from the ECFH attending at the Halifax and Dartmouth Provincial Courts on short notice to determine if grounds exist to support a request for a forensic psychiatric assessment.

Commentary:

This recommendation is adapted from a recommendation made by the NSGEU and supported by Inquiry Counsel.[88]

Recommendation #34

The Department of Justice should expand the availability of court support workers attached to the Mental Health Court to provide services to accused persons with mental health issues who are appearing in arraignment courts in Halifax and Dartmouth.

Commentary:

This recommendation is adapted from a recommendation proposed by Inquiry

Counsel.[89] Mr. Hyde and his counsel could have benefitted from the assistance of a trained court worker with information about services and resources such as was described by Steven Lurie in his evidence.[90]

Recommendation #35

Capital District Health Authority should review the initial Admission Health Assessment screening tool and process used at the Central Nova Scotia Correctional Facility to ensure that prisoners at risk for a deterioration of his/her psychological condition are readily identifiable at the time of admission.

Commentary:

The health care assessment of Mr. Hyde at the CNSCF did not identify how vulnerable he was to decompensating. I note the statement at the beginning of Chapter 7 of the Consensus Project: "Being jailed after arrest is a particularly critical period of time for a person with mental illness *because the stress of incarceration can significantly raise the risk of decompensation*."[91] (emphasis added) The Consensus Project suggests that where the initial screening shows possible indications of mental illness, arrangements should be made for a more thorough examination by a qualified mental health professional.[92]

Recommendation #36

The Capital District Health Authority should staff the Offender Health Unit at the CNSCF with registered nurses employed by Capital Health on a 24/7 basis. At least one nurse on each shift should have significant training and experience, and an active interest, in mental health issues.

Commentary:

This was recommended by Inquiry Counsel, the Attorney General, and the Nova Scotia Government and General Employees Union.[93] The NSGEU observed that nurses are, by definition, better trained and better able to provide a higher level of care than physicians' assistants, would be more integrated into the overall operation of the OHU and better able to recognize and respond to the needs of persons with a mental illness.[94]

Recommendation #37

The Department of Justice should install video surveillance cameras in the Health Care segregation cells to ensure that correctional officers are able to monitor these cells and more readily identify that a prisoner is in crisis. In keeping with the importance of respecting a prisoner's dignity and privacy, there should be an individualized determination, in consultation with health care staff, of whether video monitoring is appropriate in a particular case. Nursing re staff should regularly check on prisoners who are being monitored or who have been identified as at risk to decompensate.

Commentary:

Both Inquiry Counsel and the Nova Scotia Government and General Employees Union recommended video monitoring of Health Segregation cells.[95] Improved monitoring capabilities are not enough: with enhanced training, correctional officers would be better able to identify what they are seeing as an emotional/psy-

chological crisis. Regular checking by nursing staff should assist in identifying an incipient crisis and ensuring timely intervention.

Recommendation #38

Capital Health and the Department of Justice should determine if better use can be made of the beds in the Mentally Ill Offender Unit at the East Coast Forensic Hospital.

Commentary:

This is a recommendation proposed by Inquiry Counsel, the Nova Scotia Government and General Employees Union, and the Canadian Mental Health Association.[96] The evidence does not satisfy me that Mr. Hyde would have necessarily been better off transferred to the MIOU for his overnight stay at the CNSCF before returning to court in the morning. However it was submitted that the MIOU beds could be made available for a range of prisoners with mental health needs[97], even though the MIOU is not a hospital and does not have psychiatrists there 24/7. A very ill prisoner would still have to be transported to hospital.[98]

Recommendation #39

The Department of Justice, Capital Health, Nova Scotia Government and General Employees Union should consult on how to appropriately house prisoners with serious mental illness in conditions that ensure there is regular, compassionate human contact, reassurance, and attention paid to their needs.

Commentary:

Howard Hyde spent more than thirteen hours at the CNSCF awake and agitated with almost no human contact. He had previously responded well to reassurance, compassion and respect. The American Bar Association notes in its Criminal Justice Standards on the Treatment of Prisoners that "..,prisoners diagnosed with serious mental illness should not be housed in settings that may exacerbate their mental illness or suicide risk, particularly in settings involving sensory deprivation or isolation."[99]

Recommendation #40

Capital Health should ensure its policies on disclosure of confidential medical information permit correctional officers to be provided with information concerning symptoms and behaviours to look out for when monitoring prisoners with serious mental illnesses so that they can attend to the needs of such prisoners in an effective and timely manner. Affected prisoners should be asked to provide express consent before any additional information is disclosed.

Commentary:

This recommendation has been adapted from submissions by Inquiry Counsel, the Attorney General and the Nova Scotia Government and General Employees Union.[100] The correctional officers in need of such information are those assigned to Health Care Segregation, control post officers and escort officers.

Prisoners continue to be entitled to have their private, medical information kept confidential when they are incarcerated. Correctional officers should not have access to a prisoner's medical chart or diagnosis.[101]

This issue has been raised in the Federal corrections context: "Patient confidentiality is not likely to be breached by providing front-line staff a modicum of insight into how best to manage an offender under their direct care, observation and custody. Front-line staff does not need to know the specific diagnosis or even clinical treatment path, but they should be provided with instruction on how to best approach and deal with underlying behaviours and symptoms consistent with a mental health diagnosis…"[102]

Recommendation #41

The Department of Justice should develop and implement written reporting procedures for those working in the health and segregation area of the Central Nova Scotia Correctional Facility. This would enable correctional officers to standardize reporting on the behaviour of prisoners held in the health care segregation cells to the officers who relieve them. Copies of these reports should be sent to the Health Unit and also made available to escort officers.

Commentary:

This recommendation was put forward by the Nova Scotia Government and General Employees Union.[103] In Mr. Hyde's case, the availability of more extensive and better documented information about his night in cells would have been useful to the correctional officers who had shifts in Health Care Segregation on the night of November 21 and were assigned to escort him on the morning of November 22.

Recommendation #42

A standardized training programme on the purpose and use of the Health Information Transfer Form should be developed under the auspices of the Director of Mental Health Strategy. The programme should be delivered to HRPS, Sheriffs' Services, Correctional Services and made available to the Department of Emergency Medicine at Dalhousie Medical School for training of emergency physicians throughout the Province.

Commentary:

The evidence disclosed that there was considerable confusion and uncertainty about the proper use and function of the HIT Form in this case.[104] The objective should be to ensure that all parties who would be expected to fill out or receive (and potentially act on) a Form in the course of their duties understand the purposes of the Form and the use that is to be made of it within the justice system.[105] A number of parties suggested recommendations to achieve this.[106]

Recommendation #43

Training of physicians with respect to completion of Health Information Transfer Forms should include an emphasis on the importance of recording on the Form what medications have been administered to the person, when the medications were administered and when their effects can be expected to dissipate, especially where the person is not being discharged with a follow-up prescription.

Commentary:

It would have been valuable for police officers, sheriffs' officers, correctional of-

ficers and CNSCF Health Care staff to have known that a dose of olanzapine was considered appropriate for Mr. Hyde, was administered at the ER and would have a diminishing effect.

Recommendation #44

The Province should ensure that the only HIT Form in circulation is the 2006 Form and should take steps to recall and destroy all 2002 versions of the Form.[107]

Recommendation #45

The Province and Halifax Regional Police should rescind their recent policies that provide for the Health Information Transfer Form to be disclosed to Crown and Defence.

Commentary:

Inquiry Counsel and the Nova Scotia Government and General Employees Union recommended that the Department of Justice should "review" the current policy of providing, in certain circumstances, the HIT Form to Crown and Defence.[108] However, the current policies of the Department of Justice and HRPS risk unintended consequences: health information voluntarily provided by accused persons could be used to their detriment in the criminal justice process or accused persons, learning that it will be disclosed to the Crown, may refuse to provide information needed for ensuring their health and safety in custody.[109] Additional problems include (1) the disclosure of the HIT Form, which has as its purpose the sharing of relevant health information to ensure the health and safety of the prisoner while in custody, to persons not responsible for providing care and (2) the release to Crown and Defence of confidential health information on the Form without the prisoner's consent.

Recommendation #46

The Province should be addressing in the context of its proposed *Personal Health Information Act* (Bill 64) and the development of its electronic health record system – SHARe (Secure Health Access Record), the issues of confidentiality and privacy rights, consent, disclosure and stigma as they specifically relate to the health care records and needs of mental health service users and persons in custody, and consulting with the affected constituencies and mental health service providers.

Commentary:

In Dr. Janet MacIntyre's final submissions there was a proposed recommendation that: "*Subject to the availability of resources the Province of Nova Scotia should consider the implementation of a system for retaining electronic medical records that allows access to the entire clinical and pharmacological history of any person in custody and that such system be used where clinical resources and personnel permit to improve the management of persons with mental illness who come in custody with the justice system.*"[110] It was Dr. MacIntyre's submission that the digitization of health records is inevitable[111] which is borne out by the Province's present initiative, SHARe, Secure Health Access Record.[112] Dr. MacIntyre submitted that the circumstances under which "…this growing resource, i.e., the digital database, can be used to more effectively provide care by front-line people like police, by doctors, by others in the system" should be defined.[113]

This proposed recommendation was more expansive in its scope than the one submitted by Dr. Stephen Curry in relation to the issue of electronic records access: "*Information systems should be developed to ensure that physicians and hospital staff are given timely electronic access to a patient's complete health and medication records with respect to care provided within the province of Nova Scotia.*"[114]

I received no substantive submissions on electronic health records.[115] The issues are substantial and there has been considerable debate on their benefits and risks.[116] The Province is intending to re-table Bill 64, *Personal Health Information Act*, which empowers the Governor in Council to make regulations, "defining safeguards for holding personal health information in an electronic form." (section 115 (1)(i)) The Bill contains provisions governing consent and disclosure, including that "Express consent of an individual to whom the information relates is required for…the disclosure of personal health information by a custodian to a non-custodian unless required or authorized by law. (section 45(a)) Prior to the original introduction of the Bill in 2009, the Province circulated a Discussion Paper which described SHARe. It will create an electronic health record for all Nova Scotians which will contain "patients' up-to-date health information to support decision-making and case management by health-care providers."

I do not consider that I have enough evidence or an informed enough understanding of the issues to propose a recommendation in the area of the electronic records of persons in custody beyond what I have stated as Recommendation #46. I also want to point out that as far as having access to helpful information about Mr. Hyde, there were sources outside his confidential mental health records, such as, Mr. Hyde himself and Ms. Ellet, both of whom provided information, information in police databases, and the prescription history Nurse McLeod obtained from Mr. Hyde's pharmacy on the basis of what he told her. Better use of the information obtained, through more thorough report entries and more effective communications and information-sharing, could have assisted in understanding and anticipating Mr. Hyde's needs and issues on November 21 and 22, 2007.

Recommendation #47

District Health Authorities and the Mobile Mental Health Crisis Team should have available for clients information on advanced care/consent directives to assist persons with mental illness who are interested in putting either of these measures in place.

Commentary:

The Canadian Mental Health Association and the Schizophrenia Society of Nova Scotia proposed that advanced care and advanced consent directives could benefit persons with mental illness who anticipate the possibility of a crisis.[117] The Consensus Project also advocates the use of "…advance planning [directives] relating to any future contacts with the criminal justice system. Individuals who have had previous contact with the law or individuals whose behaviours put them at significant risk should be offered the opportunity through the mental health system to indicate consent for sharing of certain information."[118]

The Consensus Project suggests: "If possible, [mental health staff] should set up protocols that can enable an appropriate flow of information to law enforcement, detention, and other criminal justice personnel while preserving the confidentiality and privacy of individuals in the system."[119] The caution is sounded that

information about a prisoner's mental illness should "not be used to jeopardize a person's rights in criminal proceedings."[120] This suggests that independent legal advice may be needed in some cases before advanced consent directives concerning mental health information are signed.

Recommendation #48

The Halifax Regional Police Service should continue to utilize the "Contemporary Policing Guidelines for Working with the Mental Health System" prepared for the Canadian Association of Chiefs of Police in developing and implementing its policies and procedures.[121]

Recommendation #49

Training should have as its overarching purpose the development of a culture of respect and empathy for persons with mental illness in the justice system.[122]

Recommendation #50

All persons in the justice system who have contact with persons with mental illness should receive training that includes: current information about community resources and supports for persons with mental illness; basic human rights principles; empathy; anti-stigma awareness; communication and listening skills.[123]

Commentary:

Dr. Stephen Hucker observed the reality that people with serious mental illness will be ensnared in the criminal justice system. "…no matter how effective a filter you think you have, there are always people who end up in the correctional system, federal and provincial, who have a major mental illness…so it's more of a case of… how do you manage them there…it's a case of you've got to have a culture…the right attitudes as well as the right training…"[124]

Recommendation #51

Training should assist in the identification and care of persons who may be experiencing a psychiatric emergency. This would include topics such as identification of mental health issues, determination of whether a medical referral is needed, and development of skills for communicating with persons with mental illness.[125]

Commentary:

Training must emphasize and develop the skills needed to establish a rapport with a person experiencing mental illness. It has to effectively address the habituation that justice system workers (police, sheriffs, correctional officers) experience as a result of their encounters with persons exhibiting similar behaviours, so that they are able to identify more perceptively the signs of an emotional/psychological/psychiatric crisis and respond to them.[126]

Recommendation #52

All training of persons in the justice and health care systems with respect to mental health issues should involve or continue to involve persons with lived

experience with mental illness, including, where relevant and feasible, lived experience with mental illness and the criminal justice system.

Recommendation #53

The Halifax Regional Police should adopt the objective of providing Crisis Intervention Training to all patrol officers as well as all booking officers and all officers who provide use of force training in the Department.[127]

Commentary:

The Halifax Regional Police Service is to be commended for its commitment to enhanced training for its members and its efforts to identify and adopt "best practices" curricula. The Service has submitted that CIT training for all front-line officers cannot be achieved in the short-term because of HRPS' training continuum model. HRPS has a goal of developing a "critical mass" of CIT trained police officers. There is a resource issue as well in that each officer that is involved in crisis intervention training is one week off work devoted to that training.[128] That being said, the Recommendation emphasizes a critically important objective, one that was endorsed by a number of witnesses before the Inquiry, including the use of force expert.[129]

Recommendation #54

The Halifax Regional Police Service should continue training members to be part of the Mobile Mental Health Crisis Team.[130]

Recommendation #55

The Province should continue training of 911 operators and dispatchers to identify calls involving a mental health aspect so that members of the mobile health crisis team and/or police officers with crisis intervention training can attend early on scene. There should be collaboration with mental health service providers/professionals to develop a set of standard questions which could identify a mental health issue.[131]

Recommendation #56

The Halifax Regional Police should enhance the Canadian Police Knowledge Network online training "Recognizing Emotionally Disturbed Persons", which is currently offered as a "baseline" training program, with skills development through role-playing and in-classroom instruction and trainer/learner interaction.[132]

Recommendation #57

The Halifax Regional Police should provide more training to its officers on their powers under the *Involuntary Psychiatric Treatment Act*, especially in respect of their ability to rely on third-party statements to form their reasonable and probable grounds under s.14 of that *Act*. Training should be updated with any developments in the law.[133]

Recommendation #58

Training should be made available to policing agencies and the MMHCT on the difference between a forensic psychiatric assessment and a "civil" psychiatric as-

sessment, including assessments under the *Involuntary Psychiatric Treatment Act.*

Recommendation #59

The Public Prosecution Service and Nova Scotia Legal Aid should ensure that full time and per diem Crown counsel and Defence counsel, including duty counsel, receive training on the difference between a forensic and a "civil" psychiatric assessment, including assessments under the *Involuntary Psychiatric Treatment Act.* The Nova Scotia Barristers' Society and the Nova Scotia Criminal Lawyers' Association should offer education to private defence counsel on these matters.

Commentary:

This recommendation was proposed by Inquiry Counsel and the Halifax Regional Police Service.[134] Even though the evidence before me did not disclose any apparent failure on the part of Crown or Defence to understand the difference in these assessments, if my Recommendations for training/education of police, MMHCT and Emergency Department physicians are implemented it would be beneficial to ensure that lawyers in the justice system have a comparable level of knowledge.

Recommendation #60

The Department of Justice should integrate Crisis Intervention concepts and skills-instruction into the joint, use of force training program being developed in the Department.[135]

Recommendation #61

The Department of Justice should ensure that Crisis Intervention training is provided to employees in sheriff services dealing with the custody and transportation of prisoners. [136]

Commentary:

The Attorney General expressed concerns about "training on top of training" and the need for "intelligent [use] of resources" where on the facts of this case, the sheriffs intervened appropriately with Mr. Hyde and managed his anxieties very skillfully.[137] The fact that Mr. Hyde was fortunate enough to encounter D/S's Shirley Day and James Crook, who both had proven rapport-building capabilities, does not mean that other sheriffs have the same level of skill and would not benefit from being provided with the tools to assist them in their dealings with prisoners with a mental illness.

Recommendation #62

The Department of Justice should enhance the Canadian Police Knowledge Network online training "Recognizing Emotionally Disturbed Persons", which is currently offered as a "baseline" training program in mental health issues, with skills development through role-playing and in-classroom instruction and trainer/learner interaction.[138]

Recommendation #63

The Department of Justice should provide Crisis Intervention Training for all correctional officers employed at the Central Nova Correctional Facility. [139]

Commentary:

In the federal corrections context, the Correctional Investigator recognized the importance of a front-line correctional staff having "the skills, competencies, knowledge and qualities required to manage an increasingly complex array of mental health issues and disorders." The challenges of increasing numbers of prisoners with mental illness have to be met with: "…patience, compassion and empathy… strong communication skills and the ability to work in an interdisciplinary environment…Specific, advanced and continuing mental health education and training are other key elements of a comprehensive approach to frontline staffing in a correctional environment."[140]

Recommendation #64

Capital Health and the Department of Justice should collaborate on joint training of correctional staff and the staff of the Offender Health Unit concerning mental health issues.[141]

Commentary:

The Capital District Health Authority noted that it has no mandate or authority with respect to the training of Department of Justice employees but is prepared to work collaboratively on training initiatives.[142]

Recommendation #65

The Capital District Health Authority should work in collaboration with the Nova Scotia Department of Justice and the Department of Emergency Medicine at Dalhousie Medical School to develop and implement a comprehensive training program for emergency room physicians on the difference between a forensic psychiatric assessment and a "civil" psychiatric assessment, including assessments under the *Involuntary Psychiatric Treatment Act*. Emergency Department physicians should also receive training on the basics of the criminal justice process, particularly in relation to arraignment and bail and remand.

Commentary:

A recommendation of this nature was proposed by Inquiry Counsel, the Attorney General, the Nova Scotia Government and General Employees Union and the Halifax Regional Police Service.[143] The Consensus Project discusses cross-training for mental health professionals[144] in terms that can as readily be applied to emergency department physicians. The goal is to enhance the knowledge and deepen the understanding of health care professionals who will encounter persons with mental illness in conflict with the law. Consideration should also be given to in-service training can which can be productive, allowing doctors and criminal justice personnel (most importantly in the context relevant to this Inquiry, the police) to build and improve relationships.

Recommendation #66

There should be "best practices" anti-stigma education provided to health care professionals, including emergency department physicians, to establish a greater level of comfort and skill in dealing with patients who have a mental illness and are or have been in conflict with the law.

Commentary:

The effects of stigma on the delivery of health care to persons with mental illness was noted by various witnesses[145] and commented on in the Consensus Project: "In many instances, mental health providers are reluctant to take on the perceived risks associated with clients who have criminal histories, especially if they include violence."[146]

Recommendation #67

The Halifax Regional Police Service should improve, through training and policy development, the internal transfer of information about an accused person so that all police officers who are or will be dealing with the person are fully informed about contemporaneous incidents and any mental health issues that are currently relevant.

Commentary:

Inquiry Counsel and the Attorney General each proposed recommendations related to the fact that information about Mr. Hyde was not located in HRPS databases and relevant details about the various events on November 21 did not follow him through the system. Inquiry Counsel proposed that: "The Halifax Regional Police develop a protocol to ensure that all relevant information is passed along with the person to the departments dealing with that person."[147] The Attorney General proposed both that: "Halifax Regional Police review its training programs to ensure that relevant information about an accused's mental health is shared with all of the officers who will be dealing with the accused"[148] and that "The Halifax Regional Police review the workings of its internal databases to ensure that information about an accused's mental health history is quickly and easily indentifiable to Booking officers and others involved in the decisions relating to an accused's detention."[149] HRPS in its final submissions acknowledged that this case highlights the need to strengthen the internal HRPS transfer of information about an accused in relation to a particular event[150] but expressed concerns that mental health information be retained and disseminated appropriately. HRPS rightly noted that it may be "inappropriate to make determinations based on an individual's past"[151], for example, in Mr. Hyde's case, the fact that he had been found to be NCR in 2002. Although I did not hear any evidence on the point, HRPS observed that a possible reason for information about Mr. Hyde's past mental health history not being found by Cst. Gillis in his database search on November 21 was because access to that information was restricted for certain purposes.

The evidence indicates that information made available to the police officers dealing with Mr. Hyde from sources outside of police databases (Ms. Ellet and Mr. Hyde himself) could have been very useful in understanding Mr. Hyde's state of mind and dealing with him more appropriately. With better training and enhanced policies, police officers would be alive to gathering mental health information from collateral sources, listening to the accused person, interpreting behaviours, and

passing along detailed information they have gathered to their colleagues and others as appropriate.

Recommendation #68

Halifax Regional Police should enhance training of all front-line officers, including Booking officers in note-taking and report preparation to ensure the highest professional standards are met.[152]

Recommendation #69

The Halifax Regional Police Service should continue to document contacts with emotionally disturbed persons with details of observations, police response, services requested, services received, disposition.

Commentary:

The Halifax Regional Police Service proposed this recommendation.[153] HRPS also suggested that it should obtain guidance from mental health professionals concerning what types of information to record. There should be restrictions placed on the use that can be made of this information so that it is not used for collateral purposes, the issue identified by HRPS that I have discussed in the Commentary to Recommendation # 67.

Recommendation #70

Information-sharing amongst justice system participants – police, Sheriffs Services and Correctional Services – about accused persons should be improved through enhanced training in relation to existing policies and protocols and the development of new ones where necessary.

Commentary:

The evidence indicates that the thread of relevant information about Mr. Hyde did not follow him through the justice system as it should have, neither from one justice entity to another, nor within entities, such as the CNSCF. Some information did get passed along but the facts in this case[154] should be examined closely by all participants to identify the information gaps and how sharing of relevant information can be formalized and improved.

Recommendation #71

Health authorities should review their internal information-sharing protocols and policies to ensure that important information about a patient is not "lost" or unavailable.

Commentary:

The evidence indicates that the fact the ER charge nurse did not know that Dr. MacIntyre was concerned Mr. Hyde receive immediate psychiatric care and not be in a jail setting meant Health Care at the CNSCF missed out on crucial information about his mental health needs.[155]

Recommendation #72

Police agencies and health authorities should work together to establish a communication protocol that would alert police when an arrestee or an accused who was detained in hospital under the *Involuntary Psychiatric Treatment Act* is being released. If required, a Ministerial Authorization permitting health authorities to disclose this information to police should be prepared. Such an Authorization should limit the release of health information to permitting health authorities to inform the relevant police agency that the person is being discharged from hospital.

Commentary:

The Attorney General, the Nova Scotia Government and General Employees Union, Inquiry Counsel, and the Halifax Regional Police Service all proposed that information about discharge of an accused from involuntary committal should be made available to police.[156] The evidence indicated that police have a concern about an arrestee not yet subject to any charges or release conditions being discharged from hospital, for example, in a case of domestic assault, and the police having no knowledge of this.[157]

Recommendation #73

The independent review of the *Involuntary Psychiatric Treatment Act* in 2013, required pursuant to section 84(1) of the *Act*, should include a thorough legal analysis of the legislation's conformity or lack thereof as the case may be to the Charter and the United Nations Convention of the Rights of Persons with Disabilities and recommend amendments as applicable.

Commentary:

Amongst a number of principles, the Convention on the Rights of Persons with Disabilities recognizes in its Preamble the "need to promote and protect the human rights of all persons with disabilities, including those who require more intensive support" and "the importance for persons with disabilities of their individual autonomy and independence, including the freedom to make their own choices."[158] The purpose of the Convention is "to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity."[159] Under the Convention, "the existence of a disability shall in no case justify a deprivation of liberty."[160] Even where not yet implemented by statute, the "values reflected in international human rights law may help inform the contextual approach to statutory interpretation and judicial review."[161]

It was Dr. Curry who proposed that this Inquiry and its recommendations could provide "some additional guidance to the Minister when the Ministerial Review [pursuant to section 84] takes place."[162]

Recommendation #74

Capital Health should review the processes followed when the police exercise their authority to detain a person for involuntary treatment under the *Involuntary Psychiatric Treatment Act* to ensure assessments occur in a timely manner and the resources of the HRPS and the hospital are used appropriately.

Commentary:

This recommendation was proposed by the Nova Scotia Government and General Employees Union.[163] The evidence disclosed that front-line police officers seeking an IPTA assessment often have to wait long hours at the ER. This is not a good use of police resources and delays the delivery of care to persons with mental illness.

Recommendation #75

Police, Sheriff Services and Corrections should adopt a joint protocol to ensure that prisoners are adequately nourished and hydrated during the time when they are moved from one agency to another or upon their admission to a facility if they have not recently had something to eat and drink. This should include at least one hot meal in a 24 hour period.

Commentary:

This recommendation has been adapted from submissions by the Nova Scotia Government and General Employees Union[164] and Inquiry Counsel[165]. It also reflects international standards promulgated by the United Nations[166] and the American Bar Association.[167] The evidence does indicate that Mr. Hyde received some food and juice when he was admitted to the CNSCF but he had gone for many hours prior to that without anything to eat or drink and only had a drink of juice during the long night he was alone in Health Segregation. It is unclear to me that what he received, essentially as his supper, on his admission to the CNSCF would have been adequate to sustain him over the next nearly 14 hours. He did not have any hot food at all in the time he was in custody.

Recommendation #76

Suitable clothing should be maintained at HRPS Booking to ensure that prisoners can be properly clothed while they are housed in cells.

Commentary:

This recommendation[168] emerges from the evidence that Mr. Hyde was at HRPS Booking in only his shorts with no shirt or footwear in late November. Some clothing was produced for him when he was about to be transported to the Dartmouth Courthouse on the afternoon of November 21. I do not know if there is now a stock of clothing available for prisoners but when S/Cst. Gregory MacCormick testified he said a change of clothing in Booking would be "an excellent idea."[169]

Recommendation #77

The legal requirements associated with obtaining consent to treatment should be rigorously adhered to by all health professionals.

Commentary:

Although Dr. MacIntyre testified that the olanzapine injection without consent (as in Mr. Hyde's case) is done "in all kinds of situations"[170], inquiries should have been made of Mr. Hyde to assess his capacity to consent to the injection.

Recommendation #78

The Minister of Justice should undertake an annual review of the implementation of the Recommendations of this Inquiry, which review to be completed by the anniversary date of the filing of the Inquiry's Report, and made public no later than two months from that date, including by posting the review on the Department of Justice website.

Recommendation #79

The implementation of these Recommendations should be informed by and consistent with the principles of the Convention on the Rights of Persons with Disabilities.

Recommendation #80

The Province should post this Report on the Department of Justice website.

Notes

1 The Convention on the Rights of Persons with Disabilities was signed and ratified by Canada on March 11, 2010.

2 Final written submissions of the Canadian Mental Health Association, page 29, Community Systems Supports, Recommendation #10

3 Auditor General's Report, June 2010, page 54

4 Final oral submissions of the Capital District Health Authority, page 11407

5 Final written submissions of: Inquiry Counsel, paragraph 14; Nova Scotia Government and General Employees Union, paragraph 386

6 Final oral submissions of the Nova Scotia Government and General Employees Union, page 11240

7 Final written submissions of: Inquiry Counsel, paragraph 17; Halifax Regional Police Service, Summary of Recommendations, Training of Members, #3

8 The Consensus Project, 2002, was prepared by the Council of State Governments with the Association of State Correctional Administrators, the Bazelon Centre for Mental Health Law, the Centre for Behavioural Health, Justice & Public Policy, the National Association of State Mental Health Program Directors, the Police Executive Research Forum, and the Pretrial Services Resource Centre.

9 Auditor General's Report, June 2010, page 62

10 Testimony of Steven Lurie, pages 10756–10757

11 Final written submissions of the Nova Scotia Government and General Employees Union, paragraph 385. This was echoed by Inquiry Counsel in his final written submissions, paragraph 195.

12 Final written submissions of the Nova Scotia Government and General Employees Union, paragraph 385

13 Final written submissions of the Capital District Health Authority, paragraph 96

14 For a more complete discussion of Mr. Hyde's experiences with the mental health system, see Part II, Chapters 2, 3, and 4.

15 Final oral submissions of the Canadian Mental Health Association, pages 11550–11551

16 Testimony of Susan Hare, page 3946

17 Final written submissions of Inquiry Counsel, paragraph 125

18 Consensus Project, Chapter 9, page 82

19 The Capital District Health Authority made the point in its final oral submissions that while mental health needs increased funding, this should not take the form of a

reallocation of funds, coming at the expense of existing health care services and programmes. (Final oral submissions of the CDHA, pages 11405–11406)

20 Auditor General's Report, June 2010, pages 50–51

21 Auditor General's Report, June 2010, page 51. In its final oral submissions, the Canadian Mental Health Association noted that: "The hope that those dollars would be forthcoming was never realized. It is no surprise that the Auditor General most recently cited only 14 percent compliance by the District Health Authorities [with] the provincial standards." (CMHA, pages 11543–11544, referring to the Auditor General's Report, June 2010, page 60)

22 Auditor General's Report, June 2010, page 53

23 Auditor General's Report, June 2010, page 79

24 Final oral submissions of the Canadian Mental Health Association, pages 11544–11545

25 Final written submissions by Inquiry Counsel (paragraph 194), Capital District Health Authority (paragraph 20), and the Canadian Mental Health Association (Stigma, Recommendation #1) are reflected in Recommendation #12.

26 Final oral submissions of the Canadian Mental Health Association, pages 11545–11546. Steven Lurie's testimony also spoke to the nature of community-based support services. See, Part IV, Chapter 58, Living With A Mental Illness in the Community

27 Halifax Regional Police Service, Summary of Recommendations, Training of Members, #6

28 Final written submissions of the Nova Scotia Government and General Employees Union, paragraph 378; Inquiry Counsel, paragraph 196

29 Final written submissions of: the Nova Scotia Government and General Employees Union, paragraph 378; the Canadian Mental Health Association, page 28, Community Systems Supports, Recommendation #1; Inquiry Counsel, paragraph 196

30 Testimony of Steven Lurie, pages 10650-10651

31 Testimony of Steven Lurie, page 10637

32 Testimony of Susan Hare, pages 3947–3948

33 Final written submissions of the Nova Scotia Government and General Employees Union, paragraph 383

34 Final written submissions of the Capital District Health Authority, paragraph 94

35 Final written submissions of the Nova Scotia Government and General Employees Union, paragraph 384

36 Final written submissions of the Canadian Mental Health Association, page 29, Community Systems Supports, Recommendation #8; see also, Part IV, Chapter 57, Living With A Mental Illness in the Community, Accessing Services and Supports

37 United Nations Convention on the Rights of Persons with Disabilities, Article 26 (1)

38 Final oral submissions of the Nova Scotia Government and General Employees Union, page 11248

39 Final oral submissions of the Capital District Health Authority, page 11393

40 Final oral submissions of the Nova Scotia Government and General Employees Union, page 11249

41 Final written submissions of Dr. Curry, page 16, proposed recommendation #4. In oral submissions, counsel for Dr. Curry explained that he was not advocating for a separate facility for emergency psychiatric assessment, care and treatment, rather he was proposing a model similar to what the QEII has done in creating a separate area in the main ER department. (Final oral submissions of Dr. Curry, page 11511)

42 Final oral submissions of the Capital District Health Authority, page 11393

43 Consensus Project, Chapter 9, page 85

44 Final written submissions of the Capital District Health Authority, paragraphs 16 and

20; see also, Part IV, Chapter 46, Psychiatric Emergency Services at the QEII Emergency Department, An Enhanced Role for the Mobile Mental Health Crisis Team?

45 Final oral submissions of the Capital District Health Authority, page 11373

46 Final written submissions of the Capital District Health Authority, paragraph 17. In oral submissions, counsel for the CDHA pointed out that "…mandating or directing resources to come from one level of service being provided by Capital Health to enhance [the MMHCT hours]…may not reflect an appropriate[ly] nuanced balanced allocation." (Final oral submissions of CDHA, page 11374)

47 Testimony of Susan Hare, page 3969

48 Canadian Journal of Psychiatry, Vol. 55, No. 10, October 2010

49 MMHCT Evaluation Study, page 665

50 MMHCT Evaluation Study, page 666

51 MMHCT Evaluation Study, page 667

52 Testimony of Susan Hare, pages 3696, 3717–3718

53 Final written submissions of Inquiry Counsel, paragraph 121; NSGEU, paragraph 379; HRPS, Summary of Recommendations, In the Community, #2; CMHA, Summary of Recommendations, Community Systems Supports, Recommendation # 5. See also, Criminal Justice/Mental Health Consensus Project, Chapter 38 – Housing, pages 265–270, Recommendations for Implementation.

54 Final oral submissions of the Capital District Health Authority, page 11386

55 Final oral submissions of the Attorney General, pages 11198, 11197. Steven Lurie had testified that the Toronto CMHA's operation of temporary crisis housing did not involve acting as a surety. (Testimony of Steven Lurie, pages 10716–10717)

56 See, Part IV, Chapter 49, Release from Custody: Temporary Supportive Housing

57 United Nations Convention on the Rights of Persons with Disabilities, Preamble (t)

58 A proposed recommendation (Summary of Recommendations, In the Community, #8) of the Halifax Regional Police Service is reflected in this Recommendation. Inquiry Counsel and the Nova Scotia Government and General Employees Union proposed that "The Department of Health should provide increased funding for assertive care treatment teams and assertive care management." (Final written submissions, Inquiry Counsel, paragraph 193; NSGEU, paragraph 380)

59 See, Part II, Chapter 2

60 Auditor General's Report, June 2010, page 62

61 Final written submissions of the Nova Scotia Government and General Employees Union, paragraphs 50 and 51; Inquiry Counsel, paragraph 25; Final oral submissions of the Halifax Regional Police Service, pages 11346–11347

62 Testimony of Steven Lurie, pages 10738–10739

63 Consensus Project, Chapter 7, Appointment of Counsel, page 75

64 United Nations Convention on the Rights of Persons with Disabilities, Preamble (e)

65 United Nations Convention on the Rights of Persons with Disabilities, Article 8 (1)(a) (b) and (c)

66 Final oral submissions of the Canadian Mental Health Association, pages 11549–11550

67 Final written submissions of the Canadian Mental Health Association, page 28, Stigma, Recommendation #1

68 Standard 23 – 1.0 (k): "The term 'prisoner' means any person incarcerated in a correctional facility."

69 See, Part III, Chapters 35, The Cause of Death Was Not Excited Delirium and 38, My Findings on Cause and Manner of Death, and Part IV, Chapter 41, Excited Delirium

70 Final oral submissions of Dr. Stephen Curry, pages 11506–11507

71 Final oral submissions of Joanna and Dr. Hunter Blair, page 11320

72 Part IV, Chapter 42, Use of Force, Deployment of the Conducted Energy Weapon

73 Final written submissions of Inquiry Counsel, paragraph 49; Final written submissions of NSGEU, paragraph 67; Final oral submissions of NSGEU, page 11246

74 Exhibit 82, Tab D, Halifax Regional Police Standard Operational Policy and Procedure Manual, Chapter 17.3 "Incidents Involving Use of A Taser", #6 a.

75 Exhibit 246, Provincial Governance Standard for CED's, Revised July 10, 2008

76 Testimony of Dr. Joseph Noone, pages 9174–9175

77 Final oral submissions of Halifax Regional Police Service, page 11343

78 National guidelines for CEW's (Statement of Principles) announced October 15, 2010 following the Federal-Provincial-Territorial Ministers Responsible for Justice meeting in Vancouver, B.C.

79 On July 2, 1986, Harold Lowe was killed by a police officer who fired a single shot when Mr. Lowe advanced with two large knives. Mr. Lowe had been agitated and upset, and some of the officers who responded recognized the possibility that he was mentally ill. None of the officers present at the scene had any crisis intervention training. The Fatality Inquiry into Mr. Lowe's death commented on the issues of crisis intervention and less lethal force, including as follows: "The Halifax Police Department had no policies or standing orders for dealing with persons barricaded as Mr. Lowe was on the night of his death. Only a few officers in the department had been trained to deal with such persons. Officers so trained should be called to the scene of such incidents whenever possible. (Report of the Fatality Inquiry into the Death of Harold William Lowe, February 6, 1987, page 13) "There was some reference made to the desirability of using less lethal weapons, for example, mace, to subdue persons such as Mr. Lowe. However, there was virtually no evidence before me concerning the use and effectiveness of such weapons. So as to protect lives as much as possible, the Halifax police should study this subject to see if the use of guns might be limited even more than already appears to be the case." (Report of the Fatality Inquiry into the Death of Harold William Lowe, February 6, 1987, page 15)

80 Halifax Regional Police Service, Summary of Recommendations, Documentation, #2

81 Exhibit 119, Department of Justice "Taser Training"

82 Testimony of Sgt. Dean Stienberg, page 7023

83 Testimony of Dr. Stephen Curry, pages 4444, 4507, 4602, 4604

84 Final oral submissions of the Capital District Health Authority, page 11384

85 Testimony of Deborah Phillips, pages 9776–9777

86 Final written submissions of the Nova Scotia Government and General Employees Union, paragraph 155

87 Final oral submissions of the Capital District Health Authority, pages 11380–11381

88 Final written submissions of the Nova Scotia Government and General Employees Union, paragraph 196; Inquiry Counsel, paragraph 119. Peter Planetta had noted that it would be helpful to have a psychiatrist at court to assess clients. (Testimony of Peter Planetta, page 8667)

89 Final written submissions of Inquiry Counsel, paragraph 116

90 See, Part IV, Chapter 48, Mental Health Services: The Courts

91 Consensus Project, Chapter 7, page 102

92 Consensus Project, Chapter 7, page 103. At page 104, the Consensus Project notes that another option is telepsychiatry, where "a qualified mental health professional is able to interview and examine the detainee through the use of telephone or closed-circuit television".

93 Final written submissions of Inquiry Counsel, paragraph 165 ; Attorney General, paragraph 156 ; Final written submissions of the Nova Scotia Government and General

Employees Union, paragraph 265. C/O Lamond also thought this was a good idea. (Testimony of C/O Cameron Lamond, page 6207) Cpt. Doug Whitman testified that it would be of assistance to have more ready access to psychiatric nurses and psychiatrists. (Testimony of Cpt. Doug Whitman, page 6696)

94 Final oral submissions of the Nova Scotia Government and General Employees Union, page 11245

95 Final written submissions of Inquiry Counsel, paragraph 161; Final written submissions of the Nova Scotia Government and General Employees Union, paragraph 259. As the NSGEU noted, the Director of Correctional Services, Sean Kelly, testifying on December 3, 2009, indicated that the Department of Justice was in the process of determining the cost of installing monitors in the Health Segregation area. (Testimony of Sean Kelly, page 7530)

96 Final written submissions of Inquiry Counsel, paragraph 166; Final written submissions of the Nova Scotia Government and General Employees Union, paragraph 263. The Canadian Mental Health Association proposed the "increased cooperation and collaboration between the mental health clinicians [at the ECFH] and the health unit staff [of the CNSCF] to ensure greater support for individuals exhibiting mental illness symptoms in the correctional facility." (Final written submissions of the Canadian Mental Health Association, page 27, Training, Recommendation #8)

97 The Nova Scotia Government and General Employees Union made submissions that the beds could be "available to (a) prisoners for whom an Emotionally Disturbed Persons Form has been prepared by police, but for whom no forensic psychiatric assessment has been requested; (b) prisoners referred in custody by the Mental Health Court; (c) prisoners referred directly by the admissions nurse in the Health Care Unit at the CNSCF." (Final written submissions of the NSGEU, paragraph 263)

98 Final oral submissions of the Capital District Health Authority, pages 11402–11403

99 American Bar Association's Criminal Justice Standards on the Treatment of Prisoners, Standard 23 – 6.11(d) (Services for Prisoners with Mental Disabilities); see also, Part IV, Chapter 50, Mental Health Services: Central Nova Scotia Correctional Facility - Pacing and Shouting; Mr. Hyde's Long Night Alone: also, Testimony of Dr. Jacqueline Kinley, pages 9846, 9896, 9897

100 Final written submissions of Inquiry Counsel, paragraph 163; Final written submissions of the Attorney General of Nova Scotia, paragraph 156; Final written submissions of the Nova Scotia Government and General Employees Union, paragraph 262

101 Final oral submissions of the Capital District Health Authority, page 11398

102 Annual Report of the Office of the Correctional Investigator 2009–2010, Clinical Management Plans

103 Final written submissions of the Nova Scotia Government and General Employees Union, paragraph 268; This was echoed by Inquiry Counsel in final written submissions, paragraph 167.

104 See, Part II, Chapter 17 and Part IV, Chapter 51, The Health Information Transfer Form

105 See, Final written submissions of the Nova Scotia Government and General Employees Union, paragraph 157

106 Final written submissions of: Inquiry Counsel, paragraph 178 ; Attorney General of Nova Scotia, paragraph 91(3); Halifax Regional Police Service, Summary of Recommendations, Training of Members, #9; Dr. Stephen Curry, Proposed Recommendation #1

107 Final written submissions of: Inquiry Counsel, paragraph 177; Nova Scotia Government and General Employees Union, paragraph 158; Capital District Health Authority, paragraph 147; Dr. Janet MacIntyre, page 25

108 Final written submissions of: Inquiry Counsel, paragraph 118; Nova Scotia Government and General Employees Union, paragraph 192. See also, Final written submis-

sions of the NSGEU, paragraph 194: "The Department of Justice should review the current policy requiring Sheriff personnel to bring information on a Health Information Transfer Form about a medical condition which is unusual or out of the ordinary to the attention of Crown and Defence counsel."

109 Final oral submissions of the Nova Scotia Government and General Employees Union, page 11240

110 Final written submissions of Dr. Janet MacIntyre, page 28

111 Final oral submissions by Dr. Janet MacIntyre, pages 11460–11461

112 Final oral submissions by the Capital District Health Authority, page 11392

113 Final oral submissions by Dr. Janet MacIntyre, pages 11460–11461

114 Dr. Stephen Curry, Proposed Recommendation #3

115 The Inquiry did hear evidence on some examples of electronic medical records, for example, PharmaNet in British Columbia and Horizon Patient Folder in the CDHA.

116 See, for example, The Romanow Commission on the Future of Health Care in Canada, "Building on Values", November 2002, page 76, Recommendations 8–11 and page 80–81; Gibson, Elaine: "Jewel in the Crown? The Romanow Commission Proposal to Develop a National Electronic Health Record System" (2003), 66 Sask. L. Rev. 647–665. See also, the Report of the Auditor General, page 69 on CDHA patient record scanning problems.

117 Final written submissions of the Canadian Mental Health Association, page 23: "Advanced directives are useful if the individual is concerned about the possibility they may be subjected to involuntary psychiatric commitment or treatment at some future time." Final written submissions of the Schizophrenia Society of Nova Scotia, page 39: "…consumers be given the opportunity to provide informed, independent, advance consents to the release of mental health or mobile crisis team information to law enforcement in prospective crisis circumstances…"

118 Consensus Project, Chapter 25, page 198; see also, Consensus Project, Chapter 13, page 106: "Another way to facilitate the release of mental health information is to encourage individuals who are at risk of being arrested to provide their clinician with prior consent to discuss their mental health needs with jail officials if an arrest and detention occurs."

119 Consensus Project, Chapter 25, page 196

120 Consensus Project, Chapter 25, page 197

121 Final written submissions of: the Nova Scotia Government and General Employees Union, paragraph 55; Inquiry Counsel, paragraph 26. According to Supt. William Moore, these Guidelines are already informing HRPS policies and practices. (Testimony of Supt. William Moore, pages 4027–4028 and Exhibit 168)

122 Final oral submissions of the Canadian Mental Health Association, page 11543; Nova Scotia Government and General Employees Union, page 11239; Schizophrenia Society of Nova Scotia, page 11517

123 Final written submissions of the Canadian Mental Health Association, page 27, Training, Recommendations #3 and #4

124 Testimony of Dr. Stephen Hucker, page 10070

125 Final written submissions of Dr. Stephen Curry, page 16

126 See, Part II, Chapter 23 and Part IV, Chapter 50, Mental Health Services: The Central Nova Scotia Correctional Facility

127 Final written submissions of the Nova Scotia Government and General Employees Union, paragraph 71; Inquiry Counsel, paragraph 51; the Canadian Mental Health Association, page 26, Conducted Energy Devices, Recommendation #2

128 Final oral submissions of the Halifax Regional Police Service, page 11348; see also, Final written submissions of HRPS, Summary of Recommendation, Training of Mem-

bers, #2

129 See, Part IV, Chapter 54, Mental Health and Crisis Intervention Training, HRP – Crisis Intervention Training

130 Final written submissions of the Halifax Regional Police Service, Summary of Recommendations, Training of Members, #1

131 Final written submissions of the Halifax Regional Police Service, Summary of Recommendations, Training of Members, #7

132 Final written submissions of the Nova Scotia Government and General Employees Union, paragraph 78; This was echoed by Inquiry Counsel, Final written submissions, paragraph 23.

133 Final written submissions of Inquiry Counsel, paragraph 36; Attorney General, paragraph 49(4); Halifax Regional Police Service, Summary of Recommendations, Training of Members, #8; Capital District Health Authority, paragraph 116; Final oral submissions of Dr. Stephen Curry, page 11489

134 Final written submissions of Inquiry Counsel, paragraph 35; Final oral submissions of the Halifax Regional Police Service, pages 11139, 11350

135 Final written submissions of: the Nova Scotia Government and General Employees Union, paragraphs, paragraph 343; Inquiry Counsel, paragraph 168

136 Final written submissions of: the Nova Scotia Government and General Employees Union, paragraph 198; Inquiry Counsel, paragraph 117

137 Final oral submissions of the Attorney General, pages 11210–11211

138 Final written submissions of the Nova Scotia Government and General Employees Union, paragraph 344; This was echoed by Inquiry Counsel, Final written submissions, paragraph 169.

139 Final written submissions of: the Nova Scotia Government and General Employees Union, paragraph 343; Inquiry Counsel, paragraph 160

140 Annual Report of the Office of the Correctional Investigator 2009–2010, Increasing Prevalence of Mental Health Issues

141 Final written submissions of: the Nova Scotia Government and General Employees Union, paragraph 261; Inquiry Counsel, paragraph 162

142 Final oral submissions of the Capital District Health Authority, page 11397

143 Final written submissions of: Inquiry Counsel, paragraph 92; Attorney General of Nova Scotia, paragraph 91(1); Nova Scotia Government and General Employees Union, paragraph 154; Halifax Regional Police Service, Summary of Recommendations, Training of Members, #11. Inquiry Counsel also proposed that police officers receive training in relation to forensic assessments. (Final written submissions, paragraph 37)

144 Consensus Project, Chapter 31, pages 232–234

145 See, Part IV, Chapters 40, Stigma and 56, Educating Emergency Department Doctors, The Stigmatization of "Forensic" Patients

146 Consensus Project, Chapter 23, page 182

147 Final written submissions of Inquiry Counsel, paragraph 35

148 Final written submissions of the Attorney General, paragraph 49(3)

149 Final written submissions of the Attorney General, paragraph 49(2)

150 Final oral submissions of Halifax Regional Police Service, pages 11358–11359

151 Final oral submissions of Halifax Regional Police Service, page 11358

152 See, Part IV, Chapter 53, Police Report Preparation and Note-Taking

153 Final written submissions of the Halifax Regional Police Service, Summary of Recommendations, Documentation, #1

154 See Part IV, Chapter 52, Communication, Information-Sharing and Confidentiality

155 See, Part II, Chapter 22, Admission to the CNSCF; Part IV, Chapter 52, Communication, Information-Sharing and Confidentiality

156 Final written submissions of: the Attorney General, paragraph 49(5); the Nova Scotia Government and General Employees Union, paragraph 160; Inquiry Counsel, paragraph 97; and the Halifax Regional Police service, Summary of Recommendations, In the Community, #9 ["Clarify protocols for sharing of information between mental health practitioners and the police."]

157 Testimony of Supt. William Moore, pages 4128–4129

158 United Nations Convention on the Rights of Persons with Disabilities, Preamble (j) and (n)

159 United Nations Convention on the Rights of Persons with Disabilities, Purpose. The Convention's Purpose indicates that persons with disabilities include those who have "long-term mental…impairments…which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others."

160 Article 14 (1)(b)

161 *Baker v. Canada (Minister of Citizenship and Immigration)*, [1999] S.C.J. No. 39, paragraph 70, where R. Sullivan, Driedger on the Construction of Statutes (3rd ed. 1994) at page 330 is quoted: "[T]he legislature is presumed to respect the values and principles enshrined in international law, both customary and conventional. These constitute a part of the legal context in which legislation is enacted and read. In so far as possible, therefore, interpretations that reflect these values and principles are preferred."

162 Final oral submissions of Dr. Stephen Curry, pages 11492–11493

163 Final written submissions of the Nova Scotia Government and General Employees Union, paragraph 159. A variation of this recommendation was also proposed by the Halifax Regional Police Service, Summary of Recommendations, In the Community , #1

164 Final written submissions of Nova Scotia Government and General Employees Union, paragraph 387

165 Final written submissions of Inquiry Counsel, paragraph 197

166 United Nations Standard Minimum Rules for the Treatment of Prisoners, Article 20(1) Every prisoner shall be provided by the administration at the usual hours with food of nutritional value adequate for health and strength, of wholesome quality and well prepared and served. (2) Drinking water shall be available to every prisoner whenever he needs it.

167 American Bar Association's Criminal Justice Standards on the Treatment of Prisoners, Standard 23-3.4 (a), (Healthful Food): Correctional Authorities should provide each prisoner with an adequate amount of nutritious, healthful and palatable food, including at least one hot meal daily.

168 Final written submissions of Inquiry Counsel, paragraph 53

169 Testimony of S/Cst. Gregory MacCormick, pages 2098–2099

170 Testimony of Dr. Janet MacIntyre, page 4780

Part VIII

Conclusion

We shall not cease from exploration
And the end of all our exploring
Will be to arrive where we started
And know the place for the first time.

– T.S. Eliot

PART VIII

Conclusion

Mr. Hyde's story is not one that started in November 2007. And it did not end on a cold cell floor. For all the examination at the Inquiry of the events that led up to Mr. Hyde's tragic death, much of the focus was on the future. It will do some measure of justice to Mr. Hyde's memory if that future is crafted from new ideas, fresh perspectives and a resilient belief that there are better, achievable options.

It was the submission of Inquiry Counsel that the remedies identified by Mr. Hyde's tragic experience are "better communication, better education, and a multidisciplinary approach to [the] care of mentally ill individuals who come into contact with the health and justice systems."[1] And the human rights and dignity of persons with mental illness were implicit in the words of counsel for the Nova Scotia Government and General Employees Union:

> …the overarching purpose [of the Inquiry's recommendations] is to create a culture where persons living with mental illness are treated with understanding and respect by both the health care and criminal justice systems.[2]

At an immediate, fundamental level, what Mr. Hyde needed was human contact, reassurance and kindness. The evidence discloses how well he responded, even when somewhat agitated, to simple but effective interactions that incorporated these elements. Certain police officers, sheriffs and correctional officers were all successful in their interactions with Mr. Hyde utilizing approaches that were empathetic, respectful and caring. Even though he was acutely ill, Mr. Hyde was reassured and comforted "by talking to him."[3] Understanding this is to understand Mr. Hyde's humanity and recognize in him, ourselves.

What Mr. Hyde needed in a more comprehensive sense were better options from the mental health and criminal justice systems. After all I have listened to, and read, I am left to wonder, what could Mr. Hyde's story have been? There has to be another narrative, one that leads to hope and integration and speaks to alternatives to the courts and jail for persons with severe, persistent mental illness who come into conflict with the law. As the evidence before the Inquiry has vividly illustrated, grasping this nettle is not just the responsibility of the justice system; creativity and commitment to change are required of the health system and the community too.

This Inquiry can offer, in addition to the recommendations I have endeavoured to craft with an eye to where change needs to be nurtured or germinated, the wealth of information, ideas, and experience offered by so many witnesses, from front-line police officers, sheriffs, correctional workers and health providers, to experts in policing, training, community-based and alternative modalities of care, and forensic psychiatry. And seeded throughout my discussion of the issues are references to many rich resources: international instruments that amplify the human rights

and human dignity obligations of the state, policing and criminal justice initiatives such as the Consensus Project, major undertakings in the field as represented by the work of the Mental Health Commission of Canada, and recent, relevant studies and reports into mental health and criminal justice. These are just the ones I have cited and they represent only some of what is available. The materials to build the future are at hand: it is a matter of seizing the opportunity to knit together a new, more ambitious, more hopeful approach to old challenges. I hope the work of the Inquiry will materially contribute to this endeavour.

Notes

1 Final oral submissions of Inquiry Counsel, page 11107

2 Final oral submissions of the Nova Scotia Government and General Employees Union, page 11239: This was explicitly supported by the Schizophrenia Society of Nova Scotia (Final oral submissions, page 11517) and by the final submissions of the Canadian Mental Health Association.

3 Final oral submissions of the Halifax Regional Police Service, page 11328. Csts. Gyles Gillis and Bradley Jardine at the hospital, S/Cst. Daniel Fraser in Booking, Cst. Kathryn Willett, Deputy Sheriffs Shirley Day and James Crook, and Correctional Officer Christopher Dixon each sought to make a reassuring connection with Mr. Hyde.

Glossary of Terms

ACEP	American College of Emergency Physicians
ACT	Assertive Community Treatment
AHS	Autonomic hyper-arousal state
CCRB	Criminal Code Review Board
CDHA	Capital District Health Authority
CEW	Conducted Energy Weapon
CMHA	Canadian Mental Health Association
CNSCF	Central Nova Scotia Correctional Facility
CPIC	Canadian Police Information Database
CPKN	Canadian Police Knowledge Network
CPR	Cardio Pulmonary Resuscitation
ECFH	East Coast Forensic Hospital
EDIS	Emergency Department Information System
EDP form	Emotionally Disturbed Person (Form)
EHS	Emergency Health Services
EKG	Electrocardiogram
ER	Emergency Department
HIT form	Health Information Transfer Form
HPF	Horizon Patient Folder
HRPS	Halifax Regional Police Service
ICD	International Statistical Classification of Diseases
IPTA	Involuntary Psychiatric Treatment Act
JEIN	Justice Enterprise Information Network
MAPP	Municipal Association of Police Personnel
ME	Medical Examiner
MIOU	Mentally Ill Offender Unit
MMHCT	Mobile Mental Health Crisis Team
MSI	Medical Services Insurance
NCR	Not Criminally Responsible
NSGEU	Nova Scotia Government and General Employees Union
NSH	Nova Scotia Hospital
OC Spray	Oleoresin Capsicum Spray
OHU	Offender Health Unit
PPS	Public Prosecution Service
QEII	Queen Elizabeth II Health Sciences Centre
RCMP	Royal Canadian Mounted Police
SCOT	Supportive Community Outreach Team
SSNS	Schizophrenia Society of Nova Scotia
SVT	Supra-ventricular tachycardia

Acknowledgements

This Inquiry had the assistance and support of a wide variety of people. Without them, it could not have discharged its mandate. It is appropriate to try and recognize as many of these people as I can:

For his hard work, resourcefulness and dedication, Dan MacRury, Q.C., Inquiry Counsel; for calmly and capably stepping into the Acting Inquiry Counsel role when Mr. MacRury was unavailable, Charles Broderick; for assistance to Mr. MacRury and Mr. Broderick, Public Prosecution staff Sharon Grant (coordinator-administrative services and witness travel), Kelly Gardiner (disclosure), and Bridget Curran (management of videotaped evidence and transcripts); for deftly handling the court reporting and related Inquiry-management tasks, first, Arthena (Tina) Devoe and then, Kristin Naas; for proposing and then expertly handling the webcasting of the Inquiry, John Piccolo (Director of Communications for the Nova Scotia Judiciary) and Alain Bouvette (Judicial IT Analyst), and the Executive Office of the Nova Scotia Judiciary for supporting this initiative; for skilled camerawork, Chris Cuthbertson; for the untold hours of work associated with the exhibits, especially the DVD evidence, Cst. Terry Kellock (RCMP), and for assisting with the DVD evidence in court on the few occasions when Cst. Kellock was unavailable, Cst. Gordon Hines (RCMP) and Cpl. Fraser Firth (RCMP); for kindly accommodating the Inquiry proceedings, myself and Ms. Devoe at the Law Courts during July, August and October 2009, Chief Justice Michael MacDonald and Chief Justice Joseph Kennedy, Wayne Stewart and Ann Saunders; for preparing and providing to the Inquiry and all counsel the documentary exhibits in electronic form, David MacNeil (IT Director), Julie Marsden and Amy Long, all of Cox Palmer and, for orchestrating and overseeing this, Thomas Donovan, Q.C. and Loretta Manning of Cox Palmer; for the amazing job of turning empty, unfurnished space at the Centennial Building, 1660 Hollis Street, into a hearing room and offices that were the Inquiry's home from December 2009 through to June 30, 2010, the unflappable Paul McNeil (Business Manager, Public Prosecution Service of Nova Scotia), Stephen Gurnham (Property Officer, Transportation and Infrastructure Renewal), Bruce Wood (Manager Inventory Control), Paul Mckenna (Transportation and Infrastructure Renewal), Ted Crews (Transportation and Infrastructure Renewal), James Howell (Supply Technician), Chris Scott (Justice Purchasing), and Patricia Rowe (Clerk IV, Public Prosecution Service); for setting up, at short notice, the NOVO recording system, microphones and speakers at the Centennial Building site, Kelly Burke and Bobby LePlante; and for his cheerful professionalism as our sheriff, Deputy Sheriff Kevin Hurst.

I also want to acknowledge and thank: all the counsel who appeared before the Inquiry and whose skill, high professional standards and sincerity made the Inquiry a pleasure to conduct; their support staff who must have put in count-

less hours assisting them; Ms. Tooton and the *pro bono* students who acted for the Canadian Mental Health Association and made a substantial contribution to the Inquiry without the benefit of counsel; the witnesses for their time and effort, and in the case of the expert witnesses, for being willing to travel to Halifax to assist the Inquiry; and the parties themselves for the contribution they made in ensuring the Inquiry had the relevant materials it needed.

My sincere thanks go out to Ruthmarie Adams, a local artist, who contributed *Expressions*, the artwork on the cover of the Report; and to Laing House, in particular Angella Parsons, Peer Support, who facilitated the connection with Ruthmarie.

I owe a debt of appreciation to Brenda Conroy, the Report's designer, whose alchemist's skill transformed what I produced.

Finally, I want to thank those people who made it possible for me to actually write this Report: Kristin Naas for her calm and competent assistance over the past 12 months as my Hyde Inquiry assistant; Adam Hartling, Justice IT, for always coming to my rescue; also Joanne Fancy; Brenda McGilvray for patiently training me on the essentials of Summation Software; colleagues: Chief Judge Patrick Curran, and Judge Jamie Campbell who assumed some of my court responsibilities, liberating me to write; Judge Bill MacDonald; Judges Peter Ross and Bill Digby who checked in with me to see how I was faring; and Jocelyn Bastarche, Executive Assistant to Chief Judge Curran, who had to juggle the strained judicial resources of the courts during a challenging time but rarely came looking for me. And my heartfelt gratitude to Archie and our girls, for once again drawing on their reserves of patience, generosity and good-humour.

List of Appendices

APPENDIX 1

Minister's Letter, Minister's Order, Notice

NOVA SCOTIA
Attorney General
Justice
Office of the Minister

PO Box 7, Halifax, Nova Scotia, Canada B3J 2L6 • Telephone 902 424-4044 Fax 902 424-0510 • www.gov.ns.ca

The Honourable Chief Judge Patrick P. Curran
Nova Scotia Provincial Court
5250 Spring Garden Road
Halifax, NS B3J 1E7

Dear Chief Judge Curran:

RE: Fatality Inquiry regarding the death of Howard Hyde

In accordance with subsection 27(2) of the *Fatality Investigations Act*, I have ordered that an inquiry be held into the death of the late Howard Hyde, of the Halifax Regional Municipality, who died on or about November 22, 2007.

I enclose a copy of the Order dated September 17, 2008.

Please advise me when a judge has been appointed to conduct this inquiry.

Thank you for your attention to this matter. Please contact Marian F. Tyson, Q.C., if you have any questions or concerns regarding this matter.

Sincerely,

Cecil P. Clarke

Encl.
c. Marian F. Tyson, Q.C.

IN THE MATTER OF
THE *FATALITY INVESTIGATIONS ACT*
Chapter 31 of the Acts of 2001, s. 27

WHEREAS the Chief Medical Examiner has submitted a report to the Minister of Justice respecting his investigation, pursuant to Section 11 of the *Fatality Investigations Act*, into the death of the late Howard Hyde of Halifax Regional Municipality, who died on or about November 22, 2007.

AND WHEREAS the Minister of Justice is of the opinion that it is in the public interest that a fatality inquiry be held into the death of the late Howard Hyde.

IT IS HEREBY ORDERED, in accordance with subsection 27(2) of the *Fatality Investigations Act*, Chapter 31 of the Acts of 2001, that a fatality inquiry shall be held into the death of the late Howard Hyde, of Halifax Regional Municipality, on or about November 22, 2007.

IT IS ORDERED that the Chief Judge of the Provincial Court of Nova Scotia shall appoint a judge to conduct the inquiry.

IT IS ORDERED that the judge appointed to conduct the inquiry shall make and file with the Provincial Court a written report containing any findings made by the judge as to:

- the date, time and place of death;
- the circumstances under which the death occurred;
- the cause of death;
- the manner of death; and
- any recommendations of the judge about any matters arising from the inquiry.

DATED this 17th day of September, 2008, at Halifax, in the Halifax Regional Municipality, Province of Nova Scotia.

Honourable Cecil P. Clarke
Minister of Justice and Attorney General

NOTICE

The Inquiry into the death of Howard Hyde

Halifax Regional Municipality

Public Notice is hereby given that the Honourable Cecil P. Clarke, Minister of Justice and Attorney General, has ordered a Fatality Inquiry, pursuant to Section 27(2) of the Fatality Investigations Act into the death of Howard Hyde, Halifax Regional Municipality, on or about 22 November 2007.

The Honourable Anne S. Derrick of the Provincial Court of Nova Scotia has been appointed to conduct the Inquiry and to make recommendations on the following issues:

1. **The date, time and place of death;**
2. **The circumstances under which the death occurred;**
3. **The cause of death;**
4. **The manner of death; and**
5. **Any recommendations of the judge about any matters arising from the Inquiry.**

On **Wednesday, 18 February 2009** at Halifax Provincial Court, 5250 Spring Garden Road, Halifax, NS, the Inquiry will open at 9:30 a.m. in Courtroom No. 6. The purpose is:

1. **To consider applications for standing;**

Applications for standing: It is recommended but not required that Applications for Standing be submitted in writing to inquiry counsel prior to 18 February 2009.

Future Inquiry dates are April 22, July 6-10, 13-17, 20-24; August 4-7,10-14 of 2009.

Interested parties may contact Daniel A. MacRury, Q.C., Chief Crown Attorney (Cape Breton Region), who has been appointed to act as counsel to assist in the above-noted Inquiry. Mr. MacRury may be contacted at: 3rd Floor, Commerce Tower, 15 Dorchester St., Sydney, NS, B1P 5Y9. Telephone (902) 563-3530; Fax (902) 563-0506; e-mail macrurda@gov.ns.ca

NOVA SCOTIA

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APPENDIX 2

List of Counsel

Dan MacRury, Q.C. Inquiry Counsel

Charles Broderick (Acting Inquiry Counsel - February 2010)

Edward Gores, Q.C., and **Dana MacKenzie**
Counsel for the Attorney General of Nova Scotia

Kevin C. MacDonald
Counsel for Joanna Blair and Dr. Hunter Blair

David Roberts
Counsel for the Nova Scotia Government and General Employees' Union

Sandra MacPherson, Q.C., and **Elizabeth Buckle**
Counsel for the Halifax Regional Police Service

Rory Rogers, and **Matthew Pierce**
Counsel for Capital District Health Authority

Thomas Donovan, Q.C., and **Loretta Manning**
Counsel for Dr. Janet MacIntyre

Michael Wood, Q.C., and **Jennifer Ross**
Counsel for Dr. Stephen Curry

Blair Mitchell, Angela Byrne, Michelle Cleary and **Marion Ferguson**
Counsel for the Schizophrenia Society of Nova Scotia

Carol Tooton, Executive Director,
Canadian Mental Health Association
Pro Bono Students: Simon Li, Mallory Treddenich and Susan Margison

APPENDIX 3

Rules of Procedure

1. INQUIRY COUNSEL

Inquiry Counsel shall assist the Inquiry in the orderly conduct of the Inquiry and ensure that all relevant evidence is submitted to the Inquiry.

2. INQUIRY PROCEDURE

At any time, the Inquiry may hold Procedural Hearings for the purpose of determining what persons shall have the right to be heard as interested persons and for the purpose of having Inquiry Counsel tender documentary or other evidence which Inquiry Counsel determine shall be tendered in advance of the public hearings for the convenience of the Inquiry or the parties.

3. PRE-INQUIRY INTERVIEWS

It is anticipated that Inquiry Counsel may request any person or any organization to submit to one or more interviews with Inquiry Counsel or other persons designated by Inquiry Counsel for preparation purpose, at any reasonable time appointed by Inquiry Counsel. No person or organization is required to submit to such interviews.

4. IN CAMERA PROCEEDINGS

Section 32 of the Fatality Investigations Act, provides that the Hearing shall be open to the public except where the Inquiry Judge is of the opinion that

(a) matters involving public security may be disclosed; or (b) the intimate or personal matters or other matters may be disclosed at the hearing that are of such a nature, having regard to the circumstances, that the desirability of avoiding disclosure of the matters in the interest of any person affected or in the public interest outweighs the desirability of adhering to the principle that hearings be open to the public, in which case the Inquiry Judge may hold the hearing or part of it concerning any such matters in-camera.

If any interested party wishes any portion to be in-camera, they are required to make an application to the Inquiry Judge for an Order that any portion of the proceedings be in-camera or any Order prohibiting the disclosure, publication, communication of any testimony, document or evidence. Such Applications shall be made in writing, supported by affidavit(s) at the earliest opportunity. The evidence and submission of such Applications may be presented in private or in public, or a combination of both, at the discretion of the Inquiry Judge. As stated, the Inquiry Judge may hold the Hearing or any part of it concerning any such matters in-camera.

5. WITNESSES

Inquiry Counsel will call and question witnesses to testify at the Inquiry in accordance with Section 31 of the Fatality Investigations Act. Inquiry Counsel will provide each interested party with a proposed witness and exhibit list well in advance of the commencement of the Inquiry. All parties are encouraged to provide Inquiry Counsel, at the earliest opportunity, the names and address of all witnesses whom they feel should be heard, together with a brief description of the witnesses, as well as relevant evidence and copies of all relevant documentation. Inquiry Counsel has the discretion to refuse to call a witness or present evidence. Where Inquiry Counsel refuses to call a witness or present evidence, a party may apply to the Inquiry Judge for an Order that such witness or such evidence be presented. Such Application must be made in writing, supported by an Affidavit. It must indicate the name and address of the witness, give a summary of his or her testimony or the reasons for not providing it. A copy of any document which the witness intends to file into the record must accompany his or her Application. If the Inquiry Judge is satisfied that the witness or evidence is needed, Inquiry Counsel will call the witness or present the evidence. All parties to the Inquiry should be notified of any Application by the Applicant.

6. EXPERT WITNESSES

Inquiry Counsel will provide each party with the name, address, and qualifications of each proposed expert witness. This shall include any Report which the proposed witness has prepared, as well as the area of expertise in which the opinion is being sought and a summary of the anticipated evidence and copies of all relevant documentation.

7. ORDER OF EXAMINATION

Inquiry Counsel shall proceed first with the examination of witnesses and may examine, cross-examine or re-examine all witnesses. Except as otherwise directed by the Inquiry Judge, Inquiry Counsel can adduce evidence by way of both leading and non-leading questions. Other parties who have been granted Standing may, in such order as they have agreed or as directed by the Inquiry Judge and subject to such terms as may be imposed upon such right of examination by the Inquiry Judge, cross-examine witnesses called by Inquiry Counsel.

8. ACCESS TO INFORMATION

All documentary or physical evidence filed before the Inquiry Judge shall be identified and marked "P" for public hearings in numerical order and, if necessary, in-camera hearings for which a non-disclosure, a non-publication, or non-communication ban order has been issued shall be identified and marked as "IC" in numerical order. One copy of the "P" transcript of the evidence and a "P" list of exhibits of the public hearings will be available to be shared and consulted by counsel for all parties.

9. PRESENCE OF INTERESTED PERSONS

At the time and place appointed for holding the Inquiry, the Inquiry may proceed with the Inquiry whether or not parties granted Standing or their Counsel are present.

10. ATTENDANCE OF WITNESSES

Where the Inquiry requires the attendance of any witness, either of its own motion or as a result of an application, the Notice to be served on the witness shall be in the form set out in Schedule 1 to these Rules of Procedure.

11. EXCLUSION OF WITNESSES

Any party may apply to the Inquiry Judge for an Order of Exclusion of Witnesses.

12. PRODUCTION OF DOCUMENTS

(1) Where the Inquiry requires the production of any documents by any person either of its own motion or, as a result of an application, notice to be served on that person shall be in the form set out on Schedule 2 to these Rules of Procedure.

(2) Parties granted standing may apply to Inquiry Counsel to require the production of any document and Inquiry Counsel may in his discretion require production of such document.

(3) Where Inquiry Counsel refuses to require production of documents or present evidence, a party may apply to the Inquiry Judge for an Order to require such production of documents or such evidence be presented. Such Application must be made in writing, supported by an Affidavit. If the Inquiry Judge is satisfied that the production of documents or evidence is needed, Inquiry Counsel will seek production of the documents. All parties to the Inquiry should be notified of any Application by the Applicant.

13. DISCLOSURE OF DOCUMENTS

(1) Inquiry Counsel will disclose all documents, in his possession, in a reasonable time prior to the scheduled dates of witnesses

(2) All counsel and interested parties are required to return to Inquiry Counsel all documents or witness summaries which are not produced in evidence.

14. SERVICE OF DOCUMENTS

Any notice, summons or other document issued under these Rules may be served personally at the address of the person to be served, by certified post, or by such other method of service as the Inquiry judge may direct.

15. EVIDENCE

(1) The Inquiry Judge may admit as evidence Affidavits, Statutory Declarations or other evidence made or taken under the laws of Canada that may be applicable in any case in which the Inquiry considers it fit and proper to have such evidence presented, and whether such evidence is sworn or unsworn. The Inquiry Judge may admit transcripts of related proceedings and statements of individuals whether or not such individuals are available for examination and cross-examination.

(2) Without restricting the generality of subsection (1), the Inquiry may admit such written, oral or other evidence as the Inquiry may in its discretion deem relevant, whether or not the admission of such evidence is in accordance with the normal rules of evidence.

(3) Where possible the evidence of witnesses shall be taken under oath or solemn affirmation and witnesses shall be sworn or affirmed in the manner normally used in the Provincial Court of Nova Scotia.

(4) All evidence taken in any manner provided for by these Rules of Procedure shall form part of the record of the proceedings of the Inquiry.

16. SUBMISSIONS BY COUNSEL

(1) When all evidence has been adduced before the Inquiry, Inquiry Counsel and parties with standing shall have the right to address the Inquiry viva voce in such order as the Inquiry Judge directs and Inquiry Counsel shall have the right to address the Inquiry first and make the final submission to the Inquiry.

(2) The Inquiry Judge may direct that written submissions be made by Inquiry Counsel and parties with standing in lieu of or in addition to their oral submissions.

17. THE INQUIRY JUDGE

The Inquiry Judge shall rule on any objections raised, determine all matters of procedure not provided for in these Rules and, when in her discretion it is necessary or desirable for the purposes of fully discharging the duties of the Inquiry, may allow departures from these Rules.

18. ADJOURNMENTS

The Inquiry may adjourn its inquiry from time to time and from place to place.

19. AMENDMENTS

These Rules of Procedure may be amended from time to time by the Inquiry judge as she sees fit upon notice to parties with standing.

APPENDIX 4

List of Witnesses

Witnesses Heard		
Karen Ellett	Common-law partner of Mr. Hyde	July 7, 2009
Cst. Gyles Gillis	Halifax Regional Police Officer	July 7, 8 & 9, 2009
Cst. Bradley Jardine	Halifax Regional Police Officer	July 9 & 10, 2009
Cst. Jonathan Edwards	Halifax Regional Police Officer	July 10, 13 & 14, 2009
S/Cst. Shannon Coombs	Halifax Regional Police Officer	July 14 & 15, 2009
S/Cst. Gregory McCormick	Halifax Regional Police Officer	July 16 & 17, 2009
Cst. Benjamin Mitchell	Halifax Regional Police Officer	July 17 & 20, 2009
Cst. Michael Cecchetto	Halifax Regional Police Officer	July 20, 2009
Cst. Michael Carter	Halifax Regional Police Officer	July 20, 2009
Cst. Karen Foster	Halifax Regional Police Officer	July 20 & 21, 2009
Cst. Jeffrey Buchanan	Halifax Regional Police Officer	July 21, 2009
Cst. Christopher McMahon	Halifax Regional Police Officer	July 21, 2009
Cst. Steven Hillier	Halifax Regional Police Officer	July 21, 2009
Cst. John Haislip	Halifax Regional Police Officer	July 21 & 22, 2009
Cst. Dan Fraser	Halifax Regional Police Officer	July 22, 2009
Cst. Daniel Pellitier	Halifax Regional Police Officer	July 22, 2009
Cst. David Smith	Halifax Regional Police Officer	July 22 & 23, 2009
Cst. Kathryn Willett	Halifax Regional Police Officer	July 23, 2009
Staff Sgt. Sean Auld	Halifax Regional Police Service	July 23 & 24, 2009
Sgt. Kevin Murphy	Halifax Regional Police Officer	July 24, 2009
Aaron Parsons	Paramedic, EHS	July 24, 2009
Maureen Sturgeon	Paramedic, EHS	July 24, 2009
Susan Hedley	Nurse, QEII Emergency Department	August 4, 2009
Laura Morgan	Nurse, QEII Emergency Department	August 4, 2009
Susan Hare	Program Leader, Capital Health Mental Health Program	August 4 & 5, 2009
Glenda Keyes	Nurse, QEII Emergency Department	August 5, 2009
Taryn Roberts	Nurse, QEII Emergency Department	August 5, 2009
Supt. William F. Moore	Superintendent of Community Projects, Halifax Regional Police Service	August 6, 2009
Deputy Sheriff Shirley Day	Site Supervisor, Dartmouth Provincial Court	August 7, 2009
Dr. Stephen Curry	Physician, QEII Emergency Department	August 11 & 12, 2009
Dr. Janet MacIntyre	Physician, QEII Emergency Department	August 12 & 13, 2009

Sheriff Laurel Purcell	Sheriff Services, Department of Justice	August 13, 2009
Deputy Sheriff Brian Williams	Sheriff Services, Department of Justice	August 13, 2009
Deputy Sheriff James Crook	Sheriff Services, Department of Justice	August 14, 2009
Cheryl Byard	Crown Attorney, Public Prosecution Service	October 19, 2009
Staff Srgt. Donald Fox	Halifax Regional Police Service	October 19, 2009
Christopher Dixon	Correctional Officer, CNSCF	October 20, 2009
Sandra McLeod	Nurse, Offender Health Unit, CNSCF	October 20 & 21, 2009
Maureen Walford	Administrative Clerk, Offender Health Unit, CNSCF	October 21, 2009
Stephen Kayongo	Correctional Officer, CNSCF	October 21, 2009
Bradley Morris	Correctional Officer, CNSCF	October 21, 2009
Renee Jones	Correctional Officer, CNSCF	October 21 & 22, 2009
Christopher Digout	Correctional Officer, CNSCF	October 22, 2009
Herman Mrvelj	Correctional Officer, CNSCF	October 22, 2009
Cameron Lamond	Correctional Officer, CNSCF	October 22 & 23, 2009
Alergon Smith	Correctional Officer, CNSCF	October 23, 2009
Ian Prall	Sergeant, CNSCF	October 26, 2009
Peter Lloyd	Correctional Officer, CNSCF	October 26, 2009
John Currie	Correctional Officer, CNSCF	October 26 & 27, 2009
Todd Henwood	Captain, CNSCF	October 27, 2009
Douglas Whitman	Captain, CNSCF	October 27, 2009
Michael Green	Correctional Officer, CNSCF	October 28, 2009
Cheryl Champion	Nurse, Offender Health Unit, CNSCF	October 28, 2009
Charlene Casey Gomes	Nurse, Offender Health Unit, CNSCF	October 28, 2009
Karen Daigle	Nurse, Offender Health Unit, CNSCF	October 28, 2009
Sgt. Dean Steinburg	Sergeant in the Training Section for Halifax Regional Police Service	December 1 & 2, 2009
Diana MacKinnon	Director of Public Security with the Public Safety and Security Division of the Nova Scotia Department of Justice	December 2 & 3, 2009
Sgt. John Parkin	Halifax Regional Police Service	December 3, 2009
David Webber	Photographic Lab Technician, Halifax Regional Police Service (civilian member)	December 3, 2009
Tracy Dominix	Departmental Trainer, Corrections Services	December 3, 2009
Sean Kelly	Director, Corrections Services	December 3, 2009
Dr. Martin Bullock	Forensic Pathologist	December 4, 2009
John McKay	Retired Superintendent, Vancouver Police Department	December 7 & 8, 2009
Dr. Matthew Bowes	Forensic Pathologist and Chief Medical Examiner for the Province of Nova Scotia	December 8 & 9, 2009
Dr. John Butt	Forensic Pathologist and former Chief Medical Examiner for the Province of Nova Scotia	December 9, 2009

Michael Oliver	Correctional Officer, CNSCF	December 10, 2009
Ernest MacRae	Correctional Officer, CNSCF	December 10, 2009
Gordon Hamilton	General Manager, PRAXES Emergency Services	December 10, 2009
Matthew Atwell	Paramedic, PRAXES Emergency Services	December 10, 2009
Kenneth Murray	Paramedic, PRAXES Emergency Services	December 10, 2009
Peter Planetta	Duty counsel, Dartmouth Provincial Court	December 11, 2009
Robert Purcell	Executive Director, Public Safety and Security Division	December 11, 2009
Dr. Christine Hall	Emergency Medicine specialist	February 1 & 2, 2010
Dr. Joseph Noone	Forensic Psychiatrist	February 3, 2010
Dr. Charles Kerr	Cardiac Electrophysiologist	February 9, 2010
Dr. Scott Theriault	Clinical Director, East Coast Forensic Psychiatric Hospital; Clinical Director for Specialty Programs, Capital District Mental Health Program; Associate Professor of Psychiatry, Dalhousie Univerity	February 11, 2010
Deborah Phillips	Bed Management Coordinator and Health Service Manager, Capital Health Mental Health Program	February 11, 2010
Dr. Jacqueline Kinley	Director, Mental Health and Treatment Program, Capital District Health	February 12, 2010
Dr. Stephen Hucker	Forensic Psychiatrist	February 15, 2010
Dr. Michael Howlett	Chief of the Emergency Medicine Department for the Colchester Regional Hospital, Truro, N.S.	February 17, 2010
Dr. Sarban Singh	Physician	February 19, 2010
Roy Kennedy	Policing Consultant, Department of Justice	February 22, 2010
Stephen Lurie	Executive Director, Canadian Mental Health Association, Toronto Branch	February 23, 2010
Dr. Michael Webster	Clinical Psychologist	February 24 & 25, 2010

Statements Entered as Evidence		**Date of Interview**	**Exhibit**
Glenn Beck	EHS	November 22, 2007	260
Shawn Welsh	EHS	November 22, 2007	263
Kyle Meyer	Paramedic, EHS	November 22, 2007	258
Andrew Bednarz	Lieutenant, Highfield Park Fire Station	November 24, 2007	256
David Carmichael	Firefighter, Highfield Park Fire Station	November 24, 2007	261
Sherry Thibeault	Firefighter, Highfield Park Fire Station	November 27, 2007	257
Lee Mailman	Clinical Leader, Emergency Department, Dartmouth General Hospital	December 6, 2007	259
Stephen Crocker	Advanced Care Paramedic	July 23, 2009	262

APPENDIX 5

List of Experts and the Nature of the Opinion Evidence They Were Qualified by the Inquiry to Give

Dr. Matthew Bowes, a forensic pathologist and Chief Medical Examiner for the Province of Nova Scotia, qualified by the Inquiry to give opinion evidence in respect to the type and cause of injuries to the human body and to the cause of death.

Dr. Martin Bullock, a forensic pathologist, qualified by the Inquiry to give opinion evidence in respect of the cause and type of injuries to the human body.

Dr. John Butt, a forensic pathologist and formerly the Chief Medical Examiner for Nova Scotia, qualified by the Inquiry to give opinion evidence in respect to the type and cause of injuries to the human body and the cause of death.

Dr. Christine Hall, a specialist in emergency medicine, qualified by the Inquiry to give opinion evidence in respect to excited delirium and sudden in-custody death.

Dr. Michael Howlett, an emergency room physician, qualified by the Inquiry to give opinion evidence in emergency medicine around the emergency care provided to Mr. Hyde on November 21, 2007 at the QEII Health Sciences Centre Emergency Department.

Dr. Stephen Hucker, a forensic psychiatrist, qualified by the Inquiry to give opinion evidence in forensic psychiatry as it relates to hospitals, courts, clinical criminology and the law.

Dr. Charles Kerr, a cardiac electrophysiologist, qualified by the Inquiry to give opinion evidence in cardiology and electrophysiology, and on cause of death and the administration of CPR.

Mr. John McKay, a retired police Inspector of the Vancouver Police Department, qualified by the Inquiry to give opinion evidence in use of force by peace officers, the development and practical application of use of force models and theory of the use of force by police officers and by correctional officers in a jail or a correctional facility, and in training use of force theory and tactics.

Dr. Joseph Noone, a forensic psychiatrist, qualified by the Inquiry to give opinion evidence concerning forensic and emergency psychiatry and the clinical aspects of violent behaviour.

Dr. Michael Webster, a clinical psychologist, was qualified by the Inquiry to give opinion evidence in crisis intervention in the context of use of force and as an expert in the psychology of conflict.

APPENDIX 6

Opening and Concluding Remarks

Opening Remarks

February 18, 2009

Good morning and welcome to everyone in attendance. My name is Anne Derrick. I am a Judge of the Provincial Court of Nova Scotia and have been appointed by the Chief Judge of the Provincial Court of Nova Scotia to conduct this inquiry. This is the first day of the inquiry which is being referred to as the Hyde Inquiry. It has been ordered by the Minister of Justice and Attorney General for the Province of Nova Scotia, the Honourable Cecil Clarke, pursuant to section 27(2) of the *Fatality Investigations Act* of Nova Scotia.

I will be conducting the inquiry according to the legislation governing it and the Order-in-Council that has set out its terms of reference. I do not know the facts in this case. I will be listening to the evidence with an open mind as it unfolds. From time to time I may have questions of witnesses myself about their evidence but I will, by far, have the least to say of anyone in these proceedings. Once I have heard all the evidence and submissions in this inquiry, I will be writing a report with findings and recommendations on the issues identified under the Order-in-Council. I will speak about this further shortly.

At this point I want to pause for a moment to reflect on the fact that we are all here this morning because of a tragic event. Howard Hyde's death on November 22, 2007 is the reason for this inquiry. Whatever the facts may be with respect to Mr. Hyde's death and the events leading to it, and whatever recommendations may emerge from the evidence that will be presented here, it can be safely assumed that Mr. Hyde's death has been a tragedy for his family and friends, the people in his life who loved him and miss him. Some of what an inquiry like this may be able to accomplish is to provide answers to those who were closest to Mr. Hyde, to those involved with him during his last hours and to the public at large. I can hope that the work of this inquiry will be of value to anyone who is looking to better understand what happened to Mr. Hyde.

I want to make a few remarks about the legal underpinnings of this inquiry and the process that will be followed to discharge its mandate. As I mentioned, this inquiry is a fatality inquiry governed by the *Fatality Investigations Act*. Its hearings will be open to the public unless certain specific circumstances identified by the *Act* arise. Witnesses will be called and I presume, documentary evidence will also be tendered. Today I will be addressing the applications for standing that have been made or are made this morning and determining who the interested persons are who may participate in these proceedings. Inquiry counsel has been appointed, that being Daniel MacRury, a Crown Attorney, and I will introduce him in due course. Under the legislation, a personal representative of Mr. Hyde is a participant at the inquiry. And the Minister of Justice is also entitled under the legislation to participate through counsel in the examination

of witnesses and presentation of submissions.

The mandate of the inquiry is set out in the Order-in-Council dated September 17, 2008. I will be asking Mr. MacRury to tender a copy of the OIC as an Exhibit. It provides that the judge appointed to conduct the inquiry shall make and file with the Provincial Court a written report containing any findings made by the judge as to:

> the date, time and place of death;
> the circumstances under which the death occurred;
> the cause of death;
> the manner of death;
> any recommendations of the judge about any matters arising from the inquiry.

This mandate appears in the public notices about the inquiry that have been published over the past several weeks in the Chronicle Herald.

What this inquiry cannot do is make any findings of legal responsibility. That means that my report will not express any findings, conclusions or recommendations about any civil or criminal liability of any person or organization.

As I have indicated today's proceedings are to address the issue of standing for interested persons. Mr. MacRury, as inquiry counsel, has received a number of written applications for standing, a total of nine I believe. I will deal with these applications first before I ask if anyone has attended today, without a written application, but with the intention of seeking standing. I will assume that unless an objection is raised by Mr. MacRury or a party to the inquiry, that applications I am considering are not being objected to. The legislation provides for standing to be granted to anyone declared by the judge to be an "interested person."

The term "interested person" is not defined or elaborated upon in the *Fatality Investigations Act*. I found some assistance in a decision from Alberta where the legislation uses the same language of "interested person." In *Pham (Re), [2004] A.J. No. 245*, a decision of the Alberta Provincial Court the judge noted that standing at fatality inquiries has become more inclusive and said: "Disparate groups with no obvious connection to the event are being given standing on the basis of the public interest and/or expertise..." He found that parties seeking standing need only show either a direct or a substantial connection to the mandate of the inquiry. I am satisfied that is an appropriate test to apply when determining who meets the requirement of being "an interested person" under Nova Scotia's *Fatality Investigations Act* and it is the criteria I intend to use unless there are submissions that I should be considering a different approach.

Once we have dealt with standing, I will ask counsel if there are any issues they wish to raise at this point for me to consider and deal with now, if feasible, or at some future date. The inquiry will next convene on April 22 at 9:30 a.m., in this courtroom and on that occasion it is my intention to deal with finalizing Rules of Procedure and addressing any preliminary issues. If parties intend to address any substantive issues on April 22, notice will have to be provided to Mr. MacRury and to the other parties, at least two weeks in advance. If counsel are of the view that the inquiry should convene on another date after April 22 but before the start of the hearings into the evidence then we should address that this morning as well.

As for the Rules of Procedure, I will be reviewing a draft with Mr. MacRury to be circulated to the parties to the inquiry at the beginning of April. Please therefore ensure that Mr. MacRury has complete contact information for all counsel and any representatives of parties with standing. These Rules will be finalized on April 22. I expect Mr. MacRury will be in contact with counsel and representatives for parties to the inquiry to address other procedural matters.

The hearing dates for the inquiry, when evidence will be called and submissions made, are, as indicated in the public notices: July 6 - 10; July 13 - 17; July 20 - 24; August 4 - 7 and August 10

- 14. Please note that August 3 is a civic holiday and the inquiry will not be sitting. The proceedings will be conducted in a courtroom at the Law Courts at 1815 Upper Water Street in Halifax from 9:30 a.m. - 4:30 p.m. unless otherwise agreed, with appropriate breaks during each day. It is my objective to conclude the inquiry's public hearings no later than August 14.

Before I conclude my opening remarks and introduce inquiry counsel, Dan MacRury, I have a few final comments to make. This is an inquisitorial, not an adversarial process. It is an inquiry, not a trial. The purpose of the hearings is to equip me with the evidence I need to address the issues set out in the Order-in-Council. The focus of the inquiry will be on those issues. I have no doubt that I will be assisted in these proceedings by all who participate. Principally, I will be assisted in this process by Mr. MacRury. From time to time Mr. MacRury and I will have discussions about the progress and direction of the inquiry. Mr. MacRury has practiced law for 22 years as both a Crown and Defence counsel. His legal career started out with Nova Scotia Legal Aid and he then joined the Nova Scotia Public Prosecution Service in 1996. He has appeared at all levels of court in Nova Scotia - Provincial Court, Supreme Court and the Court of Appeal. He represented the Attorney General of Nova Scotia as an intervener in the Supreme Court of Canada. In short, he has had extensive experience as a court-room lawyer and is highly regarded by Crown and Defence lawyers throughout the province. Mr. MacRury has also brought his skills to bear on Federal/Provincial/Territorial projects as well as projects under the auspices of the United Nations. He was awarded his Queen's Counsel designation in 2005 and is presently the Chief Crown Attorney for the Cape Breton Region. Mr. MacRury's proven abilities and experience will be a great asset to the work of this inquiry.

I want to conclude with a disclosure. Very recently, during my work to prepare for this inquiry, I recalled that 9 years ago, as a lawyer, I had a very limited and brief professional involvement with one of the applicants for standing at this inquiry. I was consulted about a wholly unrelated matter and my contact consisted of one meeting and two letters. I am entirely satisfied this does not raise any issue for me to consider in terms of this inquiry but I make this disclosure in the interests of transparency.

Let me thank you all in advance for what I know will be a commitment of hard, serious work in the public interest. I now turn the proceedings over to Mr. MacRury.

Opening Remarks

July 6, 2009

Good morning. I want to welcome everyone in attendance - counsel, the parties who have come today, members of the general public and representatives of the media.

This is the start of the evidentiary hearings for what is being referred to as the Hyde Inquiry, a fatality inquiry ordered by the former Minister of Justice and Attorney General for the Province of Nova Scotia pursuant to section 27(2) of the *Fatality Investigations Act* of Nova Scotia.

Prior to today, there have been three procedural hearings. At these hearings - held on on February 18, April 22 and June 12 - issues such as standing, the Rules of Procedure and the decision to webcast the proceedings were dealt with. On February 18 I made opening remarks and something I said then merits repeating.

This Inquiry will be looking into the circumstances of a tragic event, the death of Howard Hyde on November 22, 2007. Whatever the facts may be with respect to Mr. Hyde's death and the events leading to it, and whatever recommendations may emerge from the evidence that will be presented here, it can safely be assumed that Mr. Hyde's death has been a tragedy for his

family and friends, the people in his life who loved him and grieve his passing. Some of what an inquiry like this may be able to accomplish is to provide answers to those who were closest to Mr. Hyde, to those involved with him during his last hours and to the public at large. I know I speak for everyone involved with this Inquiry when I say we all carry the hope that it will achieve something of value while it is ongoing and once it has completed its work.

I will be conducting the Inquiry according to the legislation governing it and the Order-in-Council dated September 17, 2008. The Order-in-Council requires me to make and file with the Provincial Court a written report containing any findings as to:

> the date, time and place of Mr. Hyde's death;
> the circumstances under which Mr. Hyde's death occurred;
> the cause of Mr. Hyde's death;
> the manner of his death; and
> any recommendations about any matters arising from the inquiry.

What this Inquiry cannot do is make any findings of legal responsibility. Accordingly, my report will not express any findings, conclusions or recommendations about any civil or criminal liability of any person or organization. Relative to that is the fact that this is an inquisitorial, not an adversarial process. It is an inquiry, not a trial. The purpose of the hearings is to equip me with the evidence I need to address the matters set out in the Order-in-Council.

Represented at this Inquiry are parties who have been granted standing to participate. They are:

> the Attorney General of Nova Scotia, represented by Edward Gores, Q.C. and Dana MacKenzie;
> Joanna and Dr. Hunter Blair, represented by Kevin C. MacDonald;
> the Nova Scotia Government Employees Union, represented by David Roberts;
> the Halifax Regional Police, represented by Sandra MacPherson, Q.C. and Elizabeth Buckle;
> the Capital District Health Authority, represented by Rory Rogers;
> Dr. Janet McIntyre, represented by Thomas Donovan, Q.C. and Loretta Manning;
> Dr. Stephen Curry, represented by Michael Wood, Q.C.;
> the Schizophrenia Society of Nova Scotia, represented by Blair Mitchell; and
> the Canadian Mental Health Association, represented by Carol Tooton, Executive Director and *pro bono* law students Simon Li and Mallory Treddenich, assisted by *pro bono* law student, Susan Margison.

Inquiry Counsel is Dan MacRury, Q.C.

This Inquiry is being live streamed to the internet. I want to publicly thank John Piccolo, Communications Director for the Nova Scotia Judiciary, and Alain Bouvette, Judicial IT Analyst, for their very hard work in both proposing and then implementing a webcast of the Inquiry to provide greater public and media access to its proceedings. Webcasting will enhance public understanding of the issues critical to the Inquiry and will serve to educate more people than can attend the proceedings about these issues.

I will also be educated in the course of these proceedings and it will be through the hard work of counsel and the *pro bono* students that this will be accomplished. In recognition of this I want to take the opportunity to thank Inquiry Counsel, all counsel for the parties, and Ms. Tooton and the *pro bono* students, for their hard work through what will have been a demanding period of preparation over the last five months, and for the work that is still to come. This is a challenging assignment for all of us and I know you will be a great assistance to me.

Concluding Remarks

August 14, 2009

I would like to, just in concluding, thank Chris Cuthbertson, I believe, and Mr. John Piccolo for the webcasting that they've been doing for the Inquiry during the period of time that we've been sitting in July and August. I'd also like to thank, I believe… is it Cst. Gord Hines and his compatriots Cst. Terry Kellock and Cpl. Fraser Firth for handling the video evidence and the exhibits. Their efforts are certainly much appreciated. And I do want to thank Ms. Devoe as well for her work on the Inquiry. And also, I want to acknowledge and thank witnesses. Of course, I don't know who they are, but I know that there's probably been a good deal of scheduling and rescheduling and that no doubt witnesses have had to be very patient. And I'd like to thank them for that.

And I also would like to thank counsel. I know that these kinds of proceedings are very grueling, and I certainly appreciate your professionalism and your skill and your diligence in assisting me with this task and I do want you to understand that has not gone unnoticed. And I feel, having been a courtroom lawyer myself for 24 years before my appointment, I have a very good understanding of what hard work this involves. And I do want to say I genuinely appreciate it. So thank you all.

You can certainly take your time packing up. Ms. Devoe and Mr. MacRury and I will be here for a while, so if you need to go get a bite to eat and then come back and pack up your things… I don't know how much of the material that's here is yours and how much of it is ours, but we'll be here for a while getting everything packed up. And then we will resume on October the 19th. Thank you.

Opening Remarks

October 19, 2009

I'd just like to welcome everybody back to the Inquiry. This is week six, and we've heard from 34 witnesses, as I believe everybody would know.

I want to extend a special welcome to John McMillan, who I understand is going to assist us with the first witness we're going to hear from today. And I'll turn matters over to Mr. MacRury and Mr. McMillan in a moment.

I do just want to make a few comments concerning the logistics that are involved in getting the Inquiry restarted. There are quite a number of people who we can extend our appreciation to, and I'll start with Chief Justices Michael MacDonald and Joseph Kennedy, who have kindly accommodated us again at the Law Courts. And also to the courthouse staff, who have been very helpful in getting us set up.

You'll notice as well that we're able to continue webcasting for these weeks of the Inquiry at least. And the Executive Office of the Judiciary has been very helpful in getting that set up, and particularly John Piccolo came in over the weekend to get the webcasting organized. I would also like to thank Ms. Devoe who came in over the weekend and early this morning, and Mr. MacRury, to get us set up. And again, we're very appreciative to Cst. Kellock, who arranged to get the exhibits down here, and that was a very generous support from him. So thank you to all of those people who enabled us to get under way.

Opening Remarks

December 1, 2009

Well, I'd like to welcome everybody back to the proceedings of the Hyde Inquiry.

Today is the start of the eighth week of our hearings. We sat for five weeks over the summer and two weeks in October and we'll sit now until December the 11th.

To date we've heard from 55 witnesses.

I understand Mr. MacRury is intending to call 17 witnesses over the next two weeks and I hope we'll be able to get through their evidence as we don't sit again until February and that will represent 12 months since we held our first pre-hearing conference.

We're sitting this time in an adapted space that will be serving as the inquiry's home until we conclude our hearings. And we've been very fortunate for the first seven weeks of our hearings to have been accommodated at the Law Courts, first in a courtroom used typically by the Nova Scotia Supreme Court and then in a courtroom of the Nova Scotia Court of Appeal. The option of using space at the Law Courts came to an end and we've been set up in this alternate space which I'm optimistic will serve our needs very well.

I'm mentioning this primarily to provide a context for acknowledging the effort of a number of people who have tirelessly worked, at very short notice, to have the inquiry ready to proceed this morning. Three weeks ago this was an empty space and this morning it is a functioning courtroom.

And I'd like to recognize and thank some of those responsible for this effort, an assignment that was in addition to their day jobs –

First of all, **Paul McNeil**, the Business Affairs Director for the Public Prosecution Service, pulled all this together with a deft and unflappable approach to every detail, and there have been many. I also want to acknowledge the time Mr. MacRury has spent on the logistics with Mr. McNeil.

Chris Scott from the Department of Justice;

Kelly Burke and **Bobby LaPlante** who set up the digital recording;

Alain Bouvette and **John Piccolo** who dealt with the IT issues and the webcasting; and we're very fortunate to have **Chris Cuthbertson** back with us again;

And **Cst. Terry Kellock** who's here today who has coordinated the systems for the DVD evidence;

I know there are other individuals who have helped in the past few weeks and I'm sure it has been too few weeks. The time and effort undertaken to find the inquiry a location to complete its hearings and set up and equip a workable space is very much appreciated.

I also want to finally take the opportunity to introduce and welcome **Kristin Naas** who has gamely agreed to take on the job of reporting for the inquiry and I want to thank her for doing so.

Tina Devoe who served the inquiry so well for our first seven weeks of hearings has assumed new responsibilities with the mental health court in Dartmouth.

Concluding Remarks

December 11, 2009

I'm pleased to be able to say that it'll be this space that we'll be able to use in the Centennial Building on the corner of either Granville or Hollis Streets for those who are watching the webcasting or if there are any members of the public who might want to attend the hearings. And I would like just to take this opportunity to thank the individuals who've assisted us in these couple of weeks, and they would of course be Cst. Kellock, once again, whose services have been so helpful to us. And, Chris Cuthbertson, Ms. Naas, our reporter, who seems to have slipped effortlessly into her new role, and Sheriff Hurst… Deputy Sheriff Hurst. And, I just want to say again how much we appreciate his volunteering for the use of force demonstration. It was outside of his normal duties, but certainly helpful to the Inquiry. I do, as well, wish to make an acknowledgement to the Executive Office of the Judiciary for their continued support for the webcasting of this Inquiry, which has taken on an especially important dimension because it does appear to me as though the local media have not been covering the Inquiry recently, although it has been of considerable public interest, and so I do emphasize the value I think the webcasting has in serving the public interest dimension of this public inquiry.

And finally, I wish everyone well over the holiday season that is about to come upon us. And I look forward to seeing everybody back on February the 1st. Thank you.

Opening Remarks

February 1, 2010

I want to welcome everyone back to the proceedings of the Hyde Inquiry and while I realize the sentiment is a little stale now, I also want to wish everyone a happy new year. We were last in session on December 11 at which time we concluded the evidence of our 72nd witness. Today marks the start of week 10 of these hearings. The testimony I have heard to date will be of great assistance to me in the discharge of my mandate and I continue to be grateful for the diligent work being done by counsel and the contribution of the witnesses coming before me.

The Inquiry is scheduled to sit for the month of February. We are expecting to hear from approximately thirteen witnesses, including a number of experts. I know these expert witnesses, like the ones we heard from previously, have undertaken a considerable amount of work in preparation for their evidence. They will also be traveling a significant distance to come here and testify and will have limited time to spend with us. A schedule of the February witnesses has been circulated to counsel and Ms. Tooton. I must note there will not be the same options for flexibility that we took advantage of with local witnesses, who were, I should acknowledge, very accommodating. We will have to respect the travel arrangements of the out-of-province witnesses.

You will be aware that Inquiry Counsel, Mr. MacRury is absent today. He will be absent for the duration of this session of the Inquiry. Very recently he experienced a medical problem that has resolved itself except for the requirement that he undertake a period of rest. He will be returning to deal with any remaining evidence after the end of February and for final submissions.

Mr. MacRury did not leave us without a solution to the problem of his absence. The solution is Mr. Charles Broderick who has generously agreed to act as Inquiry Counsel this month.

His willingness to pick up with witness #73 and carry the Inquiry forward reflects his commitment to public service and the collegiality of the Cape Breton Bar, of which he and Mr. MacRury are members.

Mr. Broderick graduated from Dalhousie Law School in 1978. Late that same year he was admitted to the Nova Scotia Bar. He practiced for 31 years, first in a partnership and then as a sole practitioner in New Waterford, Cape Breton. In April 2009 he joined the Sydney office of the Public Prosecution Service as a Crown Attorney. During his career in private practice, Mr. Broderick acted as counsel to interested parties in three inquiries: The Elstrom Fatality Inquiry; The Royal Commission of Inquiry into the prosecution of Donald Marshall, Jr.; and the Bailey Inquiry. I am very grateful indeed to Mr. Broderick for stepping into Mr. MacRury's shoes for the next month. In doing so he is discharging a great service to the Inquiry and the public interest it is seeking to serve. Welcome, Mr. Broderick, and thank you.

I will conclude these remarks by saying that Mr. Broderick has already demonstrated a quality that seems to be characteristic of everyone who has assisted this Inquiry in one fashion or another. When I indicated to him how much I appreciate his taking on these duties, he immediately advised me of the tremendous help provided to him by Mr. MacRury's administrative assistants in Sydney. And so, I would also like to thank them for their tireless work behind the scenes, especially very recently in helping us stay on course.

Concluding Remarks

February 25, 2010

This then brings us to the end of the witnesses scheduled for the Inquiry. Since last July I believe we've sat for 54 days of hearing evidence with a total of 84 witnesses testifying. I do want to express my sincere appreciation to every one of those witnesses who came before the Inquiry and patiently answered our questions. Some witnesses, notable experts and witnesses offering their expertise in areas such as policy and training, went to considerable trouble to prepare reports or materials to assist us and I know that the testimony we have heard has merely been the end result of hours of work in preparation by witnesses and counsel. I'm very grateful for the effort that was committed to this process.

At this point I want to review where we're going next and address some inquiry-management issues.

Unless there is a request by counsel for any party to have the Inquiry hear from additional witnesses, we will be adjourning today until June when we will reconvene for final submissions. If any party wishes to have the Inquiry hear from any additional witnesses, the process for advancing such a request is governed by section 5 of our Rules of Procedure. I have provided counsel with the days I have available in March and April should any further evidence be called. It will be necessary for counsel to advise Inquiry Counsel on or before March 5 concerning this issue and I'm going to assume that's a reasonable deadline unless counsel inform Inquiry Counsel that it is not, for some reason. But, I'm sure you can appreciate that if there is to be some further evidence, it's going to have to be heard in March or April and therefore it's going to be necessary to have that addressed through Inquiry Counsel without delay.

Final submissions will be heard on June 8th, 9th, and 10th. Written submissions will be filed by the parties with all counsel and the Inquiry on May 19. There has already been an agreement, acceptable to the Inquiry, amongst counsel on the limits for the written and oral submissions.

I've considered the time limits for oral submissions in relation to the three days over which submissions are being heard. And, I don't know if this is an issue that counsel have addressed amongst themselves but I do know that it has been agreed that the order for submissions is to be the same as the order for questioning of witnesses. And therefore, when I looked at the three days, I found myself identifying a concern about the overloading of day 1 and the under-utilization of day 3. So therefore, in case this had not been expressly addressed by counsel, I decided that I would indicate that the fairest arrangement seemed to me to be as follows:

Day 1 Inquiry Counsel, the Attorney General of Nova Scotia, the NSGEU

Day 2 Submissions on behalf of Dr. and Mrs. Blair, the Halifax Regional Police Service, the Capital District Health Authority and Dr. Janet MacIntyre

Day 3 Submissions on behalf of Dr. Stephen Curry, the Schizophrenia Society of Nova Scotia, the Canadian Mental Health Association and Inquiry Counsel in reply.

Now, if this is not seen as the best arrangement, please advise Inquiry Counsel who can then discuss the matter with me.

There are a few further matters I want to address at this time.

(1) I first want to take this opportunity to formally thank Ms. Manning and Mr. Donovan and their staff for downloading the exhibits to disk and providing us all with copies. That's certainly been very helpful. I also want to acknowledge Ms. MacKenzie. I believe, particularly this month, she's been very helpful behind the scene, getting materials, getting things photocopied. I certainly don't know the full extent of it and I don't doubt there may have been other people who've been of assistance, but I do want to thank you. I know counsel have worked very hard to assist in this inquiry running smoothly and to be collegial throughout a long and at times, somewhat difficult process and I do appreciate the extra efforts that you've made.

(2) I am pleased to be able to tell you that as of March 1, Mr. MacRury will be back in harness so that any issues requiring the attention of Inquiry Counsel can, as of that date, be directed to him.

(3) The obvious next issue is to express to Mr. Broderick is my profound thanks for stepping in and assuming the role of Acting Inquiry Counsel during the month of February. Although Mr. Broderick has spared no effort in undertaking this work, he has remained completely unflappable throughout. He has been undaunted by the challenge of picking up the reins at witness 73 and guiding us through to the end of the scheduled evidence. In doing so he has made a tremendous contribution to the Inquiry and I want to say how very much I appreciate the long hours and hard work he had put in with such steady grace and good humour.

Counsel, it is my intention now to conclude these proceedings with a 25 minute video kindly provided to the Inquiry by Dr. and Mrs. Blair through their counsel, Mr. MacDonald. It is an amateur video of Mr. Hyde shooting hoops at the YMCA in Halifax and talking. It will be apparent that it is not possible to hear a fair amount of what Mr. Hyde says but the benefit of the video is not diminished by this. It offers us an opportunity we would not otherwise have, the opportunity for Mr. Hyde to be seen and heard on his own terms.

Once we have watched the video we will conclude. I'll have no further comments to make

to you, and obviously if there's anything you want to address to me I'll invite you to do that now. I do want to say on my behalf though how much I appreciate and want to thank all of the counsel and the Canadian Mental Health Association representatives, Mr. Li, the others students, and Ms. Tooton, whom I've considered counsel in using the term, Ms. Naas and Sheriff Hurst, Cst. Kellock, Chris Cuthbertson, John Piccolo, and Alain Bouvette, for making this month such a productive one.

And if there is anything else anyone wishes to raise at this time… if not, then we will be watching the video and we will disperse. Thank you.

Concluding Remarks

June 10, 2010

The remarks I am now going to make represent the conclusion of the hearings of this Inquiry, a fatality inquiry ordered pursuant to section 27(2) of the *Fatality Investigations Act* of Nova Scotia. They may seem somewhat pedestrian after the eloquent submissions I have heard this week.

The Order establishing this Inquiry provides that I am to file with the Provincial Court a written report containing any findings made by me as to:

- The date, time and place of Howard Hyde's death;
- The circumstances under which his death occurred;
- The cause of death;
- The manner of death; and
- Any recommendations by me about any matters arising from the Inquiry.

The Inquiry has sat for 56 days, commencing with the first of its 84 witnesses on July 7, 2009. Prior to that date there were three procedural hearings that dealt with issues of standing, the Rules of Procedure, and the webcasting of the proceedings. Evidence was heard last July, August, October and December and this past February when the majority of the expert witnesses testified.

These proceedings have produced, through the diligence of Inquiry Counsel and counsel for the nine parties with standing, more than 11,000 pages of transcript – which you have all added to significantly this week; 11,000 pages was at the time that we concluded the evidence - and nearly 300 exhibits, including DVD evidence of Mr. Hyde in the custody of the police and correctional services. There are also a number of studies and reports that I have been referred to. In addition, I now have the benefit of written and oral submissions from the parties and Inquiry Counsel and 196 recommendations over a broad spectrum of issues. In fact, a few additional recommendations emerged from the oral representations made over the last three days. I can only say about this wealth of material that I have my work cut out for me. I am not able to tell you when I will be able to complete the onerous task that lies before me: while I feel a sense of urgency, I have to recognize the reality in which I am operating. I will be endeavouring, within the constraints of my other responsibilities and obligations, to produce a Report that is as timely as possible. That timeliness will be measured in months not weeks. The legislation provides for my Report to be filed with the Provincial Court. This indicates to me that my Report is presumptively public which befits the importance of the issues identified by the evidence in this Inquiry and the significant public interest in these issues.

There are several matters I want to now address. The first is with respect to Inquiry Counsel. What I want to speak about is the role of Inquiry Counsel at this stage of the Inquiry but before I do that, I wish to acknowledge and thank Mr. MacRury for the dedication, hard work, resourcefulness and sensitivity he has brought to the formidable task he has discharged. It is thanks to him that the Inquiry stayed on course, heard from the necessary witnesses in a coherent and organized fashion, had a venue, and benefitted from having acting Inquiry Counsel when needed. And for that contribution, I once again thank Mr. Broderick for ably carrying us through the expert witnesses when Mr. MacRury was temporarily benched in February.

Mr. MacRury and Mr. Broderick have now concluded their roles with the Inquiry subject to a limited function I will mention in a moment. They will not be part of, or consulted in, the writing of the Report. The writing of the Report will be my sole responsibility. I have regarded Mr. MacRury as essentially fulfilling the role that Professor Ed Ratushny, in his recent book, "The Conduct of Public Inquiries – Law, Policy and Practice", refers to as "hearings" counsel. In the matter of the final submissions of Inquiry Counsel, I have adopted the approach favoured by Professor Ratushny that hearings counsel "is not permitted to discuss the credibility of witnesses or the merits of alternative findings in private with the [Inquiry judge.] Any related opinions or advice are expressed only publicly in the hearing room and may be disputed by parties to the hearing." Professor Ratushny notes that hearings counsel is "completely free to make whatever submissions they deem appropriate without the concern that they will be interpreted as speaking on behalf of the [Judge.]" In keeping with the "hearings" counsel approach, Inquiry Counsel did not consult with me about their submissions.

Now what lies ahead is the writing of my Report. Therefore the very helpful advisory role that Mr. MacRury, and in February, Mr. Broderick, have played in discussions with me about the progress and direction of the Inquiry and the evidence, is at an end.

I will note that I have asked Mr. MacRury to review the Exhibit List to ensure it is appropriately descriptive of the Exhibits. The revised List will be distributed to counsel and Ms. Tooton although obviously none of the Exhibit numbering will change. I will also be contacting Mr. MacRury if I discover there is something I am unable to locate but I think that is unlikely. He is going to be sending me the articles referenced in Dr. Butt's bibliography that were provided on a DVD with his expert's report. As you might remember, I asked Dr. Butt about that when he was on the witness stand.

It is fully my intention to thank by name in my report, to the extent that I can identify them, the many individuals who have helped meet the needs of the Inquiry. I cannot imagine how we could have functioned for 1 day let alone 56, without their contributions. At various junctures in the hearings I have identified individuals who have assisted the Inquiry, but today I am going to make special mention of just one person, Cst. Terry Kellock. Cst. Kellock has patiently provided technical support we could not have managed without. He has also spent countless hours reviewing and copying DVD evidence. I am very grateful to him for his expertise, patience and time, and to his superiors for making him available to us over such a protracted period.

I also want to thank the many witnesses – 84 of them – who came and testified, often for lengthy periods of time, so that we could have a more complete picture of the circumstances and issues relevant to our work. And I also want to thank the parties represented before me whom I know have contributed much behind-the-scenes effort to ensuring that the relevant facts and issues, and related materials, are before me. Those nearly 300 Exhibits didn't come out of nowhere.

This Inquiry has had unprecedented public exposure through the live-streaming to the internet. I want to thank the Executive Office of the Judiciary for supporting this endeavour, and John Piccolo, Communications Director for the Nova Scotia Judiciary, and Alain Bouvette, Judicial IT Analyst, for their commitment to this project and their hard work in its ongoing

implementation. And I also want to thank Chris Cuthbertson for providing the technical support throughout. It is indisputable that the webcasting has enhanced media and public understanding of the evidence and the issues and had made the Inquiry's proceedings accessible to an extent that could not have been achieved otherwise.

It is appropriate for me to recognize the diligence and professionalism of counsel and those acting as counsel, including Ms. Tooton, at this Inquiry. An Inquiry, in my opinion, is only as good as the counsel who appear before it, and, using that standard, this has been a very good Inquiry indeed, and for me, a real pleasure to conduct. I have to find the task ahead to be merely daunting and not overwhelming; thank you for helping me navigate these currents. I am profoundly appreciative for all the heavy lifting that has been done by each of you, for the cooperation and respect you have shown to each other, for your patience in helping me understand the evidence and your submissions, and for the sincerity that has infused your efforts to make positive change emerge from tragedy.

The tragedy we have been excavating will leave its mark on each of us, on those who were involved with Mr. Hyde in November 2007, and most of all, on his family and friends. But it is not on this note of tragedy that I want to conclude these remarks. I want to recall the vibrant portrayal of Mr. Hyde described by Ms. Ellet. As she told us in her evidence last July, she enjoyed many good times with Mr. Hyde whom she experienced as "very sociable, very lively, loved people and nature, loved sports, music and movies, enjoyed walking on the beach and on country roads…a joy to be around, very, very likeable…just an incredible man."

The promise I can make to the memory of Mr. Hyde is that I will, to the best of my ability, endeavour to do justice in my Report to the issues his story has revealed to us. Thank you.

APPENDIX 7

Decisions

Case Name:
Hyde (Re)

Re An Inquiry Under the Fatality Investigations Act, S.N.S. 2001, c. 31 into the death of Howard Hyde

[2009] N.S.J. No. 308

2009 NSPC 32

281 N.S.R. (2d) 64

68 C.R. (6th) 172

196 C.R.R. (2d) 4

2009 CarswellNS 375

Registry: Halifax

Nova Scotia Provincial Court

A.S. Derrick Prov. Ct. J.

Heard: June 12, 2009.
Judgment: July 6, 2009.

(79 paras.)

Health law -- Public health -- Constitutional issues -- Canadian Charter of Rights and Freedoms -- Determination of scope of online access to evidence at Inquiry under the Fatality Investigations Act -- The Inquiry was ordered in respect of the death of a mentally ill individual while incarcerated -- The Inquiry was intended to be streamed live online -- At issue was whether correctional facility video surveillance footage depicting the deceased should be available on line in a direct download format -- The court held that prohibition of the download of Inquiry exhibits was not contrary to the open court principle or freedom of expression -- Privacy rights of others in the footage militated against download -- Canadian Charter of Rights and Freedoms, s. 2(b).

Constitutional law -- Canadian Charter of Rights and Freedoms -- Fundamental freedoms -- Freedom of thought, belief, opinion and expression -- Freedom of expression -- Determination of scope of online access to evidence at Inquiry under the Fatality Investigations Act -- The

Inquiry was ordered in respect of the death of a mentally ill individual while incarcerated -- The Inquiry was intended to be streamed live online -- At issue was whether correctional facility video surveillance footage depicting the deceased should be available on line in a direct download format -- The court held that prohibition of the download of Inquiry exhibits was not contrary to the open court principle or freedom of expression -- Privacy rights of others in the footage militated against download -- Canadian Charter of Rights and Freedoms, s. 2(b).

Information technology -- Internet -- Constitutional and quasi-constitutional issues -- Canadian Charter of Rights and Freedoms -- Determination of scope of online access to evidence at Inquiry under the Fatality Investigations Act -- The Inquiry was ordered in respect of the death of a mentally ill individual while incarcerated -- The Inquiry was intended to be streamed live online -- At issue was whether correctional facility video surveillance footage depicting the deceased should be available on line in a direct download format -- The court held that prohibition of the download of Inquiry exhibits was not contrary to the open court principle or freedom of expression -- Privacy rights of others in the footage militated against download -- Canadian Charter of Rights and Freedoms, s. 2(b).

Criminal law -- Prison administration -- Conditions and treatment -- Determination of scope of online access to evidence at Inquiry under the Fatality Investigations Act -- The Inquiry was ordered in respect of the death of a mentally ill individual while incarcerated -- The Inquiry was intended to be streamed live online -- At issue was whether correctional facility video surveillance footage depicting the deceased should be available on line in a direct download format -- The court held that prohibition of the download of Inquiry exhibits was not contrary to the open court principle or freedom of expression -- Privacy rights of others in the footage militated against download -- Canadian Charter of Rights and Freedoms, s. 2(b).

Application by the Nova Scotia Government Employees' Union to determine scope of online access to surveillance video evidence. Hyde suffered from mental illness. A Fatality Inquiry was ordered in respect of his death while in custody of the provincial correctional service. All parties to the Inquiry endorsed live streaming of the Inquiry on the internet. At issue was whether 16 hours of surveillance video footage should be directly downloaded to the internet independent of being streamed in the course of the Inquiry. The video surveillance footage was on a DVD and captured images of Hyde in custody at the correctional facility. The DVD was entered into evidence as an exhibit and footage was to be played in court on a flat-screen television. Images of witnesses being questioned about the footage was intended to be streamed live, as was the footage. Although the Inquiry was intended to be streamed live, other exhibits were not intended to be posted on the internet and were not publicly accessible outside the courtroom, subject to any applications granted for access. Those that supported direct downloading of the footage submitted that it was consistent with the presumptive openness of judicial proceedings and further satisfied the public interest in accountability and transparency. Supporters further submitted that the video offered the best available evidence of the events surrounding Hyde's death. Those that opposed the direct downloading of the footage cited the privacy interests of prisoners and correctional facility employees who were depicted on the surveillance and had no involvement with Hyde.

HELD: Application allowed. It was not contrary to the presumptive openness of court proceedings to prohibit the direct downloading of the surveillance footage exhibit on the internet. The issue of direct downloading of the surveillance footage engaged freedom of expression rights notwithstanding the absence of a formal application by media for access to the evidence. However, such freedoms did not guarantee the right to internet access of the Inquiry's exhibits via direct downloading. The existence of technology that permitted direct downloading did not create a constitutional right for the general public or the media to have that technology employed to provide access to the evidence in the same format that it was

presented to the Inquiry. Direct downloading provided access far beyond the type mandated by the open court principle. In addition, direct downloading of the footage without the context of related explanatory evidence from the Inquiry created the potential for distortion of the facts. Furthermore, the privacy rights of prisoners shown in the footage presented a significant obstacle to direct downloading.

Statutes, Regulations and Rules Cited:

Canadian Charter of Rights and Freedoms, 1982, R.S.C. 1985, App. II, No. 44, Schedule B, s. 2(b)

Fatality Investigations Act, S.N.S. 2001, c. 31, s. 31, s. 32, s. 36(2)(a)

Counsel:

Daniel MacRury, Q.C., Inquiry Counsel.

Edward Gores, Q.C., Dana MacKenzie, counsel for the Attorney General.

Kevin C. MacDonald, Counsel for Joanna Blair and Dr. Hunter Blair.

David Roberts, Counsel for the Nova Scotia Government Employees' Union.

Sandra MacPherson, Q.C., Elizabeth Buckle, Counsel for the Halifax Regional Police.

Rory Rogers, Counsel for Capital District Health Authority.

Thomas Donovan, Q.C. and Loretta Manning, Cousel for Dr. Janet MacIntyre.

Michael Wood, Q.C. Counsel for Dr. Stephen Curry.

Blair Mitchell, Consel for the Schizophrenia Society of Nova Scotia.

Carol Tooton, Executive DIrector, Canadian Mental Health Association.

DECISION ON AN APPLICATION OPPOSING THE DIRECT DOWNLOADING TO THE INTERNET OF SURVEILLANCE VIDEO EVIDENCE

A.S. DERRICK PROV. CT. J.:--

Introduction

1 This Fatality Inquiry has been ordered to investigate the death of Howard Hyde, which occurred on November 22, 2007. Mr. Hyde died while he was in the custody of the provincial correctional service. He had, prior to that, been in the custody of the police, at the hospital emergency department, and in court. The parties have indicated that video surveillance cameras captured images of Mr. Hyde in custody at the Central Nova Scotia Correctional Facility (CNSCF) and the Halifax Regional Police Service (HRPS). I am advised that much of the sixteen hours of footage will be introduced into evidence during the Inquiry and that witnesses will be testifying about what is depicted.

2 On April 22, 2009, at the second of three procedural hearings, a proposal was made by the Executive Office of the Nova Scotia Judiciary to webcast this Inquiry. After a discussion about the proposal with John Piccolo, Communications Director for the Nova Scotia Judiciary, answering questions raised by counsel, all parties including the Attorney General of Nova Scotia unanimously endorsed live streaming the Inquiry to the internet. The devil has been in the details of the execution, and the assistance of Mr. Piccolo and Alain Bouvette, Judicial IT Analyst, in addressing concerns raised by counsel, has been invaluable. The cost is being borne by the Executive Office and Court Services. The Inquiry itself has no budget for facilitating

such broad public access to its proceedings.

3 The merits of webcasting the Inquiry are obvious. The Nova Scotia Government Employees' Union (NSGEU) ably set out in its submissions on this application that broadcasting on the internet will:

> a) enhance the public aspect of the Inquiry in keeping with the mandate conveyed by the *Fatality Investigations Act*;
> b) promote public interest in and public discussion of important issues arising from the Inquiry, particularly the treatment of the mentally ill in the community and in the justice system;
> c) allow persons to observe the hearings without being forced to travel to Halifax.

4 On this last point, I have been advised that some members of the Hyde family reside outside of Canada and without the webcasting would be unable to access the proceedings.

5 As I have noted, the decision to live stream the Inquiry has the support of all parties. However, an issue has arisen about public access to the video surveillance of Mr. Hyde in custody at the CNSCF. The issue is whether the CNSCF video surveillance should be downloaded directly to the internet, independant of any webcasting of the Inquiry's proceedings.

The Video Surveillance of Mr. Hyde in Custody As Evidence at the Inquiry

6 The general public and the media will be able to attend the Inquiry's proceedings. Pursuant to section 32 of the *Fatality Investigations Act*, all hearings at a fatality inquiry must be open to the public except where the judge determines that a portion of the proceedings should be conducted *in camera* for reasons to do with public security or matters of an intimate or personal nature.

7 The approximately sixteen hours of CNSCF and HRPS video surveillance are on a DVD. The DVD will be entered into evidence as an exhibit and the footage will be played in the courtroom on a large flat-screen television. The cameras in the courtroom live streaming the Inquiry proceedings will film the video surveillance while the DVD is played in the courtroom. Images of the witnesses being questioned about the video surveillance will also be live streamed. Subject to the quality of the webcast, when the video surveillance is playing in the courtroom, the public will hear and see, by way of the live streaming, the surveillance images and any recorded sound.

8 In submissions by the NSGEU on the direct downloading issue, I was informed that none of the video surveillance recorded at the Central Nova Scotia Correctional Facility has sound.

The Issue of Downloading the Video Surveillance Directly to the Internet

9 The decision to live stream the Inquiry has sparked an issue that has polarized the opinion of some of the parties on the scope of public access to the evidence the Inquiry will be considering. What has emerged from the intended webcasting of the Inquiry is the issue of whether the video surveillance evidence should simply be filmed and live streamed during the course of the Inquiry's proceedings, in the same manner as any of the witnesses will be filmed and live streamed, or whether it should also be directly downloaded to the internet so that the public can access the images separately from the Inquiry proceedings.

10 The downloading would be directly to the Internet. The Inquiry will not be operating a website as it has no resources to do so. The Inquiry will therefore not be posting any of its exhibits on the internet. The evidence presented during the public proceedings will be live streamed but not otherwise publicly accessible outside the courtroom, subject to any applications made and granted for access. Direct downloading the video surveillance would be an exception to how the public will access other exhibits tendered at the Inquiry.

11 The issue of the downloading of the video surveillance to the internet was addressed on June 12, 2009 when the Inquiry convened for its third and final procedural hearing before the commencement of the evidentiary hearings. The issue came before me in a somewhat unusual form. Customarily, applications for access to exhibits or other evidence are made by media outlets. Access to exhibits is typically sought for the purpose of copying for broadcast and reporting. Here it is the Nova Scotia Government Employees' Union who seems to have anticipated the potential for direct downloading of the surveillance footage to the internet and brought this application preemptively. This seems to suggest the existence of a presumption that the DVD should be directly downloaded to the internet in the normal course of the Inquiry process. The parties that support direct downloading of the DVD regard internet access to be the only option consistent with the presumptive openness of judicial proceedings. Whether the presumption of openness requires the downloading of an exhibit to the internet is a live issue in this case. The issue was not on my radar until the NSGEU raised it. In this decision I have endeavored to map out how I believe the DVD downloading issue has to be approached and analyzed. As I will discuss, I consider the status of the video surveillance as an exhibit to be a relevant factor in addressing this issue.

The Timing of the Application to Prohibit Direct Downloading of the Evidence

12 Typically, applications for access to exhibits are made once the evidence has been tendered. Courts dealing with such applications have understandably found the request to address the issue mid-trial to be distracting and disruptive. The only advantage conferred by timing the application to follow the tendering of the evidence is that it will then have been viewed by all the parties and the judge. The video surveillance has been disclosed by Inquiry Counsel to the parties who have reviewed it in preparation for the hearings. I have not seen the footage. I did consider viewing it for the purposes of dealing with this application, but decided against it. I do not believe doing so would have assisted me. I have no context for interpreting what I would have been seeing and I would have had to make inferences to try and figure out who and what was being depicted.

13 Where it is known that the evidence will be presented, and the relevant parties have been able to view it, addressing the issue in advance of the evidence being introduced avoids an interruption in the flow of the proceedings. None of the parties objected to this approach and it is preferable to be dealing with the issue now rather than later.

Positions of the Parties - Introduction

14 None of the parties represented at this Inquiry oppose the filming of the video surveillance as part of the live web coverage of the Inquiry itself. All parties have taken the position that this is an appropriate balancing of the public interest in access to the Inquiry's proceedings and the privacy rights of individuals whose images have been captured on the surveillance video footage. As I understand it, the individuals whose images appear on the DVD include police and correctional officers, Mr. Hyde himself, and other prisoners. I will note that the police service and the union representing correctional officers are represented at this Inquiry. The police union is not, nor is the estate of Mr. Hyde or any of the prisoners whose images may appear on the video surveillance. I do not know who the lawful representatives of Mr. Hyde's estate are: his sister, Joanna Blair, and his brother-in-law, Dr. Hunter Blair, who support direct downloading of the video surveillance to the internet, have been granted standing at this Inquiry pursuant to section 36(2)(a) of the *Fatality Investigations Act* as "personal representative[s] of the deceased."

15 The NSGEU's position opposing direct downloading of the video surveillance is supported by the Attorney General of Nova Scotia (AGNS). Parties that have argued in favor of direct downloading of the video surveillance are Joanna and Dr. Blair, the Schizophrenia Society, and the Canadian Mental Health Association (CMHA). Inquiry Counsel also made submissions in favour of direct downloading to the internet. The remaining parties took no

position on the scope of public access to the video surveillance.

16 The dispute over the direct downloading issue also extends to the question of whether constitutional guarantees of freedom of expression and freedom of the press are engaged. Those parties favouring direct downloading submit that it is a constitutional issue. Those opposing direct downloading submit that it is not.

17 Written submissions were provided by the parties that took positions on the application. I want to thank Inquiry Counsel, counsel for the parties, and the CMHA for their helpful briefs and letters.

The Position of Parties Opposed to Direct Downloading of the Video Surveillance Evidence to the Internet

18 The NSGEU has concerns about the effect that direct downloading would have on the privacy of government employees, called as witnesses at the Inquiry, whose identities would be "floating around on the internet" if downloading of the video surveillance was permitted. The NSGEU submits that direct downloading also raises serious privacy concerns for individuals depicted on the video surveillance who had no involvement with Mr. Hyde. These would be correctional officers caught in the frame but not dealing with Mr. Hyde, and other prisoners. I presume some of those individuals may be called to testify at the Inquiry if they were witnesses to events.

19 The NSGEU disputes a claim advanced by other parties that the video surveillance offers "the best evidence" of events, and notes, in this regard, that the CNSCF video surveillance has no sound accompanying the images. At the Inquiry, it will be presented in its proper context with witnesses responding to questions about what appears on the footage. In the submission of the NSGEU, the images, if downloaded, would be susceptible to manipulation through altering, copying, and posting them on file sharing sites, and could exist on the internet indefinitely.

20 In the submission of the NSGEU, this issue does not engage constitutional guarantees under section 2(b) of the *Charter* protecting freedom of expression and freedom of the press. The Inquiry will be open to the media and public as required by the legislation under which it has been established. By consensus of the participants, the Inquiry is going a step farther by live streaming its proceedings on the internet. The DVD evidence will be played in open court and filmed as part of the live coverage of the Inquiry. This access to the evidence will satisfy the public interest in accountability and transparency.

21 Echoing concerns raised by the NSGEU, the Attorney General of Nova Scotia describes the internet as "an open-source medium in which any individual can access the digitized version of the video, manipulate it, and republish it again." Observing that the video surveillance contains personal information about government employees and persons who were in the custody of the province's correctional system, the AGNS acknowledges that the use of video surveillance in the workplace is already a violation of the privacy of these individuals, one that is justifiable to ensure the safety and security of prisoners, staff and the facility. The AGNS also points to section 31 of the *Fatality Investigations Act* as governing how copies of exhibits can be made and tendered in place of the original or furnished to the "person producing it or the person entitled to it." The *Act* is silent on public access to exhibits.

Position of the Parties Supporting Direct Downloading of the Video Surveillance Evidence to the Internet

22 The Blairs have submitted that directly downloading the video surveillance is the logical extension of webcasting the Inquiry. This, say the Blairs, is evidence, already in a digital format, that is ideally suited to being downloaded to the internet. They argue for direct downloading to "place the members of the public in the same position as those in

the courtroom." The mere filming of the video surveillance footage as part of the filming of the Inquiry proceedings will not achieve the same result. Those who attend the proceedings in the courtroom will have a much better "visual" of the DVD images than those watching the webcast. Direct downloading will produce the best image for the public of the video surveillance. The Blairs submit that without the downloading of the surveillance, it will be difficult for the viewing public to follow the evidence. Only true transparency, which mandates downloading, will serve to ensure the integrity of the Inquiry process is not called into question.

23 The Schizophrenia Society and the CMHA ground their support for direct downloading in the Inquiry's role to educate and inform the public about the events that led to Mr. Hyde's death. The Society describes the video surveillance as the best evidence available on what occurred between Mr. Hyde and correctional officials while he was in their custody. In the submission of the Society, there is no principled basis for treating a fatality inquiry process any differently from a trial process when weighing the public interest in open access to the proceedings.

24 The CMHA submits that the public interest is best served by this evidence being available on the internet. There it can be watched and interpreted by the viewer directly, providing invaluable insights into how correctional officers actually perform their duties.

Position of Inquiry Counsel

25 Inquiry counsel has also submitted that the video surveillance offers the best evidence available of the events at the CNSCF and should be available through a direct download to the internet to serve the crucial objectives of openness and transparency. Inquiry counsel indicated that a significant number of correctional officers will be called to testify and the video surveillance will assist with understanding their evidence. Anyone not attending the Inquiry will be at a disadvantage compared to those who are able to watch the video surveillance when it is played in the courtroom.

26 Inquiry counsel acknowledged there are important privacy rights in issue but concluded that favouring open public access to the recorded images achieved the correct balance and would serve to improve confidence in the justice system rather than diminish it. In the submission of Inquiry Counsel, it is "important for the integrity of the justice system that the general public be able to view how people are treated in the system." Inquiry Counsel characterizes the video surveillance as "a crucial witness" to be webcast just as all other relevant witnesses will be.

27 Although Inquiry counsel contrasted the NSGEU's position on the downloading of the video surveillance with the position of the HRPS in relation to video surveillance obtained from the police station when Mr. Hyde was in custody there, the HRPS has raised a concern about protecting the privacy of an individual whose image is captured on their footage. This was addressed in a letter to Inquiry Counsel from Elizabeth Buckle, counsel for HRPS, provided to me by Inquiry Counsel. In her letter dated June 11, 2009 about the HRPS video surveillance, Ms. Buckle identifies the need to obscure the face of an "unrelated" individual to protect his privacy. She says this will need to be done because neither she nor her client "has authority to waive this individual's privacy rights for the purpose of webcasting his image." She suggests exploring "the option of blurring this individual's face so that this portion of the tape containing Mr. Hyde could still be webcast."

The "Open Court" Concept -- The Dagenais/Mentuck Test

28 As I noted earlier, the controversy in this application is not confined to whether the video surveillance should be downloaded: there is also no agreement on what legal principles apply. The parties that support the direct downloading have argued the issue on the basis of the *Dagenais/Mentuck* test articulated by the Supreme Court of Canada in *Toronto Star*

Newspapers Ltd. v. Ontario, 2005 SCC 41. Fish, J. for the Court mapped out at paragraph 4 of the *Toronto Star* decision the constitutional framework and analysis for that test:

> ... Section 2(b) of the *Charter* guarantees, in more comprehensive terms, freedom of communication and freedom of expression. These fundamental and closely related freedoms both depend for their vitality on public access to information of public interest. What goes on in the courts ought therefore to be, and manifestly is, of central concern to Canadians.
>
> The freedoms I have mentioned, though fundamental, are by no means absolute. Under certain conditions, public access to confidential or sensitive information related to court proceedings will endanger and not protect the integrity of our system of justice. A temporary shield will in some cases suffice; in others, permanent protection is warranted.
>
> Competing claims related to court proceedings necessarily involve an exercise in judicial discretion. It is now well established that court proceedings are presumptively "open" in Canada. Public access will be barred only when the appropriate court, in the exercise of its discretion, concludes that disclosure would subvert the ends of justice or unduly impair its proper administration.
>
> This criteria has come to be known as the *Dagenais/Mentuck* test, after the decisions of this Court in which the governing principles were established and refined ...
> ... In my view, the *Dagenais/Mentuck* test applies to *all* discretionary court orders that limit freedom of expression and freedom of the press in relation to legal proceedings. Any other conclusion appears to me inconsistent with an unbroken line of authority in this Court over the past two decades. And it would tend to undermine the open court principle inextricably incorporated into the core values of s. 2(b) of the *Charter*.

29 The NSGEU on the other hand, disputes the contention that the *Dagenais/Mentuck* analysis applies here. The NSGEU submits that a publication ban is not being sought nor is there any request that this evidence be taken *in camera*. The public and the media will be able to see the surveillance video footage either by attending the Inquiry proceedings or watching the live streaming of those proceedings, during which the surveillance DVD will be played, and filmed as part of the webcast.

30 The question of whether accessing a court exhibit requires the application of "open court" principles has engaged the attention of a number of courts. (see for example: R. v. Casement, [2009] S.J. No. 201 (Sask. Q.B.); R. v. Cairn-Duff, [2008] A.J. No. 1053 (Alta. Q.B.); R. v. Sylvester, [2007] O.J. No. 2261 (Ont. S.C.J.); R. v. Cote, [2007] M.J. No. 60 (Man. Q.B.); R. v. Black, [2006] B.C.J. No. 3522 (B.C.S.C.); R. v. Canadian Broadcasting Corp., [2006] O.J. No. 1685 (Ont. S.C.J.); CTV Television Inc. v. Ontario Superior Court of Justice, [2002] O.J. No. 1141 (Ont. C.A.)).

31 The *Dagenais/Mentuck* test draws its life from section 2(b) of the *Charter*. The parties to this application who support direct downloading of the video surveillance are essentially arguing that the presumptive openness of court proceedings extends to all the evidence being presented such that any restriction on public access to the evidence will engage the constitutional guarantees under section 2(b) of the *Charter* protecting freedom of expression and freedom of the press. They rely on the statements of Fish, J. in *Toronto Star* which I have just recited.

32 It is legitimate to ask in this case how an order prohibiting the direct downloading to

the internet of video surveillance from a provincial correctional institution is a limitation on freedom of expression and freedom of the press where that evidence will be tendered in open court during the Inquiry's proceedings. How are the section 2(b) guarantees animated in this case? I will return to these questions shortly.

The Direct Downloading Issue Has Not Been Raised By the Media

33 As I noted earlier, there has been no application by any media for the right to directly download the video surveillance evidence to the internet. Nor have any media applied for access to the evidence for the purpose of making a copy for reporting and broadcast. I do not see that as fatal to the question of whether freedom of expression is engaged here. Whether the media are involved in this application or not, this is an issue of access to evidence which will be presented to the Inquiry. It is reasonable to think that the media would be interested in this material being available on the internet. It can safely be assumed that were the video surveillance images to be downloaded to the internet, media outlets would access the images, just as the general public would, and use them for a wide range of purposes. The media's purposes could include, for example; news reporting, the making of a documentary film specifically about Mr. Hyde's death, the production of a journalistic piece on deaths in custody. The video surveillance footage might be re-broadcast on the internet or transferred to other digital media and produced for television or film. These examples are far from exhaustive.

34 If freedom of expression rights are engaged in this case, they are engaged notwithstanding the absence of a formal application by the media for access to this evidence.

The Presumptive Openess of Court Proceedings

35 No one is suggesting that the proceedings of this Inquiry will not be open and accessible to the general public and the media. As I have noted, the live streaming means there will be more than the usual access provided for in court proceedings. The video surveillance evidence will be coming before the Inquiry as an exhibit. That is the context in which the issue of direct downloading has to be examined and it frames the essential question I must answer: is it contrary to the presumptive openness of court proceedings for a Fatality Inquiry to prohibit the direct downloading of one of its exhibits to the internet? On my way to addressing that question I want first to examine what public access to court proceedings means within the scope of the *Dagenais/Mentuck* test.

36 The argument for applying the *Dagenais/Mentuck* test to an application for access to court exhibits seeks to draw persuasive strength from Fish, J.'s disapproval in *Toronto Star* of limitations on "public access to legal proceedings." *(paragraph 9)* However there is nothing to indicate that Fish, J. had in mind a court's prohibition on courtroom cameras and internet live streaming when he was speaking about section 2(b) applying to "all discretionary court orders that limit freedom of expression and freedom of the press in relation to legal proceedings." *(paragraph 7)* There is no suggestion that the exercise of judicial discretion prohibiting the use of television cameras in the courtroom or refusing a request to live stream proceedings on the internet would conflict with the constitutional imperatives established by *Dagenais* and *Mentuck*.

37 If freedom of expression guarantees under section 2(b) of the *Charter* required internet downloading of court hearings so that the broadest possible access could be achieved, then courts would be obligated to webcast all their proceedings. The decisions of the Supreme Court of Canada in *Dagenais v. Canadian Broadcasting Corporation, [1994] S.C.J. No. 104; R. v. Mentuck, [2001] S.C.J. No. 73* and *Toronto Star* cannot be stretched to mean this. Indeed, media applications to broadcast trials have failed. *(see, for example: R. v. Pilarinos, [2001] B.C.J. No. 1936 (B.C.S.C.))*.

38 The *Pilarinos* case attracted considerable public attention as it involved a former premier

of British Columbia and allegations of corruption. The media application in *Pilarinos* challenged the Policy of the British Columbia Supreme Court with respect to televising court proceedings. The Policy prohibited "broadcasting, televising, recording or taking of photographs in the courtroom ... unless the parties to the proceeding consent, and unless prior permission has been expressly granted by the presiding judge ..." [I will note that the Nova Scotia Judiciary has a similar policy entitled: *Use of Electronic Devices in the Courtroom.*] The Policy was attacked in *Pilarinos* as an infringement of section 2(b) of the *Charter* in that it restricted news gathering and news presentation by broadcast media. Referring to the Supreme Court of Canada decisions in *Edmonton Journal v. Alberta (Attorney General), [1989] 2 S.C.R. 1326* and *Canadian Broadcasting Corporation v. New Brunswick (Attorney General), [1996] S.C.J. No. 38* and the importance of access to court proceedings to enable to media to gather information and disseminate it to the public, Bennett, J. held: "Excluding cameras and tape recorders from the courtroom does not prevent the gathering of information, as the courts are open to everyone. It only limits the technical manner in which the information is gathered. I conclude that the latter is not a constitutionally protected right." (*paragraph 75*) Bennett, J. concluded that "... filming court proceedings is not a protected right to 'gather information.' Filming court proceedings is not expressive activity protected by section 2(b)." (*paragraph 79*).

39 Later in her lengthy judgment, Bennett, J. observed how "the editorial capabilities of electronic media" can effectively distort the reality of proceedings and specifically commented on the "innumerable problems" inherent in webcasting, "not the least of which is that once the trial is on the web, the court will lose all control over the proceedings." (*paragraphs 157 (c) and (h)*).

40 Bennett, J. linked her concerns about the problems associated with webcasting to the issue of privacy, noting that:

> If the trial were webcast on the Internet, it would provide millions of people with uncontrolled access to the proceedings. The ability to manipulate images on the Internet is well-known and would seriously affect not only the privacy of all those whose images are captured and broadcast, but also the dignity and decorum of the courtroom ... The other concern relating to privacy is the fact that tapes can be archived. Images can be shown time and again, and in contexts that are unrelated to the present proceedings ... (*paragraphs 203 and 206*)

41 I do not think Bennett, J.'s reasoning on the issue of what section 2(b) guarantees in terms of openness of court proceedings can be disputed. It has not been established that the media or anyone else has a constitutional right to film or live stream court proceedings. In fact, the Nova Scotia Supreme Court came to this conclusion much earlier in *R. v. Fleet, [1994] N.S.J. No. 505* when it held that section 2(b) did not guarantee the right of cameras in the courtroom.

42 It is conceivable that as technology advances this issue will eventually find its way to the Supreme Court of Canada for a definitive pronouncement but that case has not yet materialized. As observed by Bennett, J. in *Pilarinos*: "The common law evolves gradually. Often, technology is far ahead of both the legislature and the common law. One need only look at ... the many legal problems with the internet to recognize this." *(paragraph 225)*

Access to Court Exhibits -- Legal Principles

43 If filming court proceedings is not constitutionally mandated then it follows that the media and general public are not entitled, pursuant to freedom of expression guarantees, to access court exhibits for unregulated and unlimited use. That being said, I do not want to be heard as saying that section 2(b) guarantees play no role in the determination of access

to exhibits tendered into evidence in a court proceeding. A court's jurisdiction over its own records is "anchored in the vital public policy favouring public access to the workings of the courts." *(CTV Television Inc. v. Ontario Superior Court of Justice, [2002] O.J. No. 1141 (Ont. C.A.))*.

44 To be factored into the analysis of whether to grant access to an exhibit or not is the court's obligation to exercise "supervisory and protecting power over its own records." It has long been established that denying access will be appropriate where "the ends of justice would be subverted by disclosure or the judicial documents might be used for an improper purpose." *(Nova Scotia (Attorney General) v. McIntyre, [1982] 1 S.C.R. 175 at page 9)*.

45 In *Vickery v. Nova Scotia Supreme Court (Prothonotary), [1991] S.C.J. No. 23*, the majority of the Supreme Court of Canada declined to consider a late argument under section 2(b) of the *Charter* but identified four significant factors to be assessed when deciding whether access to exhibits (including the ability to copy and disseminate) should be permitted: (1) the nature of the exhibits as part of the court record; (2) the right of the court to inquire into the use to be made of access, and to regulate it; (3) the fact that the exhibits, having been produced at trial and open to public scrutiny and discussion, means the open justice requirement has been met; and (4) the fact that different considerations may govern when the proceedings have concluded and the discussion is removed from the hearing context.

46 In its analysis of these factors, the majority in *Vickery* made some important observations:

* Exhibits are not the property of the court. Others will have a proprietary interest in them. "Once exhibits have served their purpose in the court process, the argument based on unfettered access as part of the open process lying at the heart of the administration of justice loses some of its preeminence." *(paragraphs 20-23)*
* The court is the custodian of the exhibit and "fully entitled" to regulate the use to which the exhibit is to be put by the access-seeker "by securing appropriate undertakings and assurances if those be advisable to protect competing interests ... the court must "protect [someone with a legitimate competing interest] and accommodate the public interest in access." *(paragraphs 24-25)*
* The open justice requirement is met by production at trial of an exhibit and its exposure to public scrutiny and discussion. Privacy rights may be surrendered during a court proceeding, but they are not "surrendered for all time." *(paragraphs 26-29)*
* Public access to and reporting of proceedings is a price to be paid in the interests of ensuring accountability of those engaged in the administration of justice. "The subsequent release of selected exhibits is fraught with risk of partiality, with a lack of fairness." *(paragraphs 30-31)*

47 In *Vickery*, the application to access the exhibits (which were video and audiotapes) had been granted by the Chambers judge but overturned on appeal, a decision that was upheld by a majority of the Supreme Court of Canada. Even in granting the access originally, the Chambers Judge stated that had she been asked to rule on whether the video and audiotapes could be played on television, she would have imposed restrictions on their viewing to protect the privacy rights involved. This is a clear indication that even a decision to grant access would have taken into account the extent of the public access intended and imposed conditions accordingly.

48 However useful it is to identify the principles that must be factored into determining the issue of access to an exhibit, it is necessary to maintain a focus on what I am being asked to decide. I have not been presented with an application for access to an exhibit: indeed, as I noted at the start, the video surveillance has not yet been entered into evidence. Were a media outlet to seek access to the DVD containing the video surveillance, I would, at this stage of the proceedings, deny it on the basis that there is no exhibit to access. As I mentioned, even I have not viewed the DVD yet.

49 The principles in *Vickery* resonate in this application. However, factors such as fair trial rights and safeguarding the presumption of innocence while material in the criminal context, are wholly irrelevant in the context of a Fatality Inquiry. In accordance with the provisions of the *Fatality Investigations Act*, I will be making no findings of legal responsibility. *(section 39(2))*

50 The application before me is to prohibit the direct downloading of this evidence, presumably once it has become an exhibit, to the internet. The presumption made by the parties supporting the downloading is that such direct downloading is constitutionally protected, a proposition I have rejected. However, two remaining questions must be addressed:

1) Given the principles that govern access to exhibits, should I provide access to the DVD, once it is an exhibit, for the purpose of direct downloading to the internet; and
2) Does the fact that the video surveillance will be filmed as part of the webcasting of the Inquiry remove any argument against direct downloading as the images will be streamed to the internet in any event.

Access to Exhibits And the Issue of Direct Downloading

51 As I indicated, I am not ruling on whether the media are entitled to some form of access to the DVD of the video surveillance of Mr. Hyde, nor have I received any submissions on what the purpose of any such access might be. I am effectively being asked to approve access to the DVD so that it can be directly downloaded to the internet, presumably by the parties who support this occurring. As I stated earlier, the Inquiry will not be downloading any exhibits to the internet.

52 Direct downloading would amount to the general public, in potentially infinite numbers, receiving the exhibit in the same format as it is being presented to the Inquiry. At the Inquiry's proceedings, the video surveillance will be presented in its digitalized format on a large flat-screen television monitor. Direct downloading would provide access to this evidence in the same format, accessible on computer and other media compatible with the internet. This in my view is far beyond the type of access mandated by the open court principle as developed and refined in *Dagenais, Mentuck* and *Toronto Star*.

53 The issue of access by the media to videotapes of evidence has often been regarded by Canadian courts as not engaging the *Dagenais/Mentuck* principles. In *R. v. Sylvester, [2007] O.J. No. 2261 (Ont. S.C.J.),* the Ontario Supreme Court said it was unaware of "any binding authority that holds that the concept of open courts necessarily includes the media's right to disseminate information to the public, or the public's right to receive it in precisely the same form in which it was produced and presented in the courtroom." *(paragraph 72)* In *R. v Casement, [2009] S.J. No. 201*, the Saskatchewan Court of Queen's Bench held that the trial had been entirely open to the public, including the media and that therefore an application for videotapes of statements made by an accused to undercover officers, which had been introduced into evidence, did not trigger the "open court" principles. The accused, who had been convicted of first degree murder, raised "grave concerns with regard to the recordings being on a website and what the possible results could be when individuals downloaded

the recordings for questionable, let alone sinister purposes." *(paragraph 26)* The undercover officers submitted that the media had no "format entitlement." *(paragraph 32)* The Alberta Court of Queen's Bench also rejected the notion of "format entitlement" in *R. v. Cairn-Duff, [2008] A.J. No. 1053*, holding that: "The law in this area as it is articulated by the Supreme Court of Canada does not give the public or the media the right to receive the evidence being put before the Court in the same format as it is put before the Court." *(paragraph 44)*

54 In *R. v. Canadian Broadcasting Corporation, [2006] O.J. No. 1685* the Ontario Supreme Court also rejected the notion of "format entitlement", taking the view that a media application for access to videotaped evidence tendered at a trial does not involve the principles associated with public access to court proceedings. The Court held the application involved "the manner in which trial evidence is provided to the public." *(paragraph 3)* The Court relied on *Vickery* and its statements about the court as "custodian of the exhibits with supervisory powers over material surrendered into its care." *(paragraph 32)* Durno, J. also noted that exhibits are not court records produced by the court: "They are frequently the property of non-parties, and there is ordinarily a proprietary interest in them." *(paragraph 30)*

55 In *R. v. Black, [2006] B.C.J. No. 3522*, the British Columbia Supreme Court granted a media application to broadcast the videotaped "Mr. Big crime boss" scenario that secured the pivotal confessions by the accused to the murder of her husband. However, the grant of access for the purpose of reproducing the videotaped exhibits was heavily regulated. The Court ordered editing of the tapes to protect the identity of the RCMP operatives whose identities were already protected under court order and held that the references to third persons were not to be broadcast so as to protect the privacy of those individuals. The Court required the following procedure for duplicating the tapes for broadcast:

> ... The media will get the videotapes duplicated through the registry. Within one week of receiving the duplicated tapes, send the tapes out for approval to the three relevant parties, that is, RCMP, Crown and defence. Within one week of receipt, all counsel will get back to media counsel regarding approval or rejection, and within one week of the vetted videotape being approved, the masters will be returned to [counsel for the Attorney General of Canada]. There is to be no further distribution of the vetted and approved tape without leave of the court. *(paragraph 63)*

56 The Supreme Court of Canada has not considered, since *Vickery*, the issue of public access to exhibits for the purpose of broadcast. It will be doing so in an appeal by the Canadian Broadcasting Corporation from a decision of the Quebec Court of Appeal denying permission to the media to broadcast images from a videotaped statement made by an accused, before he was charged, to a person in authority. Leave to appeal in this case was granted on April 30, 2009. *(R. v. Canadian Broadcasting Corporation, [2009] S.C.C.A. No. 84)*

57 In addition to factors that other courts have considered in determining whether access to an exhibit should be granted, factors specific to this Inquiry must be examined. These are the rights that are implicated by direct downloading, including the privacy rights of prisoners whose images are captured on the surveillance footage, and the issue of context. It is also relevant to note the practices of other inquiries.

Rights that are Implicated by Access for the Purpose of Direct Downloading

58 Deciding the direct downloading issue requires me to address the fact that the video surveillance evidence includes the images of correctional employees, including some whom I am told were not involved with Mr. Hyde, and prisoners who were present when correctional officials were dealing with Mr. Hyde.

59 It has been submitted by the Schizophrenia Society that the NSGEU employees in the

video footage were engaged in discharging public responsibilities in an environment where video surveillance was "known, accepted and consented to" by them. However, consenting to videotaping as a condition of employment cannot be treated as consent to having those images directly downloaded to the infinity of the internet. Through the representations on their behalf by counsel for the NSGEU, the correctional officers shown on the video surveillance have expressed their lack of consent to the direct downloading to the internet of their images, disconnected from their testimony.

60 Acceptance and consent associated with conditions of employment has no bearing on the issue of the prisoners' rights. Prisoners are in custody as a result of either being remanded or sentenced. Their status in the correctional institution is a coerced status. They are not in custody voluntarily and have no choice in the matter of being videotaped. However, the fact that prisoners are not entitled to refuse consent to being videotaped in a correctional institution does not mean their consent is dispensed with for all purposes.

61 Prisoners do not, as a consequence of being remanded or sentenced, surrender all their privacy rights, even if "surveillance and scrutiny" are an integral part of incarceration. A "substantially reduced level of privacy" in the correctional context *(Weatherall v. Canada (A.G.), [1993] 2 S.C.R. 872)* is not an elimination of all rights to privacy. There is therefore a privacy rights issue that must be confronted when dealing with video surveillance that contains images of prisoners. These prisoners are not represented before this Inquiry: they have not been given any notice of the potential for their images being directly downloaded to the internet. Indeed, given that the events concerning Mr. Hyde occurred in late 2007, the prisoners depicted in the video surveillance are likely to have been released by now from provincial custody. Some or all of them may be back in their communities, trying to get on with their lives.

62 The capturing on video surveillance of the images of individuals who will not be testifying as witnesses makes for a situation unlike the one described by the Supreme Court of Canada in *Vickery* where the Court referred to the "... public access to and reporting of ... proceedings as a price that [accused persons] must pay in the interests of insuring the accountability of those engaged in the administration of justice." *(paragraph 31)* Requiring prisoners to bear the burden of accountability for the proper administration of justice in circumstances that did not involve them does not seem at all fair or appropriate.

63 The privacy rights of the prisoners shown in the video surveillance of Mr. Hyde is a significant factor that, in my opinion, not only presents a serious obstacle to direct downloading, it raises the issue of whether prisoners' identities should be obscured before these portions of the video surveillance are filmed as part of the webcasting. No one, myself included as Inquiry judge, has any authority to waive these privacy rights on behalf of the prisoners nor can we just ignore them. As I indicated earlier, this point was made by Ms. Buckle in the context of the HRPS video surveillance.

64 When considering public access that is as broad as the internet, it is immaterial that the prisoners have been subject to the public processes of the courts. Such processes -- for example, bail hearings, trials and sentencing -- are not only coercive, they may have involved publication bans, including on identity, and in any event, represent even at their most open, a limited public exposure.

65 There is no question that this Inquiry will fulfill a vital educative function in discharging its mandate to investigate Mr. Hyde's death. Those parties seeking direct downloading of the video surveillance have emphasized the value of that public education and the discussion that may well ensue from the evidence that comes out. However, rights have to be respected at the same time that the public's understanding of events is illuminated. Although said in the context of an Inquiry established under the *Public Inquiries Act*, and referring to the reputational rights of persons whose conduct was under scrutiny, the Supreme Court of

Canada's observations in relation to the Krever Inquiry are apposite here:

> The inquiry's roles of investigation and education of the public are of great importance. Yet those roles should not be fulfilled at the expense of the denial of the rights of those being investigated ... This means that no matter how important the work of an inquiry may be, it cannot be achieved at the expense of the fundamental right of each citizen to be treated fairly. *(Canada (Attorney General) v. Canada (Commission of Inquiry on the Blood System in Canada -- Krever Commission), [1997] 3 S.C.R. 440 at paragraph 31)*

66 This statement by the Supreme Court of Canada emphasizes the significance of rights and the responsibility of inquiries to respect them even where the principle of public accountability is directly engaged.

Transparency, and Enhancing Public Understanding -- In Context

67 The video surveillance has been likened to a witness. This analogy ties into the submission that the video surveillance is the best evidence of events involving Mr. Hyde. Video evidence, in the context of a case that turned on the issue of identity, has been characterized as "a silent, trustworthy, unemotional, unbiased and accurate witness who has a complete and instant recall of events." (*R. v. Nikolovski, [1996] 3 S.C.R. 1197, paragraph 28)*. However, the video surveillance of Mr. Hyde is not in the category of the only evidence available to establish someone's identity. It is a visual record that witnesses are going to be asked to explain. It is dynamic evidentiary record. I understand the Inquiry will hear from numerous witnesses about what is shown on the footage. There will be a special need for witnesses to explain the footage from the CNSCF as there is no sound accompanying it. It is possible I will be asked to draw inferences once I have heard what witnesses have to say about the images. Filming of the Inquiry proceedings will capture the witnesses' testimony about the video surveillance and any submissions that will be made on what inferences should be drawn from it. Direct downloading of the images will not. Directly downloading the video surveillance will send images to the internet without any context.

68 Context is crucial. It will be critical to any factual findings and recommendations I make. The public's understanding of what happened to Mr. Hyde will be informed by all the evidence this Inquiry will hear. A critical assessment of the events on which the Inquiry is focused will be informed by a great deal more than just the video surveillance images. *(R. v. Fry, [2008] B.C.J. No. 2082, paragraph 23 (B.C.S.C.))* Directly downloading just one piece of evidence to the internet creates the potential for distorting the facts, especially where the evidence itself is incomplete in the absence of (a) sound, and (b) the explanations of the witnesses to the events.

69 It is relevant to note that the media will be able to fully report on the Inquiry and will have, through the live streaming of the proceedings, better and more complete access than any other fatality inquiry has been able to provide in this Province. Whether through the media reporting that webcasting will presumably enhance, or personal attendance, or watching the webcast, the general public will have the opportunity for a better and more complete education about the issues raised in a fatality inquiry than has previously been possible.

The Practices of Other Inquiries

70 The practices of other Inquiries with respect to videotaped evidence are instructive. As noted by the NSGEU, the Braidwood Inquiry into the death of Mr. Dziekanski in British Columbia operates a website but has downloaded no exhibits to it. Its Rules of Procedure *(Practice and Procedure Directive for Evidentiary Hearings -- August 12, 2008)* provide that once a record, which includes digital video, has been entered as an exhibit, it may be inspected by the public and the media. Inspection is the extent of the access permitted by the Inquiry's

Rules. Justice Louise Arbor, who conducted the Commission of Inquiry into Certain Events at the Prison for Women recommended that the videotape of the Institutional Emergency Response Team intervention at the prison be attached to any copy of her report which would be preserved in the Archives. Notwithstanding that those graphic video images had been shown, with the consent of the women prisoners involved, on a national television news magazine programme before the Inquiry commenced, Justice Arbor did not recommend the wholesale release of the videotapes to the general public.

71 In the Pham Fatality Inquiry, the media's request for copies of exhibits was granted subject to certain conditions that included the editing of the names of individuals not connected to the inquiry. Wenden, P.C.J. held that the editing would ensure "that the privacy interests of these people are preserved." *(Pham (Re), [2004] A.J. No. 611, paragraph 1 (Alta. P.C.))* Other conditions of Judge Wenden's order prohibited copying of the documents or photographs, imposed restrictions on use of the documents and photographs to facilitate the reporting of the inquiry only and for no other purpose, and directed that all documents and photographs were to be returned to inquiry counsel at the conclusion of the inquiry.

Direct Downloading of Exhibits to the Internet

72 Direct downloading of the video surveillance is a form of access that cannot be regulated to protect the integrity of the evidence and the privacy of individuals, some of whom had no involvement with the events. The Inquiry has an obligation as the custodian of its exhibits to ensure that exhibits are not subject to improper use or employed for improper purposes. There is no order the Inquiry can draft that could manage the risks associated with downloading to the internet.

73 Durno, J. in *Sylvester* expressed the concerns I am identifying when he said:

> "No practical limits can thereafter be imposed to prevent [the exhibit] from being viewed, duplicated, edited, re-broadcast, in the media or by the public, privately or on the Internet, well into the foreseeable future." *(paragraph 72)*

Live Streaming the Inquiry's Proceedings and the Issue of Direct Downloading

74 I indicated earlier in these reasons that I wanted to examine whether the fact that these proceedings will be webcast effectively dispenses with any issue about direct downloading. I find it does not. Indeed, now that I have been able to give some careful thought to the issue, I have concerns about the webcasting, without alteration, of the images from the video surveillance of individuals who will not be called as witnesses at the Inquiry. I will ask that counsel address this issue with me with a view to how the privacy of these individuals can be protected.

75 However even the alteration of the images of certain individuals cannot lay to rest the other concerns I have identified with the direct downloading -- the issues of context and the responsibility borne by an Inquiry to control the access to and use made of its exhibits. Direct downloading of the video surveillance probably would provide clearer images to the general public. The images would be of interest for legitimate reasons: they would shine a light into what is otherwise a closed and inaccessible environment, the inside of a correctional facility. But the shining of that light without the benefit of context and the ability to prevent illegitimate use of the images cannot be countenanced.

76 I will also note that the obscuring of persons' identities so that an exhibit can be broadcast may raise legitimate concerns about the distortion of the evidence. *(see, for example, R. v. Canadian Broadcasting Corporation, supra, paragraph 50 and R. v. Fry, supra, paragraph 22)*.

Conclusion

77 This Inquiry will be examining the circumstances of the tragic death of a man detained in custody and struggling with mental health issues. As a consequence of live streaming to the internet, there will be the opportunity for the general public to have unprecedented access to the evidence I will be hearing, evidence I will have to sift and weigh when it comes to making my findings and recommendations. This public access will satisfy the requirement for openness that is "... integral to public confidence in the justice system and the public's understanding of the administration of justice ... openness is a principal component of the legitimacy of the judicial process ... *(Vancouver Sun (Re), [2004] S.C.J. No. 41, paragraph 25).*

78 These principles are rooted in the constitutional guarantees of section 2(b). I am satisfied that what is being sought here, a prohibition on the downloading of video surveillance evidence to the internet, is not incompatible with section 2(b) of the *Charter*. Section 2(b) does not guarantee for the general public the right to have this evidence directly downloaded. Notwithstanding that downloading the video surveillance would likely provide better access to the evidence than watching it on the webcast of the proceedings, the analysis of whether access is constitutionally mandated does not turn on whether the images directly downloaded would be clearer. The analysis turns on whether direct downloading of a court exhibit comes within the ambit of the constitutional guarantee of freedom of expression. In my opinion, the existence of technology that permits direct downloading does not create a constitutional right for the general public or the media to have that technology employed for the purpose of providing access to the evidence in the same format that it is presented to the Inquiry.

79 I am wholly satisfied that the access being provided to the media and general public to these proceedings amply fulfills the open court imperatives. For the reasons I have given, I conclude that public access to these proceedings does not require and should not include the direct downloading to the internet of the video surveillance of Mr. Hyde from the Central Nova Scotia Correctional Facility.

cp/e/qlrxg/qlpwb/qlmxl/qlaxw/qlhcs/qlcas/qlcas

Case Name:
Hyde (Re)

Re
AN INQUIRY UNDER the Fatality Investigations Act, S.N.S. 2001, c. 31 into the death of Howard Hyde

[2009] N.S.J. No. 336

2009 NSPC 34

281 N.S.R. (2d) 85

Registry: Halifax

Nova Scotia Provincial Court

A.S. Derrick Prov. Ct. J.

Heard: July 15, 2009.
Judgment: July 20, 2009.

(31 paras.)

Criminal law -- Coroner's inquest or inquiry -- Procedure -- Application by media outlet for access to surveillance video evidence at inquiry dismissed -- Media had what was required to effectively report on proceedings and media outlet's constitutional rights not jeopardized or undermined by denying access to surveillance video DVDs -- Court's previous decision would be rendered meaningless if media outlet able to copy DVDs and post them to website -- Allowing media outlet to copy DVDs would expose evidence to potential for manipulation and interfere with privacy rights of employees and prisoners -- Responsible presentation of evidence required it not be divorced from context of accompanying witness commentary.

Application by media outlet for access to surveillance video evidence at inquiry. The surveillance evidence tendered at the inquiry was from the Halifax Regional Police Service and the Central Nova Scotia Correctional Facility. It totalled approximately 16 hours and was stored on DVD. Throughout the inquiry, portions of the DVD surveillance evidence from the Halifax Regional Police station booking area which contained images of police officers struggling with an individual and tasering him was viewed. The video was played in the courtroom on a large flat-screen television which was filmed for live streaming. Witnesses were examined about the video surveillance and those examinations were also filmed for live streaming. Images from the live streaming of the video surveillance had appeared in print, broadcast and online media and media outlets had accessed the images from both the live streaming and archived portions of the inquiry's webcast proceedings. No disclaimers had been posted to advise viewers that the images were, in the opinion of the media, of poor or substandard quality. The court had previously rendered a decision prohibiting the direct downloading of the video surveillance evidence to the internet independent of the webcasting of the inquiry. The media outlet sought access to the video surveillance evidence in order to duplicate the video exhibits so that it would have better quality video footage of the portions of the video shown at the inquiry and it intended to broadcast portions it considered newsworthy if permission was granted.

HELD: Application dismissed. The media covering the inquiry had what was required to

effectively report on the proceedings and the media outlet's constitutional rights were not jeopardized or undermined by denying access to the surveillance video DVDs. The court's previous decision prohibiting direct downloading of the surveillance video evidence to the internet would be rendered meaningless if the media outlet was able to copy the DVDs and post them to its website. The media was not entitled to the same quality of image as was available to the inquiry and there was no constitutional right of the media to the best visuals. The images available to the media, while not as pristine as the media outlet would prefer, were very effective for the purpose of providing the public with an understanding of the matters discussed at the inquiry. Allowing the media outlet to copy the DVDs would expose that evidence to unlimited potential for manipulation on the internet and would interfere with the privacy rights of employees and prisoners. Furthermore, responsible presentation of the evidence required that it not be divorced from its context, that being the accompanying witness commentary.

Statutes, Regulations and Rules Cited:

Fatality Investigations Act, S.N.S. 2001, c. 31,

Counsel:

David G. Coles, Q.C., Counsel for the Canadian Broadcasting Corporation.

Daniel MacRury, Q.C., Inquiry Counsel.

Edward Gores, Q.C., and Dana MacKenzie, Counsel for the Attorney General.

Kevin C. MacDonald, Counsel for Joanna Blair and Dr. Hunter Blair.

David Roberts, Counsel for the Nova Scotia Government Employees' Union.

Sandra MacPherson, Q.C., and Elizabeth Buckle, Counsel for the Halifax Regional Police.

Rory Rogers and Matthew Pierce, Counsel for Capital District Health Authority.

Thomas Donovan, Q.C. and Loretta Manning, Counsel for Dr. Janet MacIntyre.

Michael Wood, Q.C. and Jennifer Ross, Counsel for Dr. Stephen Curry.

Blair Mitchell and Angela Byrne, Counsel for the Schizophrenia Society of Nova Scotia.

Carol Tooton, Executive Director, Canadian Mental Health Association, and Simon Li and Mallory Treddenich, pro bono students at law.

DECISION ON AN APPLICATION BY THE CANADIAN BROADCASTING CORPORATION FOR ACCESS TO THE SURVEILLANCE VIDEO EVIDENCE

A.S. DERRICK PROV. CT. J.:--

Introduction

5. **1** This decision addresses the application by the Canadian Broadcasting Corporation (CBC) for an Order to copy the video surveillance exhibits at the Inquiry for broadcast purposes. The essence of CBC's request is found in the Affidavit of Nancy Waugh, sworn on July 9, 2009 where she states:That process [of filming the video surveillance footage during the Inquiry proceedings and live streaming to the internet] does not produce broadcast quality video of the standards which would usually be relied on by CBC

in its work. In effect, we are requesting a mechanism which will give us better quality footage of the same material the Inquiry has determined to release in its live stream to the internet.

6. We intend to broadcast only those portions which we believe are newsworthy and it is likely not all of the material played by the Inquiry and streamed to the internet will be broadcast by CBC.

7. We are therefore seeking a copy of the video exhibits and undertake to broadcast only those portions which are played by the Inquiry.

8. If after reviewing the exhibits, we become aware of footage not played at the Inquiry which we would like to air, we undertake to return to the Inquiry for permission before broadcasting anything in addition to that broadcast by the Inquiry.

2 Ms. Waugh has submitted a supplementary Affidavit ("Affidavit #2") sworn on July 13, 2009 in which she indicates as follows:

3. CBC does not have the technology to present a split screen of the surveillance video together with the live stream video feed.
4. I have examined the video being shown by the Hyde Inquiry, and to date, when portions of the surveillance tape are shown, there is no evidence being given when the video is playing. Because the video is shown without accompanying evidence, there is no "context" to be offered by having a blank second screen.
5. If the video is accompanied by evidence, we can certainly add a date to the video display to reference that fact.
6. I am not aware of any efforts to take contents streamed by the Hyde Inquiry and distort it.

3 Presumably, Nancy Waugh's second Affidavit is intended to address concerns about context and possible distortion of the evidence presented at the Inquiry. CBC will have anticipated these issue as they were referenced in a decision I rendered on July 6, 2009. I will address these issues as they bear on CBC's application in due course.

Background - My Decision of July 6, 2009

4 On July 6, 2009 I handed down my decision on the issue of direct downloading of the video surveillance evidence to the internet. *(Hyde Re, [2009] N.S.J. No. 308)* In that decision I prohibited the direct downloading of the video surveillance evidence to the internet independent of the webcasting of the Inquiry.

5 Although my decision referred specifically to the video surveillance from the Central Nova Scotia Correctional Facility (CNSCF), when I rendered it I was asked by counsel for the Halifax Regional Police to clarify if the prohibition against direct downloading also covered the video surveillance obtained from the Halifax Police station and I confirmed that it does. My decision specified the CNSCF video surveillance because the application I was addressing had been advanced by the union for those employees, supported by their employer, the Attorney General of Nova Scotia. The factors that lead to my prohibition against direct downloading are the same for all the video surveillance, although the issue of prisoner privacy rights is less pronounced in the case of the HPD video surveillance.

6 In my July 6 decision I noted that I was not ruling on whether the media are entitled to some form of access to the video surveillance evidence for the purpose of broadcast or whatever other purposes might be identified. *(paragraphs 33, 48, 51)* It would not have been

appropriate for me to adjudicate an application that had not yet been made.

7 This application by CBC represents the application I thought might be made once the hearing of the evidence at the Inquiry got underway. The written submissions by CBC indicate that permission is being sought "to duplicate the video exhibits so that it [CBC] will have better quality video footage of the portions of the video shown at the Inquiry." If permission were to be granted CBC intends "to show those portions we consider newsworthy on television and on CBC.ca." *(Letter dated July 8, 2009 from David G. Coles, Q.C., counsel for CBC, to Inquiry Counsel)*

The Video Surveillance of Mr. Hyde in Custody - At the Inquiry and In the Media

8 The video surveillance evidence being tendered at the Inquiry is from the Halifax Regional Police Service (HRPS) and the Central Nova Scotia Correctional Facility (CNSCF) The footage, which I understand totals approximately sixteen hours, is stored on DVD's. In the last couple of weeks, the Inquiry has been viewing some of the DVD evidence from the Halifax Regional Police station booking area. This footage contains images of police officers struggling with Mr. Hyde and tasering him. Some of the footage has sound. Some of it, the video surveillance of police officers struggling with Mr. Hyde in a hallway leading from the booking area, does not.

9 The Halifax Regional Police Service video surveillance is being played in the courtroom on a large flat-screen television. The cameras in the courtroom live streaming the Inquiry proceedings are filming the footage while the DVD's are played. Witnesses have been and will continue to be examined about the video surveillance. The examinations of witnesses by Inquiry counsel and counsel for the parties are also being live streamed. As I noted in my July 6 decision, subject to the quality of the webcast, when the video surveillance is playing in the courtroom, the viewing public sees and hears, by way of the live streaming, the surveillance images and any recorded sound.

10 Images from the live streaming of the video surveillance have been appearing in the print, broadcast and online media. Media outlets, including CBC, have been accessing the images from both the live streaming and the archived portions of the Inquiry's webcast proceedings. No disclaimers have been posted to advise viewers that the images are, in the opinion of the media, of poor or substandard quality.

11 To this point, none of the video surveillance from the Central Nova Scotia Correctional Facility has been shown at the Inquiry. The proceedings have not reached the point of inquiring into the events that occurred when Mr. Hyde was in the custody of provincial correctional officials.

The CBC Application

12 In CBC's submissions, obtaining a duplicate copy of the video surveillance for their broadcast and internet purposes is necessary to enable the Corporation to properly discharge its constitutional right to report on the Inquiry. CBC argues that the general public's understanding of the Inquiry's proceedings and the matters being examining by the Inquiry will be enhanced by video images that are of a superior quality than those available through the live streaming process I described earlier. CBC says it is simply looking for the opportunity to provide better public access to the proceedings, in keeping with what the webcasting is achieving. This, CBC submits, best satisfies the requirements of open justice. CBC wants to duplicate the video exhibits to ensure that "television journalists enjoy the same benefit which print and radio reporters already enjoy." CBC states in its written submissions: "The existing practice of the Inquiry - to live stream from the television screen to the internet - may be satisfactory for print media and radio broadcast purposes, but it disadvantages television journalists who work in a visual medium."

13 In advancing its case for permission to copy the video surveillance DVD's, CBC emphasizes its role as a facilitator of the public's access to and understanding of court proceedings, a role described by the Supreme Court of Canada in *Edmonton Journal v. Alberta (Attorney General), [1989] S.C.J. No. 124*: "It is only through the press that most individuals can really learn of what is transpiring in the courts." *(paragraph 10)* CBC submits that live streaming does not replace the benefit accorded the listening and watching public by CBC's news services on television, radio and the internet. CBC provides its consumers with predictable opportunities for obtaining encapsulated reports of newsworthy events. CBC submits it offers a unique service, distinct from the webcasting, to members of the public interested in the proceedings but too busy to sit through the live streaming of the evidence. Producing the best quality news product requires CBC to have copies of the video surveillance. In the words of its counsel: "CBC wants a good quality picture" to ensure meaningful access to the Inquiry's proceedings and enhance the media reporting about them.

14 Although CBC's application is not buttressed by any jurisprudence to support the right to better quality access to evidence than is available to other forms of media, CBC's argument is that good "visuals" are the lifeblood of television journalists.

Positions of the Parties

15 A number of parties have taken no position on the CBC application. These are:

> Joanna and Dr. Hunter Blair, Dr. Janet McIntyre and Dr. Stephen Curry, the Capital District Health Authority, the Schizophrenia Society of Nova Scotia and the Canadian Mental Health Association.

16 The Nova Scotia Government Employees Union (N.S.G.E.U.), the Attorney General of Nova Scotia (A.G.N.S.), and the Halifax Regional Police Service (H.R.P.S.), are opposing the CBC application. There are no parties that are expressly in support of CBC's request.

17 Inquiry Counsel also opposes the application.

Parties' Reasons for Opposing the Application

18 The parties that oppose the CBC application do so on the basis that granting permission to CBC to copy the video surveillance and use the duplicated footage for broadcast and posting to the CBC website would "entirely undermine" my decision of July 6, 2009 prohibiting direct downloading of the video surveillance to the internet. *(Submissions of the NSGEU by email, July 12, 2009)* The NSGEU submits that the "posting of surveillance video on the internet [by CBC] would be no different from the posting of surveillance video [to the internet] by the Inquiry ..." Inquiry Counsel and the other parties opposing the application advance the same submission. The Attorney General for Nova Scotia submits that the copying by CBC of the video surveillance for the purpose of broadcast and web posting is contrary to the reasons and spirit of my July 6 decision. *(Submissions of AGNS, letter dated July 14, 2009)* Counsel for parties opposing CBC's application elaborated their positions in their able oral submissions.

Analysis

Right to "Good Visuals"

19 Relying on *Edmonton Journal*, CBC notes that most people are unable to free up the time to attend court proceedings and therefore depend on the media to keep them informed about specific cases and the administration of justice more broadly. CBC submits that good quality visual images are crucial to facilitating public understanding of the justice system and satisfying the objective that its participants and institutions be held accountable.

20 As I noted in my decision of July 6, this Fatality Inquiry is publicly accessible to an

unprecedented extent. *(Hyde Re, paragraphs 20, 35, 77)* My decision dealt with the issue of whether the video surveillance evidence -- evidence which is the focus of this application by CBC -- should be directly downloaded to the internet. I will not review my reasons for deciding that would not be appropriate and should not occur. I am unable to see how CBC's request to duplicate the video surveillance DVD's for broadcast and posting to its website is any different from what I have already prohibited. My decision prohibiting the direct downloading of the surveillance video evidence to the internet would be rendered meaningless if CBC was able to copy the DVD's and post them to its website. This would, in effect, be a direct downloading to the internet, albeit on the website of a responsible media institution. The fact that the downloading would be to the CBC webpage would not eliminate any of the concerns I articulated in my earlier decision.

21 As a matter of law, the media are not entitled, in my view, to the same quality of image as is available to the Inquiry. There is no "format entitlement" to use the term employed in several cases as noted in my decision of July 6. *(paragraphs 53-54)* As I have already found, there is no constitutional right of the media to the clearest images, what might also be termed, the best "visuals." *(Hyde Re, paragraph 78)* Indeed, I am satisfied that the images available to the media, while apparently not as pristine as CBC would prefer, are very effective for the purpose of providing the public with an understanding of the matters being discussed at this Inquiry. That was the hope embedded in the decision by the Inquiry to live stream its proceedings. I believe webcasting is offering meaningful access to the general public including as an aid to the media reports on the proceedings that are utilizing the live streaming and its archive. In my opinion, CBC cannot make out a persuasive case that without access to the copies of the video surveillance for broadcast and downloading to its website it is disadvantaged in discharging its media role or suffering a diminution of its constitutional rights.

Image-manipulation, Context and Privacy - Has Anything Changed?

22 CBC has urged me to re-examine, through the lens of its application, issues I confronted in my July 6 decision. CBC assures me that its application does not plough the same ground I have already decided and submits that concerns identified by me when considering the direct downloading issue, such as the risk of image-manipulation, decontextualization of the evidence, and privacy rights, do not deserve the same prominence or influence in my reasoning on this application. CBC argues for my re-visiting these factors with the following points: (1) any exhibit that is copied for media broadcast can be manipulated by an unscrupulous third party, a fact that should not prejudice CBC who is not responsible for this happening if it does; (2) the video surveillance evidence is being shown at the Inquiry at least some of the time without witness commentary; and, (3) surrender of privacy is the cost of doing democratic business.

23 I have a short answer to the manipulation and privacy arguments. I dealt with them on July 6. Downloading by CBC of video surveillance evidence to its website exposes that evidence to unlimited potential for manipulation on the internet. There are more and better opportunities to manipulate and distort DVD video surveillance on the internet than any other evidence, even if permission is given to copy other exhibits, such as photographs or documents, for media broadcast purposes. The DVD evidence downloaded to the internet cannot be regulated. I made this point previously. *(Hyde Re, paragraphs 39, 40, 72, 73)* And I have emphatically rejected the notion that employees and prisoners must sacrifice their privacy rights to the infinity of the internet. *(Hyde Re, paragraphs 59-66)*

24 Furthermore, there is not only the problem of regulating evidence that is posted to the internet. It is relevant to also note that the Inquiry will not be able to police the use of the video surveillance, if duplicated, certainly not once the Inquiry has concluded its mandate. When the Inquiry has discharged its statutory role there will be no one to respond to the

future requests CBC undertakes to make if it wishes to use footage that is not played at these proceedings.

25 As for the issue of context, CBC submits that the video surveillance is already going to the internet without any accompanying witness testimony in those segments of the Inquiry's proceedings where the video surveillance footage has been played for a witness before the witness is asked to comment. It is accurate to say that the live streaming of certain segments of the proceedings shows just the video footage before the witness is questioned about it. I do not accept however that this method of presenting the evidence bleeds the life out of my reasoning on the issue of context as I discussed it in my earlier decision. The playing of the video surveillance footage before a witness is asked to comment is a very limited part of the presentation of this evidence. The DVD images are primarily shown in segments interspersed or sometimes even over-laid with witness commentary. Although a person viewing the live streaming might choose to just watch those moments of video surveillance before a witness comments, it is hard to accept that webcasting watchers will not access at least some of the witnesses' testimony about the footage.

26 CBC makes the point that its viewers and listeners rely on it to provide context and interpretation of the evidence. This acknowledges that the general public are looking to have events placed in their proper context. I think it is reasonable to assume that this interest in context and interpretation will exist amongst a majority of those viewers who are watching the live streaming. Furthermore, the video surveillance includes the sounds of events occurring off camera and the visual depiction of events with no sound. Witness testimony about what was happening where there is only sound or only images is both helpful to the viewer and fair to those involved in the events.

27 The video surveillance is embedded in the Inquiry's proceedings. Responsible presentation of such dynamic evidence requires that it not be divorced from its context, the context of accompanying witness commentary in response to questioning from lawyers endeavoring to assist the Inquiry discharge its mandate. Furthermore, broadcasting media-selected parts of the video surveillance, presumably with reporter commentary, is already available through the webcasting. CBC is not disadvantaged by the Inquiry retaining control over the public's access to this evidence.

28 It is my view that the video surveillance evidence in this Inquiry presents a greater challenge when issues of access are being considered than does the videotaped evidence in criminal proceedings that has, on occasion been made available to the media for broadcast. In my earlier decision I referred to the successful media application to obtain the videotaped admissions of a murder suspect in a "Mr. Big crime boss" police sting operation. *(Hyde Re, paragraph 55, referring to R. v. Black, [2006] B.C.J. No. 3522 (B.C.S.C.))* The court imposed strict conditions for the duplication of this evidence, but it was, in any event, evidence of a vastly different character than the video surveillance footage being considered by this Inquiry. The "Mr. Big" interviews speak for themselves. They constitute footage of the unwitting suspect providing incriminating information to police posing as crime figures. Such interviews are usually going to be of interest for what is said, not what is happening. There is a greater likelihood that such evidence can be understood without witness testimony, and the issues of context and fairness, related to providing those involved with the opportunity to explain the events, do not necessarily arise.

29 It also seems likely to me that the case to be heard on appeal by the Supreme Court of Canada, *R. v. Canadian Broadcasting Corporation*, [2009] S.C.C.A. No. 84, mentioned at paragraph 56 of my earlier decision, concerns issues that do not precisely track those that have had to be confronted in these proceedings.

Television Broadcast

30 CBC has sought access to the video surveillance DVD's for television broadcast and internet posting purposes. I do not want to be thought to have overlooked CBC's request to duplicate the video surveillance for television use. I note that CBC acknowledged in its written submissions that the live streaming by the Inquiry "may be satisfactory for print media and radio broadcast purposes", but not for television. As I noted at the start of this decision, the issue is "good visuals." However, even in the case of television broadcast the issue of context arises, as do the privacy and image-manipulation issues. Locating the evidence in its context of accompanying witness testimony and as part of the Inquiry's proceedings provides the greatest likelihood that everyone seeing it, including the media, will consider the commentary of the witnesses who were involved in the depicted events. The Inquiry is permitting unprecedented access to its proceedings: releasing the DVD's of video surveillance to CBC for its use in any of the formats proposed would surrender too much control over this evidence.

Conclusion

31 CBC understandably would like the best visual images it can obtain and the right to virtually unlimited use of those images. It does not regard any of the concerns raised in my July 6 decision as impediments to what it is seeking. I do. I am amply satisfied that CBC, and other media covering this Inquiry, have what is required to effectively report on the proceedings. CBC's constitutional rights are not jeopardized or undermined by denying access to the video surveillance DVD's. The views I expressed in my July 6 decision remain unchanged. Not releasing the video surveillance evidence for broadcast or downloading to the internet properly respects all the rights and interests affected by the technology that enables such wide distribution of these images. None of CBC's arguments persuade me that I should permit access to the video surveillance so that it can be duplicated for television broadcast or website purposes. The application is dismissed.

A.S. DERRICK PROV. CT. J.

cp/e/qlfxs/qlpwb/qlbdp/qlaxw/qlhcs/qlrxg

Case Name:
Hyde (Re)

Re
AN INQUIRY UNDER the Fatality Investigations Act, S.N.S. 2001, c. 31 into the death of Howard Hyde

[2009] N.S.J. No. 357

2009 NSPC 37

281 N.S.R. (2d) 93

68 C.R. (6th) 194

2009 CarswellNS 424Registry: Halifax

Nova Scotia Provincial Court

A.S. Derrick Prov. Ct. J.

Heard: July 23, 2009.
Judgment: July 24, 2009.

(17 paras.)

Constitutional law -- Canadian Charter of Rights and Freedoms -- Fundamental freedoms -- Freedom of thought, belief, opinion and expression -- Freedom of expression -- Internet -- Application to determine whether it is was necessary for the Attorney General of Nova Scotia to provide notice to the media of its application to have the webcasting of an inquiry into the death of a prison inmate not include certain video surveillance images from a prison facility -- Media did not have a constitutional right to require the Inquiry to live stream its proceeding and had no entitlement to standing to address this issue -- Issue of what webcasting should include did not engage the media's constitutional rights -- It was therefore not required or appropriate for the Attorney General to provide notice so that standing could be applied for.

Information technology -- Internet -- Broadcasting over internet -- Freedom of expression -- Constitutional and quasi-constitutional issues -- Canadian Charter of Rights and Freedoms -- Application to determine whether it is was necessary for the Attorney General of Nova Scotia to provide notice to the media of its application to have the webcasting of an inquiry into the death of a prison inmate not include certain video surveillance images from a prison facility -- Media did not have a constitutional right to require the Inquiry to live stream its proceeding and had no entitlement to standing to address this issue -- Issue of what webcasting should include did not engage the media's constitutional rights -- It was therefore not required or appropriate for the Attorney General to provide notice so that standing could be applied for.

Media and communications law -- Legislative framework -- Legislation -- Constitutional issues -- Canadian Charter of Rights and Freedoms -- Application to determine whether it is was necessary for the Attorney General of Nova Scotia to provide notice to the media of its application to have the webcasting of an inquiry into the death of a prison inmate not include certain video surveillance images from a prison facility -- Media did not have a constitutional right to require the Inquiry to live stream its proceeding and had no entitlement to standing to address this issue --

Issue of what webcasting should include did not engage the media's constitutional rights -- It was therefore not required or appropriate for the Attorney General to provide notice so that standing could be applied for.

Application to determine whether it is was necessary for the Attorney General of Nova Scotia to provide notice to the media of its application to have the webcasting of an inquiry into the death of a prison inmate named Hyde not include certain video surveillance images from the Central Nova Scotia Correctional Facility. The evidence before the Inquiry included video surveillance of Hyde. The Court previously prohibited direct downloading of the video surveillance to the Internet outside of the webcasting of the Inquiry proceedings themselves. It also denied an application by the Canadian Broadcasting Corporation for access to the DVDs of the video surveillance for duplication for broadcast and for Internet purposes. The images from the Facility were relevant to the Inquiry proceedings. The Attorney General brought its application because the footage of Hyde's struggle with correctional officers before his death raised issues of dignity, privacy and propriety and should not be live streamed. It was not opposed to the images being played in open court.

HELD: Application dismissed. The media right to report and inform the public of the Inquiry proceedings was protected by s. 2(b) of the Canadian Charter of Rights and Freedoms, which provided for freedom of expression. The notice issue arose since the media's s. 2(b) rights were being engaged. Notice to the media served to inform media outlets that their constitutional rights were in play and could be subject to restriction as a consequence of the exercise of judicial discretion. Informed media could then decide whether to seek standing to be heard before a judicial determination was made. Media notice was therefore directly connected to the entitlement to standing to defend the constitutional right to freedom of expression. However, the media did not have a constitutional right to require the Inquiry to live stream its proceeding. It therefore was not entitled to standing to address a live streaming issue. Since there was no entitlement to standing there was no entitlement to notice. The issue of what webcasting should include did not engage the media's constitutional rights. It was therefore not required or appropriate for the Attorney General to provide notice so that standing could be applied for.

Statutes, Regulations and Rules Cited:

Canadian Charter of Rights and Freedoms, 1982, R.S.C. 1985, App. II, No. 44, Schedule B, s. 2(b)

Fatality Investigations Act, S.N.S. 2001, c. 31, s. 32, s. 32(a), s. 32(b)

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Rory Rogers and Matthew Pierce, Counsel for Capital District Health Authority.

Thomas Donovan, Q.C. and Loretta Manning, Counsel for Dr. Janet MacIntyre.

Michael Wood, Q.C. and Jennifer Ross, Counsel for Dr. Stephen Curry.

Blair Mitchell and Angela Byrne, Counsel for the Schizophrenia Society of Nova Scotia.

Carol Tooton, Executive Director, Canadian Mental Health Association, and Simon Li and Mallory Treddenich, *pro bono* students at law.

DECISION ON THE ISSUE OF NOTICE TO THE MEDIA IN THE CONTEXT OF AN APPLICATION BY THE ATTORNEY GENERAL OF NOVA SCOTIA TO LIMIT THE WEBCASTING OF VIDEO SURVEILLANCE EVIDENCE FROM THE CENTRAL NOVA SCOTIA CORRECTIONAL FACILITY

A.S. DERRICK PROV. CT. J.:--

Introduction

1 This decision addresses the issue of whether it is necessary or even appropriate to require the Attorney General of Nova Scotia (AGNS) to provide notice to the media of its application to have the webcasting of the Inquiry not include certain video surveillance images from the Central Nova Scotia Correctional Facility (CNSCF). Some background for this issue will be helpful.

Webcasting the Inquiry's Proceedings

2 In my previous two decisions, (*Hyde Re, 2009 NSPC 32* and *Hyde Re, 2009 NSPC 34*), I described the live streaming of the Inquiry and the filming by the webcast cameras in the courtroom of the video surveillance evidence. As I noted, the webcasting of the Inquiry is an initiative of the Executive Office of the Nova Scotia Judiciary and is cost-shared with Court Services. There are no media cameras in the courtroom filming the proceedings: all the filming is being done by the Executive Office with its equipment and expertise.

The Video Surveillance Evidence

3 The evidence before the Inquiry includes video surveillance of Mr. Hyde. To date, the video footage that has been played at the Inquiry has been from the Halifax Regional Police Service (HRPS) booking area. This evidence has been live streamed to the internet along with witness testimony associated with it. There is also video surveillance of Mr. Hyde in custody at the Nova Scotia Correctional Facility although this footage has not been seen by the Inquiry yet.

4 In my earlier decisions I prohibited direct downloading of video surveillance from the HRPS and the CNSCF to the internet outside of the webcasting of the Inquiry proceedings themselves and denied an application by the Canadian Broadcasting Corporation (CBC) for access to the DVD's of the video surveillance for duplication for broadcast and internet purposes. The Inquiry has maintained control over the DVD's containing the video footage, DVD's which are exhibits in the Inquiry.

The Impending Application by the Attorney General of Nova Scotia

5 The Inquiry has been advised by Inquiry Counsel that the video surveillance footage from the Central Nova Scotia Correctional Facility will be relevant to the next phase of the Inquiry scheduled to commence on August 4. The AGNS and the Nova Scotia Government Employees' Union (NSGEU) have indicated that they will be proposing that some of the CNSCF video surveillance not be live streamed because of security concerns. I have directed the AGNS to file an application supported by Affidavit evidence so that interested parties at the Inquiry can respond to the proposal to limit the live streaming. It has been indicated to me that Inquiry

Counsel and the Blairs will be making submissions in response to the AGNS' application. The Halifax Regional Police Service has reserved the right to do so.

6 Until the application is filed I do not know what portions of the CNSCF video surveillance are the subject of the concerns being raised by the AGNS and the NSGEU relating to security. The AGNS has indicated that the footage of Mr. Hyde's struggle with correctional officers just before his death while not engaging security concerns, raises issues of dignity, privacy and propriety and also should not be live streamed.

7 The AGNS has indicated that he is not opposed to the CNSCF video surveillance being played in open court. Therefore the issue is not one of closing the courtroom or prohibiting the media from reporting on the evidence and the testimony that will accompany it. The issue is whether the video surveillance, identified as sensitive due to security or propriety considerations, should be webcast as the Halifax Regional Police Service booking video surveillance has been. If restrictions are placed on the webcasting, the media will still be entitled to attend the proceedings and report on them to the public.

The Privacy Rights of Non-Witnesses

8 I will note for the sake of completeness that the issue of the privacy of individuals depicted on the CNSCF surveillance footage who will not be appearing as witnesses -- employees at the CNSCF and prisoners -- was dealt with in my earlier decisions. I understand the footage will be modified so that the video surveillance containing such images can be played in the courtroom with the identity of these individuals obscured, and live streamed to the internet, subject to a determination of the security and propriety issues, if there are any for those segments.

Live Streaming of the Inquiry and the Charter

9 In *Hyde Re, 2009 NSPC 32*, I addressed the *Dagenais/Mentuck* test that was relied on by parties arguing in favor of direct downloading of the video surveillance to the internet. The CBC also relied on the "open court" principle in its application. In my decision, I reached the conclusion that:[36] The argument for applying the *Dagenais/Mentuck* test to an application for access to court exhibits seeks to draw persuasive strength from Fish, J.'s disapproval in *Toronto Star* of limitations on "public access to legal proceedings." *(paragraph 9)* However there is nothing to indicate that Fish, J. had in mind a court's prohibition on courtroom cameras and internet live streaming when he was speaking about section 2(b) applying to "all discretionary court orders that limit freedom of expression and freedom of the press in relation to legal proceedings." *(paragraph 7)* There is no suggestion that the exercise of judicial discretion prohibiting the use of television cameras in the courtroom or refusing a request to live stream proceedings on the internet would conflict with the constitutional imperatives established by *Dagenais* and *Mentuck*.

[37] If freedom of expression guarantees under section 2(b) of the *Charter* required internet downloading of court hearings so that the broadest possible access could be achieved, then courts would be obligated to webcast all their proceedings. The decisions of the Supreme Court of Canada in *Dagenais v. Canadian Broadcasting Corporation, [1994] S.C.J. No. 104; R. v. Mentuck, [2001] S.C.J. No. 73* and *Toronto Star*, [2005] 2 S.C.R. 188, cannot be stretched to mean this. Indeed, media applications to broadcast trials have failed. *(see, for example: R. v. Pilarinos, [2001] B.C.J. No. 1936 (B.C.S.C.))*.

10 The live streaming of this Inquiry is not the result of a constitutional mandate. No court in Canada has determined that live streaming is required to satisfy section 2(b) of the *Charter*. To the contrary, as indicated above, I have expressly found that the live streaming is not constitutionally required. I have acknowledged that "... webcasting is offering meaningful access to the general public as an aid to the media reports on the proceedings that are utilizing the live streaming and its archive." *(Hyde Re, 2009 NSPC 34 at paragraph 21)* The webcasting of the Inquiry's proceedings is providing the public and media greater access to the proceedings, the merits of which are readily identifiable: (1) enhancing the public aspect of the Inquiry in keeping with the Inquiry's mandate; (2) promoting public interest in and public discussion of important issues arising from the Inquiry; and (3) allowing people to follow the proceedings without having to attend them. There are likely other benefits as well that are emerging as this unprecedented exercise of webcasting the proceedings unfolds, including the potential for live streaming to assist in improving accuracy in reporting.

11 The live streaming of the Inquiry is an enhancement of the openess and transparency of the proceedings. In addition to accessing the proceedings on the internet, the media and general public can attend the Inquiry. The media are entitled to report on and publish what occurs at the hearings. The media right to report and thereby inform the public is protected by section 2(b) of the *Charter*. Section 32 of the *Fatality Investigations Act* mandates that a fatality inquiry be open to the public subject to a judge's decision that access be restricted. The exercise of judicial discretion to close fatality inquiry proceedings is structured by the legislated considerations under section 32(a) and (b) and applicable open court principles.

The Issue of Notice to the Media

12 The AGNS' application to have certain video surveillance exempted from the webcasting of the Inquiry's proceedings raises the issue of whether there is a requirement for notice to be provided to the media. The notice entitlement arises where the media's section 2(b) *Charter* rights are engaged. *(Dagenais v. CBC, [1994] S.C.J. No. 104)* Judicial discretion that limits media freedom of expression must be exercised in accordance with the *Charter*, whether it is pursuant to common law (*Dagenais/Mentuck* style publication bans); statutory authority (e.g. section 486(1) of the *Criminal Code*); or rules of court. *(Vancouver Sun (Re), [2004] S.C.J. No. 41 at paragraph 31)*

13 Notice to the media serves to inform media outlets that their constitutional rights are in play and could be subject to restriction as a consequence of the exercise of judicial discretion. Informed media can then decide to seek standing to be heard before a judicial determination is made. Where freedom of expression rights are in the mix, standing should be given to media who wish to be heard on how the rights being implicated in the case should be balanced in the exercise of judicial discretion. *(Dagenais, supra, paragraph 58)*

14 Media notice is therefore directly connected to the entitlement to standing to defend the constitutional right to freedom of expression.

15 The media and the general public are benefitting from the live streaming of the Inquiry's proceedings. Both the media and the general public are no doubt interested, with good reason, in this enhanced access continuing. This interest is not a right. The application by the Attorney General of Nova Scotia relates to whether, in the context of an open court proceeding that is being live streamed to the internet, certain video surveillance evidence should not be webcast due to security and propriety concerns. As the media have no constitutional right to require the Inquiry to live stream its proceedings, there can be no entitlement to standing to address a live streaming issue. If there is no entitlement to standing there is no entitlement to notice. The issue of what webcasting should include is not a matter that engages the media's constitutional rights. Consequently I find that it is neither required nor appropriate to provide notice so that standing can be applied for.

16 Given what I have found about the live streaming not being mandated by any section 2(b) *Charter* guarantees, requiring notice would lead to an inconsistent and illogical result. Notice would lead to a standing application or applications with their only purpose being to assert a constitutional right in the webcasting of the Inquiry. I have already determined that the media enjoy no such constitutional right. The media's constitutional entitlements guarantee the right to attend the proceedings and report on them which they can do whether there is webcasting or not.

17 Yesterday, during brief oral submissions on this notice issue by counsel, I noted that the media will have notice of the Attorney General's impending application via the live streaming. Having applied greater clarity of analysis to this issue, I can say that this kind of incidental notice of what is happening in these proceedings is of a different character than the formal notice that would have to be given to the media if section 2(b) *Charter* rights were being weighed in the exercise of judicial discretion. That not being the case, I find that the Attorney General of Nova Scotia is not obliged to give formal notice to the media of his application and, for the reasons I have given, I will be considering the application without hearing from the media.

A.S. DERRICK PROV. CT. J.

cp/e/qlfxs/qljxr/qlaxw/qlced/qlaxw/qlhcs/qlcas

Case Name:
Hyde (Re)

Between
Re: An Inquiry Under the Fatality Investigations Act, S.N.S. 2001, c. 31 into the death of Howard Hyde

[2010] N.S.J. No. 109

2010 NSPC 21

Registry: Halifax

Nova Scotia Provincial Court

A.S. Derrick Prov. Ct. J.

February 10, 2010.

(15 paras.)

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Rory Rogers and Matthew Pierce, Counsel for Capital District Health Authority.

Thomas Donovan, Q.C. and Loretta Manning, Counsel for Dr. Janet MacIntyre.

Michael Wood, Q.C. and Jennifer Ross, Counsel for Dr. Stephen Curry.

Blair Mitchell and Marion Ferguson, Counsel for the Schizophrenia Society of Nova Scotia.

Carol Tooton, Executive Director of the Canadian Mental Health Association, and Simon Li and Mallory Treddenich, pro bono students at law, for the Canadian Mental Health Association.

DECISION ON MEDIA ACCESS TO EXPERTS' REPORTS

1 A.S. DERRICK PROV. CT. J.:-- The Canadian Press (CP) has requested a copy of the report of Dr. Christine Hall who testified at the Inquiry on February 1 and 2, 2010. Dr. Hall was qualified to give opinion evidence in excited delirium and sudden in-custody death. At the Inquiry she was examined and cross-examined on her opinions and the report she prepared for the Inquiry, dated June 25, 2009. That report was entered as Exhibit 247.

2 Since making its initial request for a copy of Dr. Hall's report, the Canadian Press has asked that it also be provided with a copy of the report of Dr. Joseph Noone who testified at the Inquiry on February 3. Dr. Noone was qualified to give opinion evidence in the realm of emergency and forensic psychiatry and the clinical aspects of violent behaviour. Dr. Noone's report dated May 31, 2009 has been entered as Exhibit 251.

3 The CP request for Dr. Hall's report was made informally to the Inquiry by a representative of the news organization. I did not require CP to provide a formal application supported by an Affidavit and asked only for an initial letter and then clarification on the issue of the use to which CP intended to put the reports. CP responded through Inquiry Counsel that it wanted the reports "for background only to explore excited delirium."

4 The original request for Dr. Hall's report, the further request for Dr. Noone's report and the indication from CP as to the use to made of the reports were communicated to counsel for the parties and Ms. Tooton representing the Canadian Mental Health Association. Counsel and Ms. Tooton were asked to indicate their clients' positions on the CP request and I received a response from everyone on the issue. I concluded it was not necessary to conduct an oral hearing on the issue and CP did not request one.

1) **5** The position of the parties to the CP request was unanimous. There was universal support, including from Inquiry Counsel, for the position set out by the Nova Scotia Government and General Employees' Union (NSGEU). The NSGEU submitted that these expert reports, and any others to be tendered as Exhibits at the Inquiry, should be made available by the Inquiry for viewing by the news media but should not be released for publication, in whole or in part, by the media. The NSGEU advanced three grounds for its position:The NSGEU noted that the Inquiry previously affirmed the importance of maintaining control of its exhibits. That control would be surrendered if experts' reports were released for possible publication.

2) The experts who appear at the Inquiry have expertise in certain, defined areas. They are subject to cross-examination on their qualifications following which they are qualified by the Inquiry to give opinion evidence in the defined areas of their expertise. In some cases, the NSGEU submitted, opinions have been offered that are outside the experts' area of expertise. The NSGEU noted that counsel are able to deal with these issues through cross-examination and submissions concerning the admissibility of some or all of the reports and the weight to be accorded to them. However, the NSGEU submitted, if experts' reports are released for publication, notwithstanding the Inquiry's determinations concerning weight or admissibility, the public would receive a distorted version of the evidence.

3) The NSGEU submitted that "release of expert reports for publication is not necessary to maintain the Inquiry's statutory and constitutional obligations to conduct an open hearing. The public and the media have full and unprecedented access to the Inquiry [through the live streaming of the proceedings on the internet.] The hearings are open to the media and representatives of the media should have the opportunity to view Inquiry exhibits, including expert reports." The NSGEU submitted that the requirement to conduct an open Inquiry "does not extend to

allowing the publication of documentary exhibits which may be qualified by other evidence or eventually found to be wholly or partially inadmissible."

6 I was also advised that the approach proposed by the NSGEU is consistent with the manner in which the Nunn Commission of Inquiry dealt with media access to its exhibits. In my decision *Re An Inquiry Under the Fatality Investigations Act, S.N.S. 2001, c. 31 into the death of Howard Hyde, (2009 NSPC 32),* I had noted another precedent on media access to exhibits: the Braidwood Inquiry in British Columbia operated an extensive website but did not post the exhibits tendered in its proceedings on the site. In the fatality inquiry into the deaths of Huu Dinh Pham and Adam Stanley Miller, the inquiry provided the media with access to the exhibits for the duration of the inquiry for the purpose of facilitating the reporting of the inquiry on the condition that no copies would be made of the documents and photographs provided. (*Pham (Re), [2004] A.J. No. 245 at paragraph 71*) The Pham fatality inquiry was not webcast.

7 On February 9 at the conclusion of the day's proceedings I advised counsel that I was denying the CP request for copies of the doctors' reports. I asked Inquiry Counsel to communicate the following to the CP representative who initiated the request: "I have decided that the Inquiry will provide access to CP to these reports at the hearing offices at a time convenient to the Inquiry. No copies will be provided and no photographs or dictation of the contents of the reports will be permitted. CP can review the reports on site at the Inquiry offices."

8 As I indicated to counsel at the Inquiry and asked CP to be advised, I am satisfied that my decision appropriately balances the principle of open proceedings, the constitutional rights of the media and the right of the Inquiry to control its exhibits. The following is an elaboration of these reasons.

9 I previously held in *Re An Inquiry Under the Fatality Investigations Act, S.N.S. 2001, c. 31 into the death of Howard Hyde, 2009 NSPC 32* that the media and general public are not entitled, pursuant to freedom of expression guarantees, to access court exhibits for unregulated and unlimited use. I acknowledged that section 2(b) guarantees do play a role in the determination of access to exhibits tendered into evidence in a court proceeding and noted that a court's jurisdiction over its own records is "anchored in the vital public policy favouring public access to the workings of the courts." *(CTV Television Inc. v. Ontario Superior Court of Justice, [2002] O.J. No. 1141 (Ont. C.A.))*

10 To be factored into the analysis of whether to grant access to an exhibit or not is the Inquiry's obligation to exercise "supervisory and protecting power over its own records." It has long been established that denying access will be appropriate where "the ends of justice would be subverted by disclosure or the judicial documents might be used for an improper purpose." *(Nova Scotia (Attorney General) v. McIntyre, [1982] 1 S.C.R. 175 at page 9)*

11 Although decided without reference to section 2(b) of the *Charter*, the Supreme Court of Canada decision in *Vickery v. Nova Scotia Supreme Court (Prothonotary), [1991] S.C.J. No. 23* is helpful in that it identified four significant factors to be assessed when deciding whether access to exhibits (including the ability to copy and disseminate) should be permitted: (1) the nature of the exhibits as part of the court record; (2) the right of the court to inquire into the use to be made of access, and to regulate it; (3) the fact that the exhibits, having been produced at trial and open to public scrutiny and discussion, means the open justice requirement has been met; and (4) the fact that different considerations may govern when the proceedings have concluded and the discussion is removed from the hearing context.

12 As I stated in my earlier decision, the majority in *Vickery* made some important observations:

- Exhibits are not the property of the court. Others will have a proprietary interest in them. "Once exhibits have served their purpose in the court process, the argument based on unfettered access as part of the open process lying at the heart of the administration of justice loses some of its preeminence." *(paragraphs 20-23)*
- The court is the custodian of the exhibit and "fully entitled" to regulate the use to which the exhibit is to be put by the access-seeker "by securing appropriate undertakings and assurances if those be advisable to protect competing interests ... the court must "protect [someone with a legitimate competing interest] and accommodate the public interest in access." *(paragraphs 24-25)*
- The open justice requirement is met by production at trial of an exhibit and its exposure to public scrutiny and discussion. Privacy rights may be surrendered during a court proceeding, but they are not "surrendered for all time." *(paragraphs 26-29)*
- Public access to and reporting of proceedings is a price to be paid in the interests of ensuring accountability of those engaged in the administration of justice. "The subsequent release of selected exhibits is fraught with risk of partiality, with a lack of fairness." *(paragraphs 30-31)*

13 The risks posed by the unfettered dissemination of documentary exhibits include, as identified by the NSGEU, risks of unfairness and the potential for misrepresentation of evidence occasioned by the Inquiry losing control over its exhibits. An expert's report does not reflect the nuances, elaborations or clarifications of the opinion evidence offered by the expert to the Inquiry as the expert, in the course of the Inquiry's proceedings, will have been examined and cross-examined on his or her report and the opinions contained in it. Furthermore, the experts prepared their reports before the Inquiry began to hear evidence and consequently were asked questions that drew content from the testimony that has been heard in the proceedings to this point. Relinquishing control over the report creates the potential that the report will be represented or treated as the complete expression of the expert's opinion when it is the expert's testimony in its entirety, including his or her answers to questions about the contents of the report and testimony provided by other witnesses that form the evidence the Inquiry will be considering. De-contextualization of the expert's opinion is therefore one of the risks that is limited by the Inquiry maintaining control over its exhibits.

14 It is also material that the experts' reports were prepared at the request of the Inquiry for the use of the Inquiry and to ensure counsel had notice of the opinions being expressed by the experts. No permission was obtained from the experts for the release of these reports to the media.

15 This Inquiry has benefitted from being webcast, extending its public and media access far beyond what is usual for court proceedings. Drs. Hall and Noone were examined extensively by counsel on their expert opinions and this evidence was available through the internet. The ability for the media and the public to follow the expert evidence has not been restricted to only reporters and citizens able to attend the proceedings in person. Especially given this unprecedented access to the Inquiry's hearings, the denial of the CP request for a copy of the experts' reports does not compromise the media's constitutional entitlements or the public nature of this Inquiry. The availability of the reports for viewing at the Inquiry's temporary offices supports the media's vital role in informing the public on the proceedings and strikes the appropriate balance between the need for the Inquiry to control its exhibits and protect the integrity of its proceedings, and the right of public access to the evidence being considered by the Inquiry.

cp/e/qlrxg/qlpwb/qlrxg

Case Name:
Hyde (Re)

Between
Re: An Inquiry Under the Fatality Investigations Act, S.N.S. 2001, c. 31 into the death of Howard Hyde

[2010] N.S.J. No. 110

2010 NSPC 22

Registry: Halifax

Nova Scotia Provincial Court

A.S. Derrick Prov. Ct. J.

February 15, 2010.

(23 paras.)

Counsel:

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Edward Gores, Q.C., and Dana MacKenzie, counsel for the Attorney General.

Kevin C. MacDonald, counsel for Joanna Blair and Dr. Hunter Blair.

David Roberts, counsel for the Nova Scotia Government and General Employees' Union.

Sandra MacPherson, Q.C. and Elizabeth Buckle, Counsel for the Halifax Regional Police.

Rory Rogers and Matthew Pierce, Counsel for Capital District Health Authority.

Thomas Donovan, Q.C. and Loretta Manning, Counsel for Dr. Janet MacIntyre.

Michael Wood, Q.C. and Jennifer Ross, Counsel for Dr. Stephen Curry.

Blair Mitchell and Marion Ferguson, Counsel for the Schizophrenia Society of Nova Scotia.

Carol Tooton, Executive Director of the Canadian Mental Health Association, and Simon Li and Mallory Treddenich, pro bono students at law, for the Canadian Mental Health Association.

DECISION ON THE ADMISSIBILITY OF DR. MICHAEL WEBSTER'S REPORT

1 A.S. DERRICK PROV. CT. J.:-- Dr. Michael Webster, a psychologist, was contacted by Inquiry Counsel in 2009 for the purpose of providing expert opinion evidence to this Inquiry. In accordance with the Rules of Procedure for the Inquiry, Dr. Webster produced a 13 page report dated May 3, 2009. In his report, Dr. Webster indicated that he had been asked for his opinion "regarding the death of [Howard Hyde.]" I do not have any information about whether Dr. Webster was provided with any greater specificity concerning the focus for his report.

2 It is my understanding that Dr. Webster was identified originally as someone with potentially helpful expertise for the Inquiry from his involvement with the Braidwood Inquiry in British Columbia. Dr. Webster gave a presentation at Phase I of the Braidwood Inquiry (*May 13, 2008*) and was examined and cross-examined at Phase II (*May 12 and 13, 2009*). These two phases of the Braidwood Inquiry were described as the "study" commission and the "hearing and study commission" respectively. The "study" commission of Braidwood was mandated "to report on the use of conducted energy weapons (Tasers) in British Columbia, and to make recommendations respecting their appropriate use." The "hearing and study" commission of Braidwood was "to provide the Dziekanski family and the public with a complete record of the circumstances of Robert Dziekanzski's death and to make recommendations the Commissioner considers necessary and appropriate."

3 At Phase II of the Braidwood Inquiry, after Dr. Webster was cross-examined on his qualifications, he was qualified by the Inquiry Commissioner to give expert opinion evidence on "the use of force from a crisis intervention perpective." *(Braidwood Hearings, Transcript of Dr. Michael Webster's Evidence, May 12, 2009*)

4 In addition to other educational qualifications, Dr. Webster has a doctorate in counselling/clinical psychology earned from the University of British Columbia in 1981. In his curriculum vitae, he describes his present position as: "Consulting Psychologist to Law Enforcement Agencies: Private Practice." He has worked as a psychologist for the Correctional Service of Canada, including on contract from 1989-1992 at the Regional Reception Centre Matsqui and as a psychological consultant with the RCMP and FBI. He has also provided training to various police agencies, including the Vancouver Police Department where his focus has been crisis intervention training. I am aware of Dr. Webster's work with the Vancouver Police Department from a previous witness who testified at this Inquiry, John McKay, a retired Superintendent with the Vancouver Police who was qualified as a use of force expert. Mr. McKay referred to the Vancouver Police Department's crisis intervention model and indicated Dr. Webster was the psychologist who assisted with the training. (*Hyde Inquiry Transcripts, pp. 7771-7772*)

5 In Dr. Webster's May 3 report for this Inquiry, he discussed a number of topics: the role of frame of reference in the human decision-making process; Conducted Energy Weapons -- various studies and reports concerning their use and the placement of CEW's on the use of force continuum; excited delirium; and the Halifax Regional Police Service (HRPS) training. Dr. Webster offered a number of opinions specifically relating to how Mr. Hyde was managed by police while in their custody.

6 In addition to his report of May 3, 2009, Dr. Webster subsequently produced a 2 page letter addressed to Acting Inquiry counsel and dated February 10, 2009. In it Dr. Webster indicated that he has "worked as a police psychologist for over 30 years; with a speciality in crisis management." He stated: "My practice has focused on, and continues to focus on, dealing with situations that involve the application of force .... I have spent over 30 years 'training police officers in the use of force.' Those unfamiliar with the dynamics of force tend to view the phenomenon from a physical perspective. I have trained police personnel in the use of the two most frequently used, and most successful force options ... presence and communication." I have been advised that Dr. Webster forwarded this letter in response to being provided by Acting Inquiry counsel with the correspondence from counsel for the Halifax Regional Police detailing HRPS' objections to the admissibility of his report. The report and the issue of Dr. Webster's evidence are the subject-matter of this decision, as I will explain in a moment.

7 All parties at this Inquiry have a copy of Dr. Webster's report and his letter of February 10. Although I only just saw the report on February 11, 2010, there has apparently been correspondence from certain counsel to Inquiry counsel in 2009 objecting to its contents. I

have now also reviewed the correspondence from Sandra MacPherson-Duncan, counsel for the Halifax Regional Police Service, to Inquiry counsel dated November 9 and 16, 2009.

8 Ms. MacPherson-Duncan indicated in her letter of November 9 that she would be objecting to "the qualifications and report of Dr. Mike Webster as he is neither an expert in use of force nor the psychology surrounding the use of force." She went on to say that Dr. Webster's report "does not deal with anything within his area of expertise" and that furthermore, "... his report expresses a biased political view which has no place in an expert's report."

9 Once it became known to me that the Halifax Regional Police were intending to oppose the admissibility of Dr. Webster's report, I convened a meeting on February 10 with all counsel to discuss how to address the issue. It was decided that the admissibility issue should be dealt with as soon as possible and not left to when Dr. Webster is scheduled to attend at the Inquiry on February 24. I was informed that the Nova Scotia Government and General Employees' Union (NSGEU) would be supporting the submissions of the HRPS on the inadmissibility of Dr. Webster's report. We scheduled February 16 as the date for the hearing of these submissions. All other parties have indicated they are not taking a position on the issue. In light of the fact that Acting Inquiry counsel has not been dealing with this issue until very recently, I have indicated I do not expect a submission from him. It is obvious from the fact of the original invitation to Dr. Webster to attend as a witness at the Inquiry, that Inquiry counsel regarded him as having something of value to offer.

10 I have now reached my own conclusions about Dr. Webster's potential contribution to this Inquiry. I have concluded that his report will not assist me. I think it would be difficult for him to qualify as an expert in respect of certain opinions he expressed. As I am not going to admit his report into evidence, I will not engage in an analysis of it for the purpose of addressing the objections raised in Ms. MacPherson-Duncan's letter of November 16, 2009. I will add that it is relevant to my decision on Dr. Webster's report that at the time it was prepared, the Inquiry had not heard a single witness. The Inquiry has now heard a considerable amount of evidence with the result that certain issues are in sharper focus.

11 However it is my view that Dr. Webster can likely be qualified to give opinion evidence on "the use of force from a crisis intervention perspective" -- the basis for his opinion evidence at Braidwood -- and as an expert in "the psychology of conflict" which is another area he referred to in the Braidwood Inquiry as an area of his expertise. In preparing to deal with the issue of Dr. Webster's report, I read his evidence at Braidwood (which is available on the Braidwood Inquiry website), having invited counsel to do the same. I found this useful in identifying areas that Dr. Webster appears qualified to speak about with some authority based on his education and experience. I have also found it useful to review the testimony of John McKay, who testified before this Inquiry on December 7 and 8, 2009. As I have noted, Mr. McKay, a recently retired senior police officer of the Vancouver Police Department, worked with Dr. Webster on training members of the VPD. Mr. McKay spoke in his evidence specifically about some of the areas that Dr. Webster has expertise in.

12 At this point I want to reference the statutory and procedural framework governing the receipt of evidence by this Inquiry. The *Fatality Investigations Act*, S.N.S. 2001, c. 31 provides in section 31(1) as follows:Subject to subsection (2), a judge may admit in evidence at a fatality inquiry

(a) any oral testimony; or

(b) any document or other thing,

that is relevant to the purposes of the fatality inquiry but shall refuse to admit

in evidence all or part of any oral testimony or any document or other thing if the judge is satisfied that the oral testimony, document or other thing or part of it is vexatious, unimportant or unnecessary for the purpose of the fatality inquiry.

13 The Rules of Procedure for the Inquiry provide in section 15 entitled "Evidence" as follows:

> (1) The Inquiry Judge may admit as evidence Affidavits, Statutory Declarations or other evidence made or taken under the laws of Canada that may be applicable in any case in which the Inquiry considers it fit and proper to have such evidence presented, and whether such evidence is sworn or unsworn. The Inquiry Judge may admit transcripts of related proceedings and statements of individuals whether or not such individuals are available for examination and cross-examination.
>
> (2) Without restricting the generality of subsection (1), the Inquiry may admit such written, oral or other evidence as the Inquiry may in its discretion deem relevant, whether or not the admission of such evidence is in accordance with the normal rules of evidence.

14 The legislation and the rules that apply to the conduct of this Inquiry therefore permit the receipt of Dr. Webster's opinions on issues within his expertise. As a psychologist who has assisted in the training of police in relation to use of force and crisis intervention he would appear to satisfy the requirement that an expert witness possess "special knowledge and experience going beyond that of the trier of fact." (*R. v. Marquard, [1993] 4 S.C.R. 223 at paragraph 35*)

15 The leading case on the admissibility of expert opinion evidence is *R. v. Mohan, [1994] 2 S.C.R. 9* which stipulated that such evidence will only be admitted where it is:

> (a) Relevant;
> (b) Necessary to assist the court;
> (c) Not subject to any exclusionary rule; and
> (d) Proffered by a properly qualified expert.

16 While I do not accept that the requirements of *Mohan* and related cases emerging from the criminal trial context should be applied reflexively to strictly limit the nature and scope of opinion evidence heard at a fatality inquiry, I believe it is important to apply a fairly rigorous standard to the admissibility of expert evidence before me. It is my view that the integrity of the Inquiry's work and the credibility of its findings and recommendations would not be served by too relaxed an approach to the evidence it considers. However I would not want to short-change the Inquiry by refusing to admit evidence that appears to be relevant and could be of assistance. From what I can deduce by reading Dr. Webster's testimony from Braidwood, I cannot see how his evidence would be "vexatious, unimportant or unnecessary", as prohibited by the *Fatality Investigations Act.* There is considerable reason to think that Dr. Webster's evidence, focused on issues that have been addressed at this Inquiry already, is likely to satisfy the *Mohan* standard.

17 I note that the HRPS has not taken the position that expert opinion evidence from a psychologist in relation to the issue of use of force is unnecessary in this case. Indeed, they have offered their own proposed expert to testify at the Inquiry, an issue that can be resolved under the Rules of Procedure if the HRPS decides to formalize a request to have another expert called to testify.

18 In respect of Dr. Webster's potential to assist the Inquiry, I have concluded that I should

set out the areas I am interested in hearing from him on. I note that even in the criminal context, a judge has considerable latitude in fashioning the approach to the expert evidence to be received: the *Abbey* decision from the Ontario Court of Appeal indicates that the "trial judge may admit part of the proffered testimony, modify the nature or scope of the proposed opinion, or edit the language used to frame that opinion." *(R. v. Abbey, [2009] O.J. No. 3534, paragraph 63*) This discretion is to be exercised, in the criminal trial process, in advance of determining admissibility. *(Abbey, paragraph 62*)

19 As I will indicate in somewhat better detail, I am not foreclosing examination by counsel for the parties of Dr. Webster's qualifications or his opinions, or submissions on the issues of admissibility or weight with respect to those opinions. Having spent the past weekend studying this issue, including carefully reviewing Ms. MacPherson-Duncan's written submissions of November 16, the evidence I have heard at the Inquiry from John McKay, Dr. Webster's evidence at Braidwood and my mandate, I have concluded it is not a fruitful use of the Inquiry's and counsel's time and resources to be entertaining submissions on the inadmissibility of Dr. Webster's report when it does not appear to me that it offers a focus on what is most relevant to this Inquiry. However it appears probable to me that Dr. Webster has expertise that should assist my understanding of certain issues I am considering.

20 To be clear, it is my intention to have Dr. Webster interviewed by Acting Inquiry Counsel in accordance with my direction as contained in this decision to ensure a focus on relevant topics and so that all parties have notice of what his evidence will address; that during the interview and his testimony before the Inquiry he will not be referred to nor will he be referring to his report; and that counsel will be permitted to examine him on his qualifications. I will consider any objections to his opinions -- which could go to admissibility or weight -- however may defer deciding these issues, should they arise, until I am ready to do so. This could result in my hearing evidence that is subject to an objection and later deciding whether to consider it or what weight to assign to it.

21 I am therefore directing Acting Inquiry Counsel to interview Dr. Webster on the following areas and to obtain a transcript or facilitate counsel getting a disk of the interview as quickly as possible:

* Dr. Webster to describe what is meant by a "frame of reference" in the context of the human decision-making process;
* Dr. Webster to discuss use of force as having a psychological aspect. He referred to this in Braidwood (*May 12, 2009, page 54*) where he said "... there's two parts of use of force. One part is the practical part, and those are the parts you've heard here when police people that have been designated as use-of-force experts come and talk to you about. There's another part and that's the psychological part, because we are dealing with human beings."
* Dr. Webster to describe the training he has assisted in providing to members of the Vancouver Police Department on crisis intervention and the techniques used for crisis intervention; what does he teach and how does he teach it? What is the first rule of crisis intervention? What is his opinion about how extensive crisis intervention training should be in a police force and why does he hold that opinion? What should crisis intervention training for police consist of?
* Dr. Webster to provide his comments on the psychological aspects of police/citizen interaction: Dr. Webster discussed this in Braidwood (*May 12, 2009 at page 70*) where he stated: "... the genesis of human behaviour is interactional. It is not dispositional

... If [a citizen] has the power to influence the police, then the police have the power to influence [the citizen's] behaviour as well. Actually, human behaviour is determined interactionally."

* Dr. Webster to discuss "presence and communication" and what this means in use of force.
* Dr. Webster to discuss the psychological processes that are operating (or not operating as the case may be) when a person is in a state of hyper-arousal. I note that Dr. Webster spoke about this at Braidwood *(May 12, 2009 at pp. 66-67*) What are the objectives of crisis intervention where a person is in this state?
* Dr. Webster to describe the continuum that leads from an emotional crisis to a behavioural crisis; the des-escalation of a person emotionally; the role of crisis intervention techniques in de-escalating an emotional crisis. I note that John McKay, in response to questions from counsel for the HRPS, made reference to Dr. Webster's work in this area. *(John McKay, Transcript of Evidence, p. 8050*)
* Dr. Webster to discuss what he observed from the video evidence about Mr. Hyde being in an emotional crisis and what could have been done, if anything, in those circumstances to have prevented a behavioural crisis from happening, both at HRPS Booking and the Central Nova Scotia Correctional Facility. I note that John McKay offered an opinion on this issue in his evidence. *(John McKay, Transcript of Evidence, p. 8051*)
* Dr. Webster's opinion on use of force models and his criticism of them.

I note he gave evidence concerning this at the Braidwood Inquiry. *(May 13, 2009, page 37*) John McKay stated in his evidence that "use of force models can seemingly place the topic of subject resistance and officer response in a rather simplistic fashion." *(John McKay, Transcript of Evidence, p. 7792*) I am interested in knowing what a psychologist who trains police officers has to say about this.

22 I recognize that, notwithstanding my decision not to receive in evidence Dr. Webster's report, the HRPS and the NSGEU may still wish to challenge Dr. Webster's qualifications for giving some or any opinion evidence in the areas I have outlined. I have concluded however that I would be unable to make any further determinations in relation to Dr. Webster's evidence without having him available to be examined and cross-examined. The furthest I feel able to go in resolving the issue of Dr. Webster's contribution to this Inquiry is what I have decided: that his report should not be admitted and that he should be focused on specific issues that are relevant to the Inquiry in my opinion.

23 There is a further issue I have not discussed that I was made aware of in the correspondence of Ms. MacPherson-Duncan acting for the Halifax Regional Police Service and at the meeting of counsel I held on February 10. That is the allegation by the HRPS that Dr. Webster's report expresses bias. Obviously by not receiving his report in evidence, I will not be considering any opinions expressed therein, which include opinions that have been characterized as biased. I do not know if the HRPS will still want to argue that, because of bias, Dr. Webster's evidence should not be heard even in the areas I have mapped out. I have decided that this is an issue most appropriately dealt with, if at all, in the context of Dr. Webster's testimony and can likely only be properly considered by me once Dr. Webster has testified and I have had the benefit of hearing all of his evidence. What I do know at this

point is that, although Dr. Webster expressed strong opinions at the Braidwood Inquiry and was vigorously cross-examined by counsel for the police officers at the Inquiry, his evidence was not ruled inadmissible on the basis of any bias or any other ground that I am aware of. Furthermore I have evidence before me that Dr. Webster is used as a training resource by the Vancouver Police Department and has worked with police services and police officers for over thirty years. This does not suggest to me that I should be reticent about hearing from him. To the contrary: the fact that Dr. Webster was accepted as an expert at Braidwood, has trained and worked with police officers for many years and provides training to police that was referred to approvingly by an expert in use of force at this Inquiry indicates to me that I should hear from him. As I have said already, his qualifications and evidence will be subjected to the same scrutiny as other witnesses appearing as experts at this Inquiry. I have confidence that if his opinions are tainted with a bias that would make them unsafe or inappropriate to consider this will be evident to me and identified by counsel.

cp/e/qlrxg/qlpwb/qlrxg

Case Name:
Hyde (Re)

Between
Re: An Inquiry Under the Fatality Investigations Act, S.N.S. 2001, c. 31 into the death of Howard Hyde

[2010] N.S.J. No. 111

2010 NSPC 23

Registry: Halifax

Nova Scotia Provincial Court

A.S. Derrick Prov. Ct. J.

Heard: February 24, 2010.
Judgment: February 24, 2010.

(12 paras.)

Counsel:

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Edward Gores, Q.C., and Dana MacKenzie, counsel for the Attorney General.

Kevin C. MacDonald, counsel for Joanna Blair and Dr. Hunter Blair.

David Roberts, counsel for the Nova Scotia Government and General Employees' Union.

Sandra MacPherson, Q.C. and Elizabeth Buckle, Counsel for the Halifax Regional Police.

Rory Rogers and Matt Pierce, Counsel for Capital District Health Authority.

Thomas Donovan, Q.C. and Loretta Manning, Counsel for Dr. Janet MacIntyre.

Michael Wood, Q.C. and Jennifer Ross, Counsel for Dr. Stephen Curry.

Blair Mitchell and Marion Ferguson, Counsel for the Schizophrenia Society of Nova Scotia.

Carol Tooton, Executive Director of the Canadian Mental Health Association, and Simon Li and Mallory Treddenich, pro bono students at law, for the Canadian Mental Health Association.

DECISION ON THE ADMISSIBILITY OF DR. MICHAEL WEBSTER'S OPINION EVIDENCE

1 **A.S. DERRICK PROV. CT. J.**:-- On February 15, 2010 I made a decision not to receive into evidence a report written by Dr. Webster and instructed Acting Inquiry Counsel to interview Dr. Webster on certain identified areas. Counsel have been provided with a copy of the transcript for that interview which was conducted on February 18, 2010. To be fully understood, the decision I am rendering this afternoon needs to be read with the decision I made on February 15.

2 In my decision of February 15 I identified the need to have Dr. Webster on attend at the Inquiry before I could further consider the issue of his qualifications, the admissibility of his opinion evidence and any allegations of bias. When Dr. Webster took the witness stand this morning, Acting Inquiry Counsel indicated that he was being put forward as an expert witness

qualified to give opinion evidence in "crisis intervention from a use of force perspective" and "the psychology of conflict." The Halifax Regional Police Service (HRPS) has objected to Dr. Webster being qualified to give opinion evidence as described. HRPS submit that Dr. Webster could be qualified to give opinion evidence on "crisis intervention" although not on its practical application in use of force situations, and accept that he could also be qualified to testify as an expert in "the psychology of conflict."

3 Submissions have been made by Acting Inquiry Counsel, the Attorney General, the NSGEU, the Blairs and the Schizophrenia Society of Nova Scotia cautioning me not to circumscribe Dr. Webster's ability to provide useful evidence to this Inquiry. Time prevents me from setting out in this decision the arguments of HRPS and those of other parties on the issue of the admissibility of opinion evidence from Dr. Webster.

4 I will try to briefly summarize what I understand to be the issues that HRPS have advanced as underpinning its objection to Dr. Webster being qualified as an expert witness. These are issues that were the focus of an extensive cross-examination of Dr. Webster. HRPS submits that Dr. Webster is not qualified to speak about the operational use of force, in other words, the practical application of the psychology involved in crisis intervention. In the submission of HRPS, Dr. Webster is qualified only to speak about the training he has done with police officers and courses he has taught in crisis intervention. HRPS points to Dr. Webster's *curriculum vitae* as disclosing a concentration of professional consultancy work in the national security and drug interdiction contexts but not in the field of crisis intervention. HRPS argues that Dr. Webster does not have the practical application of use of force expertise that would entitle him to talk about crisis intervention in the context of unplanned, spontaneous use of force situations.

5 HRPS has also made a challenge to Dr. Webster's objectivity, citing various letters he wrote following the Braidwood Inquiry in which he was highly critical of RCMP management in particular. In a couple of these letters Dr. Webster referred to "corruption in policing" and the loss of "confidence and trust in Canadian policing" without specifically indicating that his comments were directed at the RCMP and their role in the Dziekanski incident at the Vancouver Airport. When asked about this in cross-examination here, Dr. Webster testified that he was referring to a crisis of confidence in policing in British Columbia and that he was not casting any aspersions on the Halifax Regional Police.

6 I have listened carefully to Dr. Webster's testimony this morning and read the interview he did with Acting Inquiry Counsel. I have also read his evidence from the Braidwood Inquiry in 2008 and 2009 and the materials produced in cross-examination by counsel for Halifax Regional Police Service. I am not persuaded at all that Dr. Webster comes before this Inquiry with a bias against police. I do note that he obviously has strong opinions about the death of Robert Dziekanski and the involvement of the RCMP in that incident and the Inquiry examining it. There is nothing in the Inquiry that I am conducting that touches upon the RCMP. There is nothing before me that indicates Dr. Webster has an axe to grind against the Halifax Regional Police or police forces in general or that he is seeking to exploit the opportunity of testifying here to advance a private agenda or secure a personal financial benefit. It was put to Dr. Webster on cross-examination by HRPS that he stands to benefit from recommendations on crisis intervention from this Inquiry, should any be made, because John McKay, who testified as a use-of-force expert before this Inquiry, is planning to collaborate with Dr. Webster on a course entitled "Crisis Intervention and the Use of Force -- Defusing the mentally ill" through a consultancy and training business Mr. McKay has started. I reject this suggestion and do not find that Dr. Webster is before me to promote crisis intervention for his personal financial gain.

7 On the bias issue I will repeat what I said in my February 15 decision: Dr. Webster's evidence will be subjected to the same scrutiny as other witnesses appearing as experts before

this Inquiry and I am confident that if his opinions are tainted with a bias that would make them unsafe or inappropriate to consider this will be evident to me and identified by counsel. There is nothing that causes me to conclude that Dr. Webster should be precluded from testifying before this Inquiry on the grounds of bias.

8 Dr. Webster has a long career as a psychologist who has been consulted by police forces over a range of issues including crisis intervention in the context of police use of force. John McKay testified that in 2000 he was the sergeant in charge of the training section at the Vancouver Police Department and in that role, began to look at training for front-line police officers dealing with persons with mental illness. Mr. McKay told this Inquiry that the impetus for the development of the training was the fact that there had been a number of high-profile shootings involving persons with mental illness. He said in his evidence that he "began to look at some type of training that we could use to develop our officers and prevent those kinds of things from happening." He found a programme in Albuquerque, New Mexico and a Vancouver police officer who had attended it. The course was developed and Dr. Webster was brought into the programme as the psychologist. The first programme for Vancouver police officers was offered in 2001 and continues to run. John McKay obviously still considers Dr. Webster to have expertise in crisis intervention in the context of use of force judging from the course he is offering to co-teach with him that I mentioned earlier.

9 I note from the material provided by HRPS that John McKay describes the course on "Crisis Intervention and Use of Force -- Defusing the mentally ill" in a section on his website entitled "Psychology and Use of Force." The description in that section of the real-life scenario that could be confronted is of a spontaneous, unplanned event. The text goes on to indicate that Dr. Webster will teach the psychological skills needed before and after the incident and John McKay will instruct in the legal aspects, tactics, and techniques "that will create an ability to survive and excel."

10 It is apparent to me that Dr. Webster understands the limits of his expertise in a use of force context. In his interview with Acting Inquiry Counsel at page 24 he states that dealing with a person in a behavioural emergency requires the practical application of use of force which he notes he is not "well-versed" in. I am not concerned that Dr. Webster will step over the boundaries of his knowledge and experience but I do not see how he can usefully discuss what he knows and has instructed on, in a vacuum. It is crisis intervention in the context of use of force that I am interested in understanding. Dr. Webster's expertise lies in training police officers in the psychological aspects of conflict and use of force and the role, psychology, and techniques of crisis intervention in that context.

11 I will say that perhaps it is preferable to frame the basis for Dr. Webster's opinion slightly differently from the way it was set out in the Braidwood Inquiry. As I indicated in my February 15 decision, I used Braidwood as my starting point for Dr. Webster. It may be a distinction without much of a difference but describing Dr. Webster as being qualified to give opinion evidence on "crisis intervention in the context of use of force" may give a clearer picture of what he is being asked to address. I do not expect this to satisfy HRPS's objections because it still connects crisis intervention and use of force but it is a more coherent topic for me to understand.

12 It will be apparent by now from these reasons that I am satisfied Dr. Webster is qualified to give opinion evidence in crisis intervention in the context of use of force and the psychology of conflict. I am satisfied his evidence will be reliable and relevant. I am not concerned that the dangers identified by the Ontario Court of Appeal in *R. v. Abbey, [2009] O.J. No. 3534* are an issue here. I will be able to make "an effective and critical assessment of the evidence" of Dr. Webster and I will not be abdicating my judgment on the issues in this Inquiry to any of the experts who have testified before me.

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