No. S132325
Vancouver Registry

IN THE SUPREME COURT OF BRITISH COLUMBIA
(BEFORE THE HONOURABLE MR. JUSTICE VOITH and JURY)

Vancouver, BC
September 9, 2019

BETWEEN:

HIROKO D. CRAWFORD also known as DONNA CRAWFORD

Plaintiff

AND:

PROVIDENCE HEALTH CARE, DR. ANNA NAZIF

Defendants

AND:

NICHOLAS OSUTEYE, PROVIDENCE HEALTH CARE, DR. ANNA NAZIF

Third Parties

PROCEEDINGS AT TRIAL
(Day 5)

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Counsel for the Plaintiff: S. Kovacs
J.T. Mackoff

Counsel for the Defendant Anna Nazif: J. D. Meadows
D. J. Reid
A. Catalino, A/S

PROCEEDINGS AT TRIAL
SEPTEMBER 9, 2019
(DAY 5)

PROCEEDINGS

EXHIBITS

September 9, 2019
Vancouver, BC

(Day 5)

(PROCEEDINGS COMMENCED AT 9:54 A.M.)

THE CLERK: In the Supreme Court of British Columbia at Vancouver on this 9th day of September, 2019, calling the matter of Crawford versus St. Paul's Hospital, My Lord.
MS. KOVACS: My Lord, a couple of housekeeping matters. I have an updated trial schedule, and I have a further amended trial record. We should have everything that you need.
THE COURT: Thank you.
MS. KOVACS: To give you a preview of today, it is going to be a busy day. We have a number of fact witnesses, all whom are reasonably short, so we put all five today. We'll see how it goes. There's one that can go tomorrow if necessary.
One of the -- with respect to the pleadings issue and the plea of negligence, I've said to my friends I've calmed down about that issue over the weekend. I'm not concerned. The particulars are there. They are pleadings. They were obviously served before Mr. Osuteye was released as a defendant in these proceedings and the third party notice, the amended one, could be a little bit clearer, but I'm not concerned if it was assault or negligence that they're seeking apportionment on. I think we can deal with that when it comes to the instruction in the charge.
THE COURT: Let me just ask Mr. Meadows a little bit about that then if I can. So is it the position of the defendants, will they seek to establish that Mr. Osuteye was negligent partly with respect to not disclosing failure to take medication -- partly not taking his medication?
MR. REID: Yes, My Lord. So it will be both. It will be the battery or assault on Ms. Crawford as well as, separate from that negligence, informed failure to take medication and failure to properly advise physicians. Those particulars are set out in response to particulars, and I do have case on that point, My Lord. Particulars are pleadings so --

THE COURT: I know that.
MR. REID: Yeah.
THE COURT: But thank you for that. I'm not finished. So when we talk about the duty issue, you're going to argue that for a day, the burden will be on you to establish a duty on the part of Mr. Osuteye. You'll be arguing that, will you?
MR. REID: Yes, My Lord.
THE COURT: So that will be part of what we're dealing with. I'll have to establish a duty of care or find whether there was a duty of care; yes?
MR. REID: Yes, My Lord.
THE COURT: As then, as it pertains to the standard of care, I've not seen the expert reports. Are there reports that deal with Mr. Osuteye's standard of care?
MR. REID: There's not, My Lord.
THE COURT: So I didn't expect that because I think if there had been, your friend would have -- when I say understood the issue better, I don't mean that critically, but the profile of that issue would have been raised. In the absence of expert evidence, how do you propose to deal with this issue? I'm aware that you don't need expert evidence to establish that as a standard, so I'm not raising that as a legal question as such, but you measure a standard of care with reference to the subset of individuals; right? So GPs, specialists, they're all measured as against each other and what is an appropriate standard of care. With a child, you measure the standard of care for a child. For an ill person, I don't know how we're going to do that.
MR. REID: Well, My Lord, that's something we anticipate making submissions on. The starting legal presumption is that all individuals have capacity to make decisions on their own behalf. For example, someone with schizophrenia is capable of signing a contract, and it's not inherently assumed that that contract is void because the person lacks mental capacity.
THE COURT: Right.
MR. REID: So it would be on the evidence before this court whether or not Mr. Osuteye had the capacity or had the ability to meet the standard of an ordinary person with schizophrenia.
THE COURT: Right.

MR. REID: The mere fact that he has a mental illness, it will be our submission, does not mean that he is presumptively incapable.
THE COURT: I'm telling you I'm going to want some cases, because I don't think this is a capacity issue. I think he may or may not be able to sign a contract; I don't know that. But it appears that a component of his illness extends to his medication. So he has said that he thought he was paranoid and he didn't take medications because, "Aha, I thought this was a means by which I could be controlled." The reason as I understand it -- and, again, this isn't evidence yet, but I expect your friend will now start to elicit this from experts -- the reason you inject the schizophrenics as opposed to having them take their medication orally is because of an anxiety with that subset of patients that they don't take their medication. So these are not -- the reason you give them medication that dissolves instantly is because of a concern that they will spit it out; right?
So this is partly a question of capacity but it goes in part to the nature of the illness. And what I'm saying to you is it would be helpful to me if you start to assemble cases that deal with illnesses that impact on a person's ability to address certain issues in the same way.
So he is a thoroughly unwell man; there's no issue about that. And the question will be whether that unwellness extends to these issues. The reason he lied on an ongoing basis is he minimized his illness: "I have mild schizophrenia, I have anxiety." These are symptoms of the illness; right? People don't accept it. And I'm not speaking as an expert. All of that -- whatever happens will be based on this record. But, ultimately, I will have to be satisfied that this issue should go to the jury; that's for me to decide. So I need some comfort from you that there's a real issue, because there's some question in my mind about whether it is a real issue, whether it's an issue that should go to a jury. Whether we have an individual who's as thoroughly unwell as this man was for such an extended period of time who thinks he's JP Morgan; who thinks he's Christ;

who thinks he's Jewish; who thinks all these things, as it relates to the question of medication and minimizing or not being forthright about his taking medication, are rolled into or a subset of his illness, manifestations of that illness. So that's just something we have to talk about.
MR. REID: And, My Lord, we will look for cases on that. There's some analogous ones, certainly people who have medical conditions with relation to driving who then injure people, and we will prepare -- be prepared to have cases on those points.
THE COURT: And sooner rather than later. That's not tomorrow, but sooner rather than later. And so, too, Mr. Meadows was telling me, we were talking about intention, the ability of Mr. Osuteye to form the intention to commit the assault, the only cases I've read thus far are those that your friend provided to me in connection with disclosure application, so that's what I've read, and they are cases from the 80s. I have no doubt that they'll be developed more fully. And if you're able to provide me with some further cases that expand on the test that was developed, in the authorities that I was provided with, that, too, would be helpful, so that I could wrap my head around that, too.
MR. REID: Yes, My Lord.
THE COURT: Okay.
MS. KOVACS: My Lord, just before we bring in the jury, one more issue in terms of scheduling. We have Dr. Gillespie coming over from the island -- he's a Victoria psychiatrist, he's our expert for the plaintiff -- tonight. And I had originally scheduled him for tomorrow, but one of his response reports responds to two experts, expert reports from the defence that I'm actually objecting to, and I think we need to schedule time to actually speak to that before I call him. So I managed to move him to Wednesday, but he can't stay any longer than Wednesday.
So what I propose to do in the calendar, and I sent this to my friends on the weekend, we have Carla Soregaroli, who is one of the eyewitnesses tomorrow morning, that we couldn't move to today because she's disabled, and there's been some

issues in terms of getting her here.
THE COURT: Her name was what, I'm sorry?
MS. KOVACS: Carla Soregaroli. She'll be first off tomorrow morning. I expect she'll be half an hour. And then my thought was maybe we could do some read-ins because I have quite a few read-ins, probably a half day's worth. There were two lengthy examinations for discovery of Dr. Nazif, and there's a lot. But my thought maybe tomorrow afternoon we could argue the issue of expert report admissibility, and then that gives you some time to then make your decision, and then we could, on Wednesday, have Dr. Gillespie here for the whole day.
THE COURT: So I understand Dr. Gillespie has prepared a report, but you're seeking to ascertain whether it's necessary because you have objections to reports. If I upheld the concerns that you have, there would be no need for the reply reports? Is that the theme here?
MS. KOVACS: Exactly.
THE COURT: And you've disclosed to your friend what those particular concerns are? You understand that?
MS. KOVACS: Yes.
THE COURT: In a similar vein, have you provided your friend with a list of your read-ins yet?
MS. KOVACS: I have not. I've been working on that on the weekend. I hope to finish that tonight, and I'll certainly give him a list. I mean, they are quite extensive.
THE COURT: That's okay. I'm sure it will be helpful to Mr. Meadows so that he can have his objections ready as opposed to be reading with you.
MS. KOVACS: And I've actually been cautious to make sure that context is included; I'm not simply grabbing sound bites.
THE COURT: I have no doubt.
MS. KOVACS: Yes. One of the issues with the discovery transcripts, though, frankly, there are such extensive read-ins, I wonder if it would be appropriate, as opposed to an impeachment of the transcript, to have blacked-out transcripts with the read-ins for the jury. And I'm in your hands on that, My Lord, as to whether or not you think that's necessary. But because it is so much and so long, I wonder if it would be helpful for the

jury to have the read-ins in paper form with what's not being read in blacked out.
THE COURT: Are you suggesting that much of the transcript will be read in?
MS. KOVACS: A good chunk of it.
THE COURT: Mr. Meadows, have you turned your mind to this issue?
MR. MEADOWS: No, I had no idea that my friend intended to read in so much of the transcript.
THE COURT: Why don't we do this? Why don't the two of you have that conversation first before I resume so Mr. Meadows can wrap his head around this, and then we'll figure out how to move forward. It strikes me that if you have that much volume, and these are just options for you -- I'm not ruling at all; they're just things to think about -- the suggestion of blacking out, you may have some reservations about that certainly until context and all these things are resolved. But absent that, it may be that the parts you have read are sort of excised in some way and provided to the jury, because if they're material it will be hard for the jury to retain those things some weeks from now when they have to rule. So, you know, we'll just have to see what you think is the best means of moving forward with that. I'll let you speak first, I'll hear from each of you, and then we'll figure out how to move forward.
MS. KOVACS: And if my friend needs more time than what I can give him overnight, given they are so extensive, then I can push the read-ins to Thursday or something. But we'll sort it out.
THE COURT: We should have -- we should talk about that by the end of the day, today or tomorrow, only so I can tell the jury what they can expect for their own purposes tomorrow because we'll either be letting them go in the morning or by the noon hour, so they can plan their day, something like that.
Okay. Can we get the jury in now.
THE SHERIFF: The jury, My Lord.

(JURY IN)

MS. KOVACS: My Lord, the plaintiff calls her next witness, which is Kevin Hawken. And I'm just

going to step outside to get my friend, or my colleague, Ms. Mackoff, who will be asking questions.
THE COURT: Yes.

KEVIN HAWKEN, a witness called for the plaintiff, affirmed.

EXAMINATION IN CHIEF BY MS. MACKOFF:
Q Mr. Hawken, you're currently the manager of emergency shelter at the Salvation Army Vancouver Harbour Light?
A That's correct.
Q How long have you held this position?
A Since 2011.
Q Could you please explain what Harbour Light is?
A Harbour Light is a Salvation Army ministry unit that offers a variety of services including shelters.
Q And Harbour Light has a number of shelters in Vancouver's Downtown Eastside?
A Yes. We operate five year-round shelters and seasonal shelter.
Q One of those shelters is called the Beacon shelter; correct?
A That is correct.
Q Where is the Beacon shelter located?
A It's located at 138 East Cordova.
Q That's on East Cordova between Columbia Street and Main Street?
A That is correct.
MS. MACKOFF: Madam Registrar, if we could have Exhibit A.
Q Mr. Hawken, I'll ask that you turn to tab 30 of this binder. And this is a map taken from Google Map?
A Okay.
Q Is the location of the Beacon shelter on this map?
A Yes, that looks correct.
Q And so that's 138 East Cordova is where that red mark is that says the Salvation Army Harbour Light?
A That is correct.
MS. MACKOFF: My Lord, I'll ask that tab 30 be marked

as the next exhibit.
THE COURT: Mr. Meadows?
MR. MEADOWS: No objection, My Lord.
THE COURT: I think we're at Exhibit 27, Madame Clerk.
THE CLERK: Exhibit 27, My Lord.

EXHIBIT 27: Common Book of Documents, tab 30: 1 page, Google map, depicting a route from The Salvation Army Harbour Light to St. Pauls Hospital, colour copy

MS. MACKOFF:
Q Mr. Hawken, if you can turn to tab 31, please, and this is another map just taken from Google Map. Is the location of the shelter on this map as well?
A Yes, it is.
Q And that's the correct location; the Salvation Army Harbour Light is where the shelter is?
A 138 East Cordova.
MS. MACKOFF: And I'll ask this tab 31 be marked the next exhibit.
MR. MEADOWS: No objection.
THE COURT: Exhibit 28.
THE CLERK: Exhibit 28, My Lord.

EXHIBIT 28: Common Book of Documents, tab 31: 1 page, Google map, depicting a route from The Salvation Army Harbour Light to 700 Pacific Boulevard, colour copy

MS. MACKOFF:
Q Now, Mr. Hawken, the Beacon shelter is a 24-hour shelter?
A That is correct.
Q What does that mean?
A It means it's open 24 hours a day and offers a variety of services with the end goal of helping people move from homelessness to housing. So we have outreach workers and caseworkers. Caseworkers help the individuals set goals to get housing.
Q And are there staff members present around the clock at the shelter?
A Yes. There are shelter workers working three shifts 24 hours a day.
Q Does the Beacon shelter have a curfew for its

guests?
A It does, it's 10:30 P.M.
Q Was that the same curfew back in December of 2012?
A Yes, it was.
Q Why does Beacon shelter have a curfew?
A Well, for safety purposes. But it's a communal living, so we have a diversity of individuals staying with us. We have about 25 percent seniors, working individuals, new Canadians, refugees, and hospital referrals. So we want everybody to get a good sleep. Our overnight shelters have -- do admissions until 2:00 A.M., so that's a later curfew.
Q What happens if someone misses curfew at the Beacon shelter?
A Generally speaking, we would pack up their personal belongings. The majority of time when individuals don't come back, they don't come back at all. So -- and we operate pretty close to 100 percent occupancy, so there's people waiting to get in. We do have two other 24-hour shelters, and they would be able to gain admission to those shelters.
Q I understand Harbour Light has a written policy with regard to client medications at shelters?
A That is correct.
Q Can you describe that policy for me?
A We support individuals in self-administering. So we're a homeless shelter, not a health care facility.
Q Based on that policy, is Harbour Light responsible for administering clients' medication?
A No.
Q So --
THE COURT: Hold on a second. I want to see the answer.
Will you develop what that means, that is, when you support people with self-administration.
MS. MACKOFF: Yes.
THE COURT: Yes, thank you.
MS. MACKOFF:
Q Mr. Hawken, where is medication stored when individuals bring medication with them?
A It is stored in the shelter office in a locked cabinet.

Q Are clients permitted to keep medication on themselves as well?
A The majority do.
Q What is the shelter staff's role in enforcement of medication regimen?
A We don't play a role in the enforcement of -- shelter clients aren't held captive so it would be -- even if we did medication management or dispense meds, it would be impossible for us to make sure that they did throughout the day.
In serious or significant health issues, either the pharmacy or a representative from Vancouver Coastal Health would take on that role.
Q What is the shelter's practice if staff members become aware that a client has not been taking their medication?
A We would report that to -- internally to outreach and casework staff and also let the Vancouver Coastal Health team be aware of that.
Q You were with the Salvation Army in December of 2012?
A Yes, I was.
Q Did you ever meet Mr. Osuteye?
A I did not.
Q Do you have any recollection of seeing him at the shelter?
A I do not.
Q I'll ask that you turn to tab 11. Page 2 of that tab at the top, it says "Client Care Notes"?
A Yes.
Q What are client care notes?
A Well, this list itself is sort of a -- it's called a "Client Case History" and records interactions with staff and the client. Client care notes -- we run client care meetings weekly on Wednesdays at 2:00 P.M., and it's an opportunity for staff to discuss clients in our care.
Q And so this record pertains to the client Nicholas Osuteye?
A That is correct.
Q And at the top there it says "Case Plan Social," I'm assuming "Assistance"?
A Yes.
Q "Housing, schooling"?
A Yes, that's correct. So connecting somebody with income with the end goal of housing and

indicating that Nicholas had wanted to continue with his education.
Q And November 5th, 2012, "Outreach intake"?
A Yes.
Q What is this entry?
A Clients are admitted, and we connect them, as soon as possible, with our outreach workers to do an initial assessment. What we're looking for is underlying issues that got them to homelessness. Typically that would be ID, income, and health.
Q And the last line there under the November 5 entry says:

Nicholas was referred to the nurse's clinic today by Outreach.

What is the nurse's clinic.
A At that time, there was -- Vancouver Coastal Health had a team called the Primary Outreach Team, and they were operating nurse's clinics with us on Tuesdays and Thursdays at 10:00 A.M. Yes, that was the nurse's clinic. And it operated in our Anchor of Hope, which is a community centre by day and a shelter by night, and it's adjacent to our Crosswalk and Beacon shelters.
Q And there's some references to a caseworker in here saying:

Caseworker left note on bed to contact caseworker.

Who are caseworkers?
A Caseworkers are the next step in our assisting someone moving towards housing and they help the individual develop goal-setting to get towards independent living.
Q And are caseworkers part of the Beacon shelter staff?
A They're part of the Harbour Light shelter department staff.
Q Jumping down to November 27th, 2012 -- there's two entries for November 27, 2012 -- the second one says:

Nicholas was in the nurse's clinic today. They are concerned that Nicholas is not

taking his meds.

How would this information have been communicated to a caseworker?
A It would have been included in the client care meeting and then subsequent to that the client care meeting minutes, which are shared with shelter staff.
Q December 5th, 2012, right below that:

Nicholas spoke to evening staff wanting to go to hospital. Staff offered to call Safe Ride.

What is Safe Ride?
A Safe Ride I believe was operated by the Recovery Club and offered -- they offered transportation to the hospital for homeless individuals.
Q Then it says:

Nicholas said that he would go to police station and ask them to take him. Nicholas was a no-show at curfew.

Where is the police station nearest to the shelter?
A At that time, it was on Main and approximately Cordova, so half a block away.
Q Okay. The next entry is December 6, 2012. It says:

At 12:40 A.M. today, the VPD came and said that Nicholas was in the hospital and asked if his belongings could be held indefinitely.

What would that entail, holding an individual's belongings indefinitely?
A Anytime somebody is taken to the hospital, we'll hold their belongings until they return or until we get direction from the hospital.
Q And then it says:

Nicholas returned from hospital later in the day with medication saying that he had come from the hospital and was discharged. Staff booked him in later that night.

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What is your own recollection or understanding of the events that happened on December 5th and December 6th?
A Well, what I can refer to is just the notes that are given specifically.
Q When would you have learned -- or would you have learned about these events? Would someone have told you about them?
A I would have been aware that he -- yeah, I would have been aware of those things. They would have been emailed to shelter management, casework, outreach, that kind of thing.
Q And then December 7th, 2012:

> Nicholas was arrested today for suspected assault of a senior woman.

Do you remember learning about this?
A I believe I learned about it the morning of, and I wasn't aware that it was Nicholas but the loading dock supervisor -- which the loading dock's located next to the alley -- reported that there was an incident.
Q If you could turn to the next page, page 3, at the top it says "New Client Assessment Outreach." What is this document?
A This is reporting from the outreach worker, again, the initial assessment to identify issues like ID, income, and health.
Q And near the top it says "Date of arrival 02/11/12," so that would have been November 2nd, 2012?
A That is correct.
THE COURT: So when you say "issues like ID," are you just talking about identification, who is this person?
THE WITNESS: Well, in order to get income you need ID, and so many of the individuals that come into our shelters don't have any ID, so they can't get income, et cetera.
THE COURT: I see. Thank you.
MS. MACKOFF:
Q At the bottom it says:

> Comments: This client arrived from Edmonton. He has mild schizophrenia for

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> which he takes medication risperidone.

Based on this information, how much further information would have been gathered regarding the medication?
A I think with this information, what would have happened next is that the client would have been referred to the nurse's clinic.
Q If the client provided information about the medication schedule or the doses, would that information have been recorded somewhere on this document?
A Yes, that's possible.
Q Turning to the next page, page 4, at the top it says "November 28, 2012," and it says "Client care meeting." What can you tell me about this record?
A These are client care meeting minutes from November 28, 2012.
Q And is this the weekly meeting that you were talking about earlier?
A Yes.
Q And near the bottom it says:

> Addis B5. Osuteye, Nicholas. Nurse is concerned because he hasn't been on medication for the past two weeks.

Is that what you're referring to, in terms of the nurse's concerns being addressed in the meetings?
A This would have been -- yes. At the conclusion of the nurse's clinic there would be a debrief with the outreach team and then they would share this information.
Q What would have been done with this information?
A This, essentially, is reporting that the nurses would be following up with this, so they're letting us know that this is what's going on.
Q Okay. If you could turn to page 6, what are we looking at here?
A This is a screenshot from -- from at that time, which was called HIFS, Homeless Information System, a database. And this just generally provides information on when somebody was admitted and when somebody was discharged.
Q And so in the kind of main box it says "Admit 01/11/12," I'm assuming discharge "05/12/12," and

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it says "No show. Freebie. S. Roberts." Do you know what that indicates?
A What it means is although the person no-showed, we're not going to discharge them.
Q And there's another note saying "Admit," again for 06/12/12, so the client would have come back the next day?
A Yes.
Q If you could turn to tab 15 at page 6, page 6 of tab 15. And it says, date entry from November 27, 2012:

> Writer met with client at Anchor shelter.

Do social workers attend to the clients at the shelter locations?
A Yes. And this -- Rosalie was part of the primary outreach team, so nurses and counsellors and concurrent-disorder counsellors.
Q And you're referring to Rosalie down at the bottom as the signature there or the name at the bottom that would have been the social worker?
A That is correct.
Q Flipping back to page 2 of this tab, the third line from the bottom there, it says:

> Writer asked shelter staff to please call when client returned RX into them.

Is that a normal practice for staff to be in contact with social workers regarding prescriptions?
A It was normal practice for shelter staff to be in contact with members of the primary outreach team.
Q Okay. And the next line says:

> This afternoon, shelter staff from the Beacon, Mike W, did call to confirm that client had dropped off prescription and had taken daily dose.

Do you know who Mike W is?
A He was a shelter worker at the time.
Q What was his particular role at the shelter at that time? Do you remember?
A He would have been operating out of the Beacon

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office, and during the day we have -- I'm not sure what time of day this was, but we have three shelter workers on staff.
Q So, if asked, the shelter staff would call the outreach team to confirm whether or not a client had taken their medication?
A In this case, calling to confirm that Nicholas had picked up his -- dropped off his prescription and had self-reported that he took his daily dose.
MS. MACKOFF: Those are my questions.
MS. KOVACS: My Lord, I wonder if we had marked the shelter records already. I haven't --
THE COURT: I believe we have. Yes, they're Exhibit 23.
MS. KOVACS: The binder in front of me.

CROSS-EXAMINATION BY MR. REID:
Q Mr. Hawken, I'm going to start by asking you a little bit about clientele. You mentioned you have about 25 percent seniors, you mentioned immigrants as well. At the Beacon shelter, do you also have clients who have substance abuse issues?
A Yes, about 50 percent.
Q What about mental health issues?
A Yes. Some -- my understanding from the concurrent-disorder counsellor from Vancouver Coastal Health is close to 100 percent of the individuals struggling with addiction have an underlying mental health issue.
Q So a significant portion of clients who are at Beacon shelter have mental health issues?
A That would be fair to say.
Q And was that also the case in 2012?
A That's fair to say.
Q Would that include individuals with schizophrenia?
A There have been occasions that we've had -- I can recall two in particular. One was also using crystal meth, which is a sort of tragic -- seems to be a tragic occurrence where individuals with schizophrenia gravitate towards that particular drug.
Q You mentioned two. There was another?
A There was another -- not -- I don't recall if there was -- if there was addiction issues as

well.
Q Those are two that you remember. There may have been others as well?
A Yes.
Q In terms of -- you mentioned the primary outreach team. What does that team entail?
A Essentially, the idea was to bring health care to the individuals. So for many of them getting into the clinic was a difficult process, so they were bringing nurses to the shelters.
Q And in addition to nurses, social workers as well?
A That is correct.
Q You also mentioned a concurrent-disorder counsellor. What's that?
A So, again, addiction and mental health.
Q So a concurrent-disorder counsellor is one who deals with clients who have both addiction issues and mental health issues?
A That is correct.
Q And all of that was present at the Beacon shelter in 2012?
A It wasn't present at the Beacon shelter but it was -- they offered clinics at the Anchor of Hope, which clients from the Beacon could access.
Q Did staff from the Beacon communicate frequently with the primary outreach team at the time?
A I wouldn't say frequently. The majority of the communication occurred at the clinics at the debrief.
Q I'll ask you to turn to tab 11, which is the client care notes. You've gone over before that part of what Beacon and Harbour Light do is provide more than just a place to live; it's trying to get people into social assistance, housing, schooling, things like that?
A Yeah. I mean the primary goal is to get them into independent living.
Q Entry at the top "Nicholas came from Edmonton." Previously you said you've got a number of people who are immigrants. Was it unusual to have someone who comes from outside of the Lower Mainland to stay at the Beacon shelter?
A Not at all.
Q So it's quite common to have homeless people from all over Canada?
A Yes.

Q Looking at the November 27 note:

> Has Nicholas called to set up an appointment?

Sorry, November 26.

> Nicholas set up an appointment with caseworker for 1 P.M. He didn't show. He said he has an application for PWD. And then the following day Nicholas called to set up appointment again for 1:00.

When it says "Nicholas called," do you know who clients call when they're setting up appointments with caseworkers?
A The caseworker themselves.
Q And how would that have been communicated to Beacon staff that he had called?
A Would have left a voicemail.
Q So Nicholas would have left a voicemail or the caseworker would have left a voicemail for Beacon?
A "Nicholas called to set up appointment again for 1:00." Okay, so what happens is the caseworker will set up an appointment for the resident, shelter staff will leave a note on their bed or at their dorm, and that's how they're informed.
Q So how would the staff have known that Nicholas set up an appointment for 1:00?
A This would be the caseworker that's reporting that, so...
Q Two shelters?
A The client would have contacted the caseworker directly.
Q What I'm asking about is how did this record -- this is a shelter record. How did the shelter know about these communications between Nicholas and the caseworker?
A These are case history notes that the caseworker is providing.
Q In terms of clients, has Beacon shelter had clients who are aggressive?
A Yes.
Q Or disruptive?
A Yes.
Q Violent?

A Yes.
Q And what are the policies and procedures for dealing with clients of that nature?
A Well, we try first to de-escalate, and then if that doesn't work then -- and they refuse to leave, we would call 911.
Q And would that type of behaviour or those concerns be included in Beacon records?
A Yes.
Q And there's no indication from the records that you reviewed that there was a concern that Mr. Osuteye was violent, disruptive, or aggressive?
A Not from these records, no.
Q I'd like you to turn to tab 15, please. So these are the notes -- do you recognize these documents?
A No. The only one I'm familiar with is the one from Rosalie Rossi.
Q And who is Rosalie Rossi? Who was Rosalie Rossi?
A She was a social worker with the Vancouver Coastal Health primary outreach team. She has since passed away.
Q You indicated on page 2:

> This afternoon, shelter staff from Beacon, Mike W, did call to confirm client had dropped off a prescription, taken daily dose.

You said that that meant that the client had said self-reported, he had taken the daily dose.
A Yeah.
Q Why do you say that that's the client's self-reporting that he had taken --
A Well, in that case, we would provide the individual with their medication, so it was delivered, I guess, our RN. And then the client would take the medication. And in some cases they will appear to take it in the office, but we can't determine if they did for sure or not.
Q So, effectively, that note means they may appear to have taken their medication but it's not -- as you said, sometimes they'll appear to take it but do not?
A Well, in this particular case, the shelter worker's reporting from what they saw that they

had taken the dose, but we don't actually, you know, look to see that they swallowed it.
Q Don't check their mouth --
A No.
Q In that case it's possible that the client -- Mike W did actually see the client take the dose, just not necessarily swallow it?
A That's correct.
Q In terms of medication policy, and you testified on this, that if there is a concern that a patient is not taking their medication that shelter management will reach out to the nurses or Vancouver Coastal Health?
A Yes, and that would be -- the concerns would be based on observable behaviours.
Q What do you mean by that?
A Well, perhaps a behaviour that, at that time, was unusual than, you know, what had been seen in the past.
Q So if a client was exhibiting unusual behaviour --
A Manic behaviour, what have you, yes, they would report it.
Q They would report to Coastal Health?
A Yeah.
Q And if a patient was exhibiting, for example, manic behaviour, unusual behaviour, concerning behaviour, that's something that would be noted in the shelter records; correct?
A That's correct.
MR. REID: Thank you. Those are my questions.
THE WITNESS: Thank you.
MS. MACKOFF: No redirect, My Lord.
THE COURT: No questions either. Thank you for your time. Thank you for helping out.
MS. KOVACS: Thank you, Mr. Hawken.

(WITNESS EXCUSED).

MS. KOVACS: My Lord, the plaintiff is ready to call her next witness, and that would be Kylie Dunn. K-y-l-i-e, last name D-u-n-n.

KYLIE REBECCA DUNN, a witness called for the plaintiff, affirmed.

EXAMINATION IN CHIEF BY MS. MACKOFF:

Q Ms. Dunn, you are a primary care paramedic with the British Columbia Emergency Health Services?
A Correct.
Q And, in 2012, the British Columbia Emergency Health Services was known as British Columbia Ambulance Services?
A Correct.
Q How long have you been a paramedic?
A 12 years.
Q Which station do you work out of currently?
A 259 out of Coquitlam, the Riverview grounds.
Q And do you remember which station you worked out of in December 2012?
A According to the forms, 248 Alpha 1.
Q And what -- where is that station located?
A On Cordova in Vancouver between Heatley and Hawks.
Q Does that station service a particular area?
A Usually the Downtown Eastside.
Q While working at that station, would you ever go outside of that service area?
A We do. We get called out to go wherever the calls are in the area. As calls happen, we shift around, but we're generally based in the Downtown Eastside for the 48 cars.
Q From that station, is there a particular hospital that your station would work with and bring patients to?
A Yeah, we usually go to St. Paul's, that's the closest hospital, and they can handle 90 percent of the calls we take. Our major trauma is to VGH.
Q If you could please turn to tab 17 of the binder in front of you.
A Got it.
Q Do you recognize this document?
A Yes. It's our patient care report.
Q And what is the patient care report?

A It's where we record the information about our patient and what we find for the call, particular call that we're on.
Q In the top right corner -- it's kind of hard to read -- but it says "White commission copy; Pink admitting copy; Yellow hospital copy."
A Yeah.
Q What does that mean?
A So the white copy I would keep, and we used to hand in to the employer for records. The pink copy is what goes to admitting, it's a very small portion, so that the patient can get registered at the hospital. And then the yellow copy is the copy that I would hand over to the bedside nurse.
Q Okay. So this form is carbon copied?
A Correct.
Q So there would be three versions?
A Three versions all the same.
Q Right below that, number 3, "Region/station/shift," there's numbers 248A1, what do those numbers indicate?
A So region 2 is the Lower Mainland; station 48, that would be the station on Cordova between Hawks and Heatley; and the shift pattern is alpha 1, so that's a 12-hour day/12-hour night shift, usually 6:30 to 6:30.
Q And, again, hard to read but "Date of service," looks like "05/12/12"?
A Correct.
Q So that would be December 5th, 2012?
A Correct.
Q Below that information there are two employee numbers. Is one of those numbers your employer number?
A Yes, the bottom number, 78024.
Q A little bit further down it says:

Ambulance responded to 312 E Cordova.

That would be where you met the patient?
A Correct, that would be where the ambulance was dispatched to, and where we would have met the patient, yeah.
Q And "Destination St. Paul's," that's St. Paul's Hospital?
A Correct.
Q Is this your handwriting?

A No.
Q Whose handwriting is it?
A It would have been my partner's, who was attending.
Q Do you remember your shift on December 5th, 2012?
A Not particularly.
Q Do you remember this call in particular?
A No.
Q Based on what's written here, do you know what your role was during this call?
A My number is in the driver's slot, so I would have been driving/assisting my partner while he's evaluating the patient, usually taking vital signs on scene, and then driving while my partner would be transporting, and potentially treating the patient, to the hospital.
Q Okay. And the top left corner, the first section "Patient's Information," it says "Nicholas Osuteye." That was the patient for who the call was made?
A Yes.
Q And "postal address NFA," what does that mean?
A No fixed address.
Q Further down:

Date of birth - 22/06/77. Age - 35.
Province - Alberta. Gender - male.

Where is this information normally -- or how is this information normally obtained?
A We try to get it from a driver's licence, care card, and then the last -- any Visas, debit cards we can find anything in the patient's wallet, and is then their word of mouth.
Q And box number 4, "Vital signs," so a little bit down from there, there's some numbers written under "blood pressure, pulse, and respiratory." Are there any numbers here that are particularly alarming from your position as a paramedic?
A Nothing stands out, but having a blood glucose 4.1 with a GCS of 14 would make me err on the side of caution.
Q What is the 4.1? What does that indicate?
A Just a patient's blood glucose level. So we like to have people above 4 and acting appropriately, i.e., a GCS of 15.
Q So a GCS of 15. Can you tell me a bit about the

GCS score in general and what is recorded on this paper?
A So a 4, 5, 6 would be any one of us in this room, we're coherent, we're alert, we're orientated, I'm assuming. And then anything less than that, so this particular one, 4, eyes open, the next 4, so verbal response wouldn't be appropriate for the situation, and then motor meaning following directions, able to coordinate is a 6, is on par.
Q And the box beside that 10 examination, there's "hallucinations" are checked off. And in the column beside it "oriented person" is checked off.
A Correct.
Q Can you tell me a bit about what those boxes indicate?
A So meaning that it appears this gentleman was orientated with whom we were as emergency personnel but not orientated with where we were, as in the place outside of 312 Cordova, or with the time, meaning could be date, time, and even seasons within the year.
Q Jumping around a little bit, but box 5, "History, patient chief complaint/primary transfer diagnosis," what's written there is "hallucinations/voices," where would this information come from?
A Generally from the patient from what we would be either seeing or listening to their complaints of, so possibly complaints of hallucinations, verbal and/or hearing voices, like seeing things or hearing voices.
Q Based on what's written here, are you able to determine whether that was what was told to you or what was observed, the hallucinations and voices?
A It seems to be from what my partner had written down, stating:

Walking around since 7:00 A.M. Has been having hallucinations. Unable to focus.

It seems like the patient admits to having it -- to having the hallucinations.
Q And maybe just to clarify what's written in the box below, if you could read out what that says, because there's some signs there.

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A So "denies ETOH," denies alcohol use. And "denies drugs," at that particular time. And then it says:

Voices/hearing music.

Q And then just above there:

Unorganized thoughts, bizarre behaviour.

Is that what that reads?
A Yes. Unorganized thoughts and bizarre behaviour.
Q Below that it says:

Medical/surgical history - schizophrenia.

How is -- what does that information indicate? Is that a diagnosis that a paramedic would have made?
A No. We can't diagnose patients, so that would have been information given to us by the patient.
Q And how about below that, "Patient's medications," where would that information come from?
A Again, from the patient and/or finding an actual prescription bottle, possibly on the patient.
Q What is your practice when you arrive at the hospital? Do you normally go inside the hospital with the patient?
A Yes.
Q Do you normally speak with any hospital staff?
A Yes. So on this particular day I was the driver, so I would stay with the patient and get a fresh set of vital signs, and then my partner would take the pink copy to registration to get the patient registered.
Q Would you speak with a triage nurse?
A The attendant -- my partner would have spoke with the triage nurse, and then we would have been directed on where to go within the emergency, where our place was within the emergency.
Q And would you take the patient to that location?
A Correct. We take the patient to the bed -- to the bedside, and we hand over to the bedside primary nurse.
Q Would you speak to any doctors?
A Sometimes, if they're available, yes. If not, we

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just hand over to the nurse.
Q In general, how long do you normally stay at the hospital with the patient?
A Could be any particular amount of time. We stay with the patient until the hospital accepts responsibility.
Q At what point in the process is this form that we're looking at normally filled out?
A It's usually ongoing, so during the call, throughout the call as we're getting information, that's when it's usually written down.
Q And you mentioned copies are left with the registration desk and one of the nurses?
A The primary bedside nurse.
Q In your experience, does every call necessarily result in a patient being transported to a hospital?
A No.
Q Based on the information you have available on this form, why was this patient brought to the hospital?
A Well, with a GCS of 14, it's not 100 percent normal, low blood sugar, a history of schizophrenia, and then a prescription of medications as well implies for me to transport to the hospital.
Q You mentioned the prescription of medication was a factor in that. What do you mean by that?
A Just because someone is prescribed a medication doesn't mean that they're taking it. I can't -- I don't have the capability to do blood test on street, so we take them to the hospital, so the hospital can do blood testing and find out blood levels and medications and see if people are properly medicated.
MS. MACKOFF: My Lord, I'll ask that this be marked as the next exhibit. I don't believe it's an exhibit yet.
MR. MEADOWS: No objection.
THE COURT: Yes. Next exhibit.
THE CLERK: Exhibit 29, My Lord.
THE COURT: Yes, thank you.

EXHIBIT 29: Common Book of Documents, tab 17: 2 page, British Columbia Ambulance Service, Patient Care report, Osuteye, Nicholas, Date of Service 05/11/12

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MS. MACKOFF: Those are my questions.

CROSS-EXAMINATION BY MR. REID:

Q I'll start by -- on the same page, the circle "denies." I understand that's what that circle with a line through it means?
A Yes.
Q "Denies suicidal, denies threatening"?
A Okay.
Q Would that be in response -- in standard practice to specific questions? Is that something that's specifically asked to people, "Are you suicidal?"
A "Do you want to kill yourself?" Yes. We have to bluntly ask people. We're supposed to bluntly ask people, yes.
Q So what are the questions that you're supposed to bluntly ask someone dealing with suicidal or threatening --
A "Are you thinking of hurting yourself; are you thinking of harming others," and whether or not they're under the influence of drugs or alcohol and, if they are suicidal, if they have a plan.
Q And then that's what's charted here. So the fact that is says "denies suicidal, denies threatening," that's the standard charting you'd see in response to those questions if their answer is negative.
A Every paramedic is different, and like I said before, I didn't write this down. So every form's going to be different from what we read, but that is as I read this.
Q You read it as denying suicidal, denying threatening?
A Correct.
Q On the box on the right there under "Examination 10," there's something that says "combative"?
A Yes.
Q What does that --
THE COURT: Sorry, I don't have that. Where is that, please?
MR. REID: Sorry, My Lord. It's on the same sheet, there's various numbers, there's "10 mental status," which is on the right-hand and upper-mid side of the page.
THE COURT: Sorry, not to comment on my eyes at this point -- I do see it now. Okay. I'm good.

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Thank you.
THE WITNESS: Sorry, can you repeat that?
MR. REID:
Q What does "combative" mean on this form?
A I would associate combative with physical violence or not complying with the -- not complying physically with what we're asking to do.
Q So a patient who wasn't complying or who was physically violent, that would be when you check off "combative"?
A Myself, yes.
Q At the time, you were working you said primarily from that dispatch on the Downtown Eastside?
A Correct.
Q In your experience, at the time, did you have many patients who were combative?
A Yes.
Q Many were violent?
A Yeah.
Q Ones who needed to be restrained?
A At times, yes. It's -- yeah.
Q And is that something that you, or you'd expect the person you were working with, would have charted in this record if there was any such concerns?
A I would hope so.
Q So you'd expect it to be in there?
A Yes.
Q Final question for you, are you familiar with what a section 28 is?
A Yes.
Q What is a section 28?
A In brief terms, something that the police sectioned peoples on the street.
Q So have you ever been involved in bringing in a patient under a section 28?
A Yes.
Q And that's where the police call the ambulance to say "This person needs to go to hospital"?
A Correct.
Q And they're required to go to hospital on those circumstances?
A Correct.
Q Is there any indication that Mr. Osuteye was a section 28 in this case?
A It's not written down, so I cannot say.

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MR. REID: Thank you. Those are my questions.
MS. MACKOFF: No redirect, My Lord.
THE COURT: And I have no questions either. Thank you very much.
THE WITNESS: Thank you.

(WITNESS EXCUSED)

MS. KOVACS: My Lord, we have one more witness this morning who will be a little bit longer, and I wonder if we might take the morning break a bit early and then get her started after.

(JURY OUT)

THE CLERK: Order in court. Court is adjourned for the morning break.

(PROCEEDINGS RECESSED AT 11:01 A.M.)
(PROCEEDINGS RECONVENED AT 11:19 A.M.)

THE CLERK: Order in court.
THE SHERIFF: The jury, My Lord.

(JURY IN)

MS. KOVACS: My Lord, the plaintiff calls her next witness, which is Registered Nurse, Alison Jordan, who is already in the witness stand. And Nurse Jordan will be affirmed.

ALISON MARGARET JORDAN, a witness called for the plaintiff, affirmed.

EXAMINATION IN CHIEF BY MS. MACKOFF:

Q Nurse Jordan, you are a registered nurse?
A Yes.
Q And would you be able to tell us what that means?
A Registered nurse, so I look after patients with medical concerns, primarily.
Q What does it mean to be registered as opposed to another kind of --
A Registered; we are licensed with a college, so standards of practice, and we're unable to work unless we're licensed.

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Q And I understand you're employed by Providence Health Care; is that right?
A Yes.
Q And Providence Health Care is the health authority that operates St. Paul's Hospital?
A Yes.
Q How long have you been a nurse?
A Since 1985.
Q So do the math for me. How many years is that?
A 34.
Q How long have you been at St. Paul's?
A Since 1987.
Q Not long after you got your license to nurse?
A Yes.
Q So well over 30 years. That's a "yes"?
A Yes.
Q What is the address of St. Paul's Hospital? If you could just give us that.
A 1081 Burrard Street.
Q And just to orient us, if I could have you turn -- I think you've got Exhibit A in front of you, or perhaps not yet. It's a big binder.
A Big binder, yes.
Q All right. Tab 30, if you could look to that, it's already marked as Exhibit 27 in these proceedings. Do you have that before you?
A Yeah.
Q It's an overhead Google map.
A Right.
Q And St. Paul's Hospital is identified on the left side?
A Yes.
Q Is that in the right spot?
A Yeah.
Q So 1000 block of Burrard Street?
A Yes.
Q Now -- so you've worked at St. Paul's pretty much your entire career.
A Yes.
Q How long have you worked -- and I understand you work in the emergency room; is that right?
A Yeah.
Q How long have you been working in the emergency room?
A I started in emerg in 1999, and I worked, I think, to about 2002 and 2003, and then I went to a different position called clinical coordinator,

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which is the site lead, so we do flow and access, and then I went back to the emergency about 2010.
Q I see. And since 2010, you've consistently been working in the emergency room?
A Yes.
Q Now, I take it, having worked in the emergency room for most of your career, you've seen a lot of changes over the years.
A Yes.
Q Can you describe those changes for me?
A Changes in terms of patient population or in terms of...
Q Yes.
A We've all been, sort of, the hospital for the Downtown Eastside population. That population has changed in terms of numbers. We see an increase in overall numbers.
What has been primarily, probably, the worst change or the most negative change for us is the introduction of crystal meth. Stimulant-type drugs have caused a lot of violence, a lot of aggression, out-of-control patients. We see a lot more of that now than we ever did before. It sort of started with crack cocaine, but crystal meth has really made it pretty bad.
Q Can you estimate for us when that sort of introduction of crystal meth happened or when you started seeing it in the emergency room?
A I would say like 2010 onward maybe. Yeah.
Q So over time, you mention the patient demographic and that there's been an increase in numbers; is that correct?
A M'mm-hmm.
Q That's a "yes"?
A Yes, sorry.
Q "M'mm-hmms" don't turn up on the record, so I'll try to catch you.
And in terms of those admissions, I mean obviously there are drug abuse concerns, what about organic mental health concerns from the Downtown Eastside? Do you see a lot of those in the emerg?
A Yes.
Q What kinds of patients?
A We see a lot of, like, schizophrenic, bipolar. A lot of -- that's where it's gotten probably the biggest change. We rarely see strictly mental

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health anymore; we see mental health with, you know, the complicating factor of substance misuse. We don't see a lot of people who are functional, like highly functional in their lives and maybe have an episode of their mental illness where they've decompensated and need treatment. We primarily see what's called dual diagnosis, which is mental health and substance.
Q And so that's considered a complex patient.
A Yes.
Q We've heard that before in this trial. Complex and sort of chronic, would that be of concern?
A Yeah, yeah.
Q You see a lot of repeats?
A Yes.
Q Just generally speaking, and I don't need your detailed recollection on this, but do you have a memory of an external review happening at St. Paul's Hospital?
A Yes.
Q And do you recall roughly when that was?
A I think that was 2013/2014.
Q So that's your estimate?
A Yeah.
Q Could have been earlier?
A Could have been, yeah.
Q Now that external review did lead to some changes. Correct?
A Yes.
Q You mentioned a couple of different roles. So you've been an RN in the ER. We're using a lot of acronyms there, so we need to be careful to explain what the acronyms mean. ER is obviously the emergency room, or you refer to it as the emerg; correct?
A Yes.
Q You also referred to something called the CNL. Is that what I caught there earlier?
A Yes.
Q What is that?
A That's a clinical nurse leader, so that is the on-shift charge nurse, so responsible for staffing, flow in and out of the department, redeploying resources depending on how busy the department is, if there's an area that is more acute or if there's, you know, multiple trauma patients, that sort of thing.

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Q You've been a CNL before?
A Yes.
Q I take it you actually are one now; is that right?
A Yes.
Q Do you recall if you were a CNL in or around December of 2012?
A I think I had just taken the CNL position. I can't remember, specifically, the date.
Q And since December 2012, then, have you changed positions?
A I have. In May of 2017, our manager was sent to be part of the redevelopment, and so they had looked for a replacement for her and not had a lot of success, so I agreed to step in to do the manager's position. But because I'm not technically qualified, because you need a master's for that position, and I'm very close to retirement, I did not want to come out of the union so I went into -- well, they created a role, a supervisor's role. So I went into that until June of this year, and then things have changed at the redevelopment, so our manager has come back, so we didn't need a manager and a supervisor, so they've deleted the supervisor role, and I've gone back to clinical nurse leader.
Q So that role was created for you, and you became a supervisor or a manager, in effect.
A Yes.
Q And now you're a CNL again.
A Yes.
Q Which still has some supervisory duties, the way you've described them to me.
A Yes.
Q If I could take you to tab 28, because I'd like to get a bit of an understanding of the various wards and departments in St. Paul's Hospital. It's a big hospital; correct?
A Yeah.
Q And there's an older building, there's some somewhat newer buildings, and it's a complicated layout.
A Right.
Q And I take it there are wards that have different codes, but you know those codes, and you can decipher those for us; right?

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A M'mm-hmm, yes.
Q So -- and prior to your work in emerg, I take it you worked as a ward nurse; is that right?
A Yes.
Q Where did you work?
A I worked on the medicine floor.
Q All right. So if we look at this page at tab 28, this is a document that was produced by Providence Health Care, and you can see at the top it says "How many psychiatric beds are there in SPH," which is St. Paul's Hospital?
A M'mm-hmm.
Q And were they occupied between December 6, 2012, at 7:00 A.M. to I think it says 11:30? So it looks as though a question was being asked in terms of bed availability at St. Paul's Hospital on the morning that brings us here, really, which is the assessment of Mr. Osuteye.
A Yes.
Q And this is produced, I'm going to suggest to you, by Providence Health Care, which is your employer.
A Yeah.
Q And it says "Data source bed map and census." Do you know what that is?
A Yes.
Q What does census mean?
A Census means the number of beds that the unit is funded for and also the level of staffing that they have for that number of patients.
Q And it looks like they've given us a December 6, 2012, midnight census count. So is there a midnight census count that happens at St. Paul's Hospital?
A I believe on the inpatient units there is. There isn't in the emergency.
Q I see. So below "Site SPH" it says:

> Note - psychiatric bed count is based on the allocated beds to the unit. Midnight census count is based on patient's location at the time when midnight census is taken.

So it can change; this is not a static document.
A Correct.
Q This is simply a snapshot of what it was at midnight.

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A Yes.
Q And it says:

> Occupancy rate can exceed 100 percent.

What does that mean?
A Over capacity.
Q So even when beds are full there's a way to make room for more?
A Every unit I believe -- every inpatient unit in the hospital has the ability to go two over census, and that's it. They can only go two over.
Q What happens in those instances if an admission has to happen? Is it transferred to another ward or another hospital?
A If they're full? If they're over census?
Q M'mm-hmm.
A They stay in the emergency.
Q Now if you look at -- there's a table below and it's got a unit code, column for number of beds, midnight census count, and the occupancy rate in the far right column.
A M'mm-hmm, yes.
Q Can you decipher what each of the unit codes are for us, on the left?
A 2N is 2 North, that's the psychiatric unit. Probably a little bit -- patients are a little bit more stable. 4 Northwest is for eating disorder patients exclusively, so under the mental health program but only those patients go to 4 Northwest. 8C is also an inpatient mental health unit, again, a little bit less acute. 9A, a mental health unit and I believe -- I'm not 100 percent -- but I believe 9A came about because -- in part because of the crystal meth crisis. There was so many patients that were -- had drug-induced psychosis that they actually expanded their beds. And then PASU is -- that's the name of the unit now. It was formerly called 2 East, a mental health unit as well. And it was -- generally that's where the emerg sends their patients as the first inpatient unit, and as they're stabilized on 2 East, then they will go to one of the other units eventually after however many days.
Q So it used to be called 2 East, but here it's

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called PASU?
A Right.
Q Which is an acronym.
A It's called Psychiatric Stabilization Unit. I can't remember. Psychiatric Acute Stabilization Unit, I think.
Q Psychiatric in any event, and it's meant to be a unit where patients are stabilized.
A Yes.
Q And you've already described it, it was 2 East or PASU, it is a unit that patients from emerg were sent to.
A Generally, yeah. Generally to that unit first.
Q So would you, as an RN in the emerg, would you actually go to the PASU or 2 East?
A Only for the patients -- patients who are certified under the *Mental Health Act* have to be escorted by security and by a registered nurse, or a registered psychiatric nurse, so, yes, go and hand the patient over to the staff in PASU.
Q So when someone is certified, security is involved?
A Yes.
Q Why?
A In case they decide to try and leave, security's there to make sure they get safely to where they're supposed to be.
Q And we've a little bit in this trial about what "certified" means before, but it's an involuntary admission --
A Yes.
Q That person is there against their will.
A Yes.
Q Under a certificate.
A Yes.
Q And earlier, and I don't want you to start giving medical opinion, but you talked about drug-induced psychosis. Can you just describe for me what you understand that to mean, so we know what we're talking about?
A It's a psychosis, you know, that's not sort of organic like schizophrenia or bipolar disease or a mental illness like that. It's generally a psychosis that is caused by an external agent being a stimulant-type drug.
Q So crystal meth, in your experience, can cause psychosis?

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A Yes.
Q But sometimes psychosis can be caused by an organic condition such as schizophrenia.
A M'mm-hmm.
Q Sorry, that's "yes"?
A Yes.
Q And if we look -- we've got the "number of beds" column, and then we've got the "midnight census count," and it looks as though in the first four units the beds are full, if not over capacity; is that right?
A Yes.
Q Except the PASU, which is 2 East, is not.
A Correct.
Q And, in fact, there are actually four beds available.
A It appears that way, yes.
Q And can you just describe for me, logistically speaking, where 2 East or PASU was in relation to the emerg? How far is it?
A It's on the second floor. It's, essentially, right above the emerg.
Q Not too far?
A Not too far, no.
Q Generally speaking, can you describe the emergency department for me? What is it like in that room?
A In terms of environment?
Q Yes.
A It's not nice. It's loud. It's usually bright. People are coming and going; people are coming and going for tests; there's paramedics; there's physicians; there's nurses; there's housekeepers, porters; there's a lot of people. And it doesn't matter what time of day; it's always pretty chaotic and busy.
Q Chaotic and busy.
A Yeah.
Q And I appreciate that you probably haven't actually worked as a nurse in the PASU; correct?
A No, I have not.
Q But you have certainly walked into that room to deliver a patient?
A Yes.
Q Okay. Can you describe what your observations are of that unit in comparison to the emerg?
A It's quieter, definitely. It's sort of -- it's a

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funny unit. Like, the old building is a little bit strange in the way it's set out, and it's been renovated so many times. So it's long and sort of narrow, so when I drop a patient off at the nursing station I can't necessarily see what's going on in the unit. I have been up there and opened the door to deliver a patient, I have had another patient run out. I mean, it can be...
Q It can be busy?
A It can be busy, yeah.
Q But as compared to the ER.
A Yeah.
Q Less so.
A Less -- I would say so, yeah.
Q All right. And you said quieter, generally speaking.
A Yes.
MS. KOVACS: My Lord, I wonder if we can mark this as the next exhibit, the bed census.
THE COURT: Mr. Meadows?
MR. MEADOWS: No objection.
THE COURT: Yes, I think we're at 29, aren't we?
THE CLERK: Exhibit 30, My Lord.
THE COURT: 30, my goodness. Hopeless. Thank you.

EXHIBIT 30: Common Book of Documents, tab 28: 1 page, ..."How many psychiatric beds are there at SPH and were they occupied between Dec 6, 2012 00:07AM to 11:3...

MS. KOVACS:
Q Now, Nurse Jordan, I want to take you to the night of December 5th, 6th, 2012. Do you know if you were working that night?
A Yes.
Q When you work a night shift, what is the standard shift?
A Starts at 1920, so 7:20 P.M., and goes till 0730, 35.
Q So it's about a 12-hour shift?
A Yes.
Q And a few minutes. All right. I'm going to have you turn to tab 21 in the binder. And you'll see that we have eight pages of records that are titled "Emergency Department Nursing Assessment" and then some? There are some more documents?

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A Yes.
Q Sorry. You have that before you?
A Yes, thanks.
Q And just before we go there, actually, if you can just bear with me for a moment.
THE COURT: Just to interrupt to make sure we all have it, I have eight pages in total, and your question suggested that there might be more pages.
MS. KOVACS: My apologies; I didn't mean to confuse things. It is eight pages in total.
THE COURT: Thank you.
MS. KOVACS:
Q When a patient is brought to hospital by ambulance to the ER, can you explain just how that intake happens?
A Patients brought by ambulance, they stop at triage. The triage nurse does a brief assessment and assigns them a CTAS code and score, and that's just sort of the preliminary diagnosis, and the CTAS score indicates how fast they should be seen by a physician. So a CTAS 1 would be like a cardiac arrest, needs immediate attention; CTAS 5 is somebody who can wait a little bit.
Q I see.
A And then --
Q Just before you move on from there, sorry, I want to take this in pieces. Can I just have you turn back to tab 14, page 18, in the bottom right-hand corner? So tab 14 is already marked as a whole as Exhibit 13. And my sincere apologies to everyone but this was a photocopy and collating error, but page 18 of that set appears to be a triage note from December 6th of 2012. Do you have that before you?
A Yes.
Q And it says at the top "Nicholas Alexander Osuteye"?
A M'mm-hmm. Yes.
Q Top right, "SPHED," which is emergency department. "Acute 2," and then "ESTR 14," is that the stretcher number, 14?
A Yes.
Q That's where he was placed, in the emergency room?
A Yes.
Q And it says "Triage Note - Wrigley, Helen J."

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And then in parenthesis "RN". Do you know Helen Rigley?
A Yes, I do.
Q Was she the triage nurse then?
A Yes.
Q So she did what you just described, which was triaging the patient from the ambulance.
A Yes.
Q And you talked about the CTAS code, and it looks like he's a 4 here?
A M'mm-hmm, yes.
Q "MH details CTAS description," what does that mean?
A That's the coding, so mental health, and the description of his presenting behaviour.
Q And it says "bizarre paranoid behaviour" and then it says "harmless"?
A Right.
Q So that's not someone who is presenting as aggressive.
A Right.
Q

Patient History and Comments: Patient was wandering on street and VPD stopped patient, called EHS.

That's the ambulance?
A Yes.
Q

Patient bizarre behaviour, denies SI.

A Suicidal ideation.
Q

Disorganized thoughts. Query - hearing music. Calm and co-operative. Patient from Alberta. History? Schizophrenia.

Where would -- in your experience, where would the triage nurse get this information from?
A From the paramedics.
Q And there's a number of -- there's some data produced below. Is that all produced from the paramedic as well?
A The vital signs or the allergies?
Q All of it.
A The allergies would likely come from the paramedics, and the vital signs the triage nurse

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does.
Q So she's actually taking another set of vitals?
A Yes.
Q Assuming the paramedics had already taken some as well.
A Yeah.
Q Do these vitals tell us anything, like the glucometer?
A No. They're all pretty normal.
Q What about the Glasgow Coma Scale? What's that?
A That is -- so that's how we determine whether somebody is confused or not. So eyes opening spontaneously, 4 is the score. Disoriented, so he appears to Helen to be confused. He's obeying her commands. So a 15 is a perfect score. A 15 out of 15 is a normal presentation.
Q And Mr. Osuteye has not received a 15. He's got a 14.
A A 14.
Q Where has he lost points?
A Disoriented and converses. So the questions you would ask somebody are "do you know the date, the time; where are you right now?" Those are the questions you ask and whether or not somebody can answer them accurately.
Q So he's fallen short on those questions.
A M'mm-hmm.
Q Sorry, that's "yes"?
A Yes. Sorry.
Q It's okay. But he's obeying instructions?
A Yes.
Q And motor responses?
A Yes.
Q So we're going to leave that tab entirely now.
THE COURT: Can I just ask one question? Counsel focussed on the "disoriented" but the words beside it "and converses," what does that mean? What, if any, significance does that have?
THE WITNESS: That he's conversant. He's answering questions. He's just not answering them correctly.
THE COURT: So that doesn't inform -- thank you.
MS. KOVACS:
Q And just to be clear, the best verbal response, 4 is out of -- is that out of 5 then or what's --
A Out of 5, yes.
Q Okay. So now we're going to go back to tab 21,

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which we've already identified as an eight-page document. Is your handwriting on this document?
A Yes, it is.
Q December 6th at the top?
A Yes.
Q Times 0045, so 45 minutes after midnight?
A Yes.
Q Bed number 14?
A Yes.
Q And, of course, this is pertaining to Nicholas Alexander Osuteye?
A Yes.
Q Who is the physician, the admitting physician?
A Dr. Pourvali.
Q He's an emergency room --
A Emergency physician, yes.
Q And then there's some address details in there, Edmonton. Do you see that? "2739 - 41 Street Northwest, Edmonton." In the top right corner?
A Yes. That's what I guess the paramedics would have given to admitting, the registration clerk.
Q So what we know is this gentleman is not from Vancouver, he's from Edmonton.
A Right.
Q So let's walk through this form carefully, because this is your handwriting throughout the form; is that right?
A Some of -- yeah, most of it. There's other handwriting that is not mine.
Q Maybe as we go through you can tell us what's yours and what's not. Okay? So I take it the date, time, that's your handwriting?
A Yes.
Q "Admitted per," and then he's walking, so he's ambulatory?
A Yes.
Q "Accompanied by EHS," that's the ambulance?
A Yes.
Q Language spoken is English?
A Yeah.
Q And it says "Chief Complaint." Can you read for us what it says there? Is that your handwriting?
A Yes.

Found wandering on street. Approached by VPD. Found him to be disorganized but co-operative.

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Q Homeless?
A I can almost read my own writing here.

Homeless. EHS called. Not sectioned by VPD. Denies alcohol or drugs. Recently has moved here from Alberta. On arrival appears to be responding to internal stimuli. Laughing, smiling inappropriately.

Q Let's just break some of that down. The first four sentences, sort of the history I guess, if we could call it that, where is that information from?
A From the paramedics.
Q So this is not something you've elicited yourself from the patient?
A I ask again, but that's the initial report from the paramedics.
Q And it says:

On arrival appears to be responding to internal stimuli.

Was that your observation?
A Yes.
Q What does that mean?
A He was talking but not -- he was talking to -- having a conversation but not with anybody present. So he was talking, laughing, very distracted.
Q What do you mean by "very distracted"?
A Looking around -- like, it would appear to me that he was possibly hallucinating, like he was looking around. But when I spoke to him directly and asked him to do something, he would do it. Sometimes he would answer, sometimes he wouldn't.
Q I see. And then you said "laughing, smiling inappropriately." What does that mean?
A He's laughing when nobody's talking. Not laughing with people. He's just laughing.
Q And that's something of significance for you to observe and record?
A Yeah, because he appears to be engaged, but he's just engaged with somebody that I can't see, so...
Q And then there's "Allergies noted, yes, Demerol."

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Do you know where you got that information?
A Paramedics.
Q So, generally speaking, before we go further down into this document, how is it that you came to be the nurse that was actually taking him on to bed 14?
A That night I was the float nurse. So what a float nurse is, goes around and does break relief for the nurses in that assignment. So I was relieving that particular assignment which was stretchers 13 to 16. Then at 1:00 o'clock, I moved on to the assignment next to that, stretcher 17 to 20, and then after that, I go and I break-relieve the triage nurse. So we just rotate through and make sure everybody gets their breaks.
Q I see. So that's why you're there; you're there as a float nurse to relieve people for their breaks?
A Yes.
Q Who was the primary care nurse in charge of Mr. Osuteye?
A Yvette.
Q Do you know her last name?
A Mueller.
Q Is she someone you work with frequently?
A No. She doesn't actually work in the department anymore.
Q I see. If we look at page 6, and we're going to come back to page 1, but if you look at page 6, bottom, there appears to be a table where it says "RN printed name." You see that?
A Yes.
Q Is this where nurses write down their names and their signatures and their initials?
A Yes.
Q Why is that done?
A Because we all don't have very good handwriting. It's a record; right? I mean, if something comes up, then you know who's been involved in the care of the patient and you can look. And we initial our medication administration records and we don't sign our full name, so it's just a way of keeping track of who's done what.
Q Who's done what in the record?
A Yeah.
Q Your name is first there, Allison J?

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A Yes.
Q And then Yvette Mueller is below you?
A Yes.
Q And then there appears to be a Jen Hughes?
A Yes.
Q And what's at the bottom there? Can you read --
A That is Irene Vandas.
Q It appears to be float 2.
A On the day shift, yeah.
Q So that would have been the next day?
A M'mm-hmm.
Q Yes?
A Yes.
Q Let's go back to page 1 now. So you are giving relief to Yvette Mueller then at the time that Mr. Osuteye comes in, I take it.
A Sorry?
Q You're relieving Yvette --
A Relieving Yvette, yes. That's correct.
Q So we just finished off speaking about allergies. And below that there's a large table and it says "medications" and you've written "risperidone," what does it say after that?
A "3 milligrams PO QHS."
Q What does that mean?
A That means he gets 3 milligrams of risperidone at bedtime, should be taking it in the evening.
Q And where did you get that information from?
A He had two boxes of that medication with his name on it in the pocket of his pants.
Q And how did you come to access that?
A Because he changed and he gave -- I wanted his belongings because he was going to be certified, so we take people's personal belongings away from them once they've been certified.
Q So you assumed at that point he was going to be certified, based on your experience.
A Yeah.
Q Based on what he was presenting with, you presumed that that was going to happen.
A Yes.
Q So you take all of his belongings away?
A For every mental health patient that's certified, yes.
Q If a patient is not certified, do they get to keep some of their belongings with them?
A They get to keep all their belongings.

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Q So you give him a hospital gown?
A Yes.
Q So you have access then to the medications that was on his person?
A Does he have access?
Q No, you were able to access those, and you've described you had two boxes?
A Two boxes.
Q Do you remember what those looked like? Do you have a memory of that?
A I do. They were kind of squished and I couldn't tell from -- they had medication and cards, you know, like a punch card.
Q Blister pack?
A Sorry?
Q A blister pack?
A Yeah, sort of like a blister pack. And I couldn't really tell how many he may or may not have taken. There were a couple of tablets missing, as far as I remember. I don't remember what date they had actually been prescribed, but they had his name and the dose and the directions were on them, on the package.
Q Just before we go on to talk about the belongings and your collection of them, do you have an independent recollection of Nicholas Osuteye?
A Not so much. I mean I have more of a recollection of him because of the news story that came on after he was discharged; right? He was in the hospital the other day.
Q So that's how you're able to recall some of the facts of his admission?
A M'mm-hmm.
Q That's a "yes"?
A Yes.
Q It's okay. So because of the events that followed, you're, like, "Oh, that was my patient." Is that fair?
A Yes.
Q Because this, of course, was almost seven years ago now.
A Yes. It was a while ago.
Q But you specifically remember seeing two boxes of smooshed risperidone?
A I do, yeah. It's not the normal -- I mean, we usually get pill bottles; right? It almost looked like something maybe -- you know when your

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physician gives you a sample, it looked like that kind of a box.
Q So it had an unusual presentation, in your experience.
A In my experience, yes.
Q And do you recall actually seeing if there were pills missing or not?
A I remember looking but being unable to tell, and he wasn't forthcoming with the information when he might have taken his last dose.
Q What do you mean by "he wasn't forthcoming with the information"?
A He was answering all my questions pretty much just "yes" and "no." If I asked something that required more than that he was mumbling and not making eye contact.
Q And to the right you've got a "Medical and Surgical History, schizophrenia"?
A Yes.
Q Where would you have gotten that information?
A Paramedics.
Q And "cervical fusion"?
A That is not my writing.
Q Okay. That's somebody else's writing?
A Yeah.
Q It says, "Use of tobacco, yes"?
A Yeah. That's not my writing either, though.
Q Someone else at a later time, as you were the first to see him --
A Well, because I would have handed over what I had done to Yvette and she would have carried on with the assessment if it wasn't quite complete.
Q I see. So were you able to ask him questions about his tobacco use, on the intake assessment?
A She filled in -- I think I put "yes," and she filled in "half a package," because I did ask him about alcohol, and I did ask him about drugs, and he denied use of both.
Q I see. And "denies marijuana," is that Yvette's handwriting or yours?
A That's Yvette's handwriting.
Q "Last use, query, once a week," that's Yvette's handwriting again?
A That's Yvette, yeah.
Q "Domestic violence" section, it says "Lives at Salvation Army." Is that your handwriting?
A No.

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Q Do you know whose that is?
A Maybe Yvette's. I don't know.
Q "Vital signs," did you take vital signs?
A Yes.
Q So that's your handwriting?
A Yes.
Q All right. Turning the page over, page 2, it appears in the -- there are a number of columns.
A Yes.
Q It appears at the top there are written, sort of, I guess, perpendicular -- in a vertical fashion you've got what appear to be times; is that right?
A Yes, times.
Q What does that represent?
A That's what time the vital signs were taken.
Q So on each of these occasions, 0150, 0300, I think that says?
A That's hard to read.
Q 0350, 0575, 0602, 0620, 0720, the patient's vitals were taken at each of those times?
A Yes.
Q By different nurses attending to him, I take it.
A Yes.
Q And, again, it's "vital signs" and then "GCS," which we already talked about, the Glasgow Coma score?
A Yes.
Q Are you able to tell me what's written sideways? It says "asleep" at some point in time, at 6:00 A.M. Do you see that?
A Yes.
Q So the GCS wasn't --
A So it wasn't done.
Q And that's at 6:02 A.M.?
A Yes. Looks like it, yeah.
Q And what about the checkmarks under "35"?
A So those are the scores. So there's a number and the box corresponding to the number is checked.
Q I see. And the scores are on the left there?
A Yeah.
Q Okay. And it looks as though at 1:50 A.M. he has a GCS of 13; is that right?
A That's what it looks like, yes.
Q And then it appears he has a GCS of 15 by 3:58 or 3:50?
A Yes.

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Q And a 15 by 7:20. Is that right?
A Yes.
Q And do you know if you did those assessments or Yvette?
A That's not me. That would have been Yvette.
Q Now if we turn the page over, now page 3, and "Emergency Department Nursing Assessment," there's a box below "medications." What does this box tell you?
A What time a medication was given; what the medication was; what route it was given, whether it was orally, IV, injectable; and the initials of the person that administered it.
Q So 0500?
A Yeah.
Q "Ativan," is that "2 MG"?
A 2 milligrams.
Q What is Ativan?
A Sorry?
Q What is Ativan?
A It's a sedative.
Q Route?
A PO, orally.
Q Your initials?
A Yes.
Q So you administered an Ativan to this man at 5 A.M.?
A Yes.
Q If there's nothing else below this table, is this the only medication he received during his entire admission?
A Presumably, yeah. I mean, it has happened that nurses have forgotten to chart, but...
Q But usually the practice, the standard practice is --
A Is to chart.
Q -- to chart any medications that are administered.
A Yes.
Q And earlier you talked about taking his belongings, including the risperidone. Why did you take the risperidone?
A We don't leave medications -- if a patient requires medications while they're in the hospital, we get those medications from our pharmacy, our in-house pharmacy where they're verified and dispensed by our pharmacist. Nobody

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really gets to keep their own medication, especially if they're not certified. You know, if he's not reliable, it's a safety thing. I don't know that a patient wouldn't take the medication they were in procession of, if they're under the *Mental Health Act*, we need to take all their belongings.
Q So everything is taken away from him, including his medication.
A Yes.
Q So he can't take it on his own?
A No.
Q And you said normally if you're going to administer some of the medication, it's ordered from the pharmacy in the hospital.
A Yes, unless we have ward stock. We have dispensing cabinets in the department that have some meds, but if it's a med that's not in the cabinet, then the pharmacy dispenses.
Q Down below it says "IV infusion and intake."
A Yes.
Q And it appears this gentleman has had an IV inserted.
A Yes.
Q What time was it inserted?
A 1:50.
Q Into his left hand, it looks like?
A Yes.
Q And what's the solution?
A Normal saline.
Q So salt water?
A Yes.
Q And then there's a measurement in terms of what's absorbed, et cetera?
A Yes.
Q Whose initials are those?
A At 1:50 and 3:20, that is Yvette. At 4:45, that is me. At 6:00 o'clock and 7:00 o'clock, that's also Yvette. Yeah, I think that's Yvette.
Q So he had his IV bag changed five times that morning.
A Yes.
Q The last would have been at 0700?
A Yes.
Q And you changed it once at 4:45 A.M.
A Yes.
Q So after your intake at 12:45 A.M., you then, at

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some point, are giving relief to Yvette Mueller again.
A Yes.
Q So you're coming back on with Mr. Osuteye, and you're changing his IV bag.
A Yes.
Q To your knowledge, why was he receiving an IV?
A He had an elevated CK, which is like a myoglobin. It's -- athletes get it who over-exercise, people get it from -- elderly get it if they have fallen and they lie in the same position for hours and hours. The muscle tissue starts to break down. CrossFit athletes get it from over-exercising. The danger of it is is it's not -- it goes into your bloodstream and the molecules are too big for your kidneys, so the danger is that you can actually get renal failure, so we try and flush the system as much as we can until the level starts to decrease.
Q So that's the goal of the IV, is to flush the system?
A Yes.
Q And get him rehydrated, I assume.
A Yes.
Q Now turning the page over, I just want to walk through carefully, make sure I'm not missing anything. Page 4, do you know if you would have checked the boxes?
A Yes.
Q So this was part of the initial intake assessment?
A Yes.
Q So I take it this document is a dynamic document; you start it but others put in --
A Yes.
Q Is there anything on this document that tells us anything of importance to this patient?
A No. It's a routine head-to-toe assessment. There was nothing abnormal.
Q So you were able to do a head-to-toe physical assessment of this individual --
A Yes.
Q Now turning over to page 5, is this your handwriting again?
A Yes.
Q What are you telling us on this page?
A The psychosocial, that he wouldn't make eye

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contact; his gait was steady; his hygiene was normal; behaviour was not appropriate; smiling, laughing inappropriately. The only thing -- I think the only thing he told me that wasn't "yes" or "no" was that he felt like he was in a fog. He had been up for many, many hours walking around the city so I don't know -- he must have been exhausted. I didn't get reliable responses to many of the questions I asked.
Q How do you know that?
A They were just "yes" or "no"; they weren't sort of relevant to the questions I asked.
Q What about suicidal ideation? You've checked "NA". What does that mean?
A Not applicable. He wasn't paying any attention. Towards the end -- like, I was with him for about 15 minutes on the intake, and towards the end of the intake he was just not really engaging with me at all.
Q So you asked him this question?
A Yeah, but I couldn't get a reliable response.
Q So we turn the page over to page 6 now, we have a table at the top with times in the left column and some handwriting to the right?
A Yeah.
Q And not all of this, again, is your handwriting but some of it is?
A I actually don't think any of it is.
Q Generally speaking, is this where attending nurses write notes?
A Yes.
Q But what we can see from this is at 0200:

Dr. Pourvali aware of CK value.

A Yes.
Q

IV infusing. Patient remains smiling and unsure of situation.

So one of the nurses would have observed that at that time.
A Yes.
Q

0300: Patient has eyes closed. Mumbling to self.

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A Yes.
Q Not sleeping, then.

0355: Patient resting comfortably. Eyes are closed. Patient restless if woken.

A Yes.
Q "Refused," what does it say?
A Lab.
Q

Refused lab to draw blood. Will return in ten minutes.

So he refused --
A Blood work.
Q -- blood work.

0420: Patient awake and orientated. Not acting differently. States he was walking around for 20 hours.

A Yes.
Q That was consistent with what you had learned about this patient.
A Yes.
Q

0520: Patient co-operative. Resting comfortably in bed. Respiratory regular.

A Yes.
Q

0605 patient sleeping. Breathes easy and regular. IV infusing.

A Yes.
Q Now I want to talk about the 4:45 when you went to go see Mr. Osuteye to change his IV bag.
A Yes.
Q And we already looked at the fact that you administered an Ativan at 5 A.M. to him.
A Yes.
Q What can you tell me about that observation that you made in that administration?
A He was still talking, laughing and he had his arm -- he was holding his sheet up over his head. It wasn't like he was resting his arm, he was holding it up, and he was talking, talking,

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talking, so...
Q So you have a specific recollection of this --
A I do.
Q -- of him pulling his bed sheet above his head and talking to himself?
A Yes.
Q Wasn't resting?
A Wasn't resting as far as I could see then. Not at that point.
Q Did that concern you?
A Yes.
Q Why?
A Because he's already been up for 19 or 20 hours walking around, and I didn't know anything about him. I didn't know what his mental health history was; I didn't know if he had a history of acting out, if he had a history of escalation.
Q What do you mean "history of escalation"? What does that mean?
A Well, if he would get aggressive or unco-operative. The problem in -- the stretcher he was in, they're all very close together. So I'm concerned about the patients on either side of him. They're only a couple of feet away. So I wanted him to sleep, calm down, and hopefully he would --- by later on in the morning he would sort of be calm enough to interview and be seen by the appropriate service, so...
Q So you wanted him to calm down and sleep?
A Yeah.
Q And be able to be interviewed?
A M'mm-hmm.
Q So by giving him an Ativan it allowed him to sleep?
A Yes.
Q How does that make him calmer and be able to be interviewed, in your experience and observation?
A If someone's talking, mumbling, and responding to internal stimuli and not responding to questions -- I mean, I'm not entirely sure what his history was at this point. I knew he had a mental health history. I wasn't sure -- his reliability was questionable. I didn't know if he had a substance use history beyond the marijuana. There were a lot of questions about him and his sort of presentation that we just didn't have answers to. We didn't have collateral

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information.
Q What do you mean by "collateral information"? Sorry, I don't mean to interrupt you.
A If he had been -- we knew he wasn't from Vancouver, so we don't have any way of getting records or, I mean, at that time of night. So it's more a safety thing. I just -- I didn't want to take the chance that him continuing to talk, continuing to mumble, continuing to sort of be awake and restless, I didn't want that to escalate into something where we did have to get security involved, where we might have to restrain, where we're putting patients on either side of him at risk.
Q So it's a safety concern?
A Yes.
Q And the worry is if things escalate he may become aggressive and need to be restrained. Is that accurate?
A Yes.
Q In your experience, that can happen?
A It can.
Q So you were trying to prevent that from happening?
A Yes.
Q So if we look back to the table, then, we just reviewed "0605: Patient sleeping," so he falls asleep.
A Sorry?
Q He ended up falling asleep.
A Yes.
Q And by 0700 it says "Patient snoring." So he was actually snoring he was so soundly asleep.
A Yes.
Q

0720: Received patient. Sleeping. Roused easily. Patient answers one-word answers.

So still only one-word answers at that stage.
A Yes.
Q

Responds by shaking and nodding as well. Denies SOB.

That's sort of breath?
A Yes.
Q

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Denies chest pain.

And it says "0900," what does it say there?
A

Up walking to bathroom earlier.

Q Okay. And then it says he's eating breakfast at some point. 9:00 o'clock?
A Looks like, yes.
Q And by 9:30:

Patient being seen by psych team.

A Yes.
Q So if you turn over to page 7 now, you were off shift by 7:30-ish; is that right?
A Right.
Q So in terms of page 7, then, you can't really speak to personally having witnessed any of this. This is simply nurses' notes recorded in the usual practice?
A Right. No, I wasn't there at this time. Yeah.
Q Now I want to just back up and talk briefly about some of the standard practices in the emerg. What can you tell me about the standard practice with respect to collateral information or records?
A We attempt to get -- usually the PAN nurse would start with that when a mental health patient comes in.
Q What's a PAN nurse?
A Psychiatric assessment nurse.
Q Was there one involved in Mr. Osuteye's care? Do you know?
A I'm not sure. I believe on the night shift there was not. We were short-staffed. There was not a psychiatric assessment nurse. Medical records are difficult to get at night, so we would have put it today's -- and usually -- I mean, we don't usually sort of just spontaneously go and get medical records. There's rules around confidentiality. But a physician can direct either the unit coordinator or the psychiatric assessment nurse to fax other facilities to see if we can get collateral information.
Q Do you know if that was done in this case?
A I don't.

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Q I'm going to have you turn to page -- or tab 24. It looks like there are three --
A There's some fax cover sheets.
Q In your experience and standard practice at the ER, are these the kind of faxes that would go out to other hospitals to find out if there's collateral?
A Yes.
Q And it looks like, in this case, Royal Alex Hospital, Grey Nuns Hospital --
A Yeah.
Q -- and University of Alberta Hospital were all faxed.
A Yes.
Q So there was some effort to try and find out what this guy's history was.
A It looks like it, yes.

MS. KOVACS: My Lord, if I could have that tab marked and also tab 19. I haven't marked that one yet either.
THE COURT: All right. Tab 24 first perhaps, Madam Clerk. Mr. Meadows?
COURT CLERK: Exhibit 31, My Lord.

EXHIBIT 31: Common Book of Documents, tab 19: 1 page, Providence Health Care, Emergency Physician Assesment, Osuteye, Nicholas Alexander, date 12/6/2012

MS. KOVACS: And tab 24.
THE COURT: Sorry, which tab are we on? I thought we were on 24, but you wanted the other one marked first. I just want to make sure we're --
MS. KOVACS: Let's deal with 19 first as exhibit -- sorry, I missed the exhibit number.
THE CLERK: 32 [sic].
MS. KOVACS: And then tab 24 would be Exhibit 33.
THE CLERK: Exhibit 33 [sic], My Lord.

EXHIBIT 32: Common Book of Documents, tab 21: 1 page, Providence Health Care, Emergency Department Nursing Assessment, Osuteye, Nicholas Alexander, Date: 12/6/2012

MS. KOVACS: Thank you, Nurse. Those are my questions. My friends may have some for you.

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CROSS-EXAMINATION BY MR. REID:

Q Good afternoon, Nurse Jordan. I'm going to start by asking you a little bit about some of your evidence regarding types of patients you see or saw at St. Paul's at the time.
A Okay.
Q You indicated that there are many patients who would be seen in the emergency department who I believe were characterized as complex patients, so polysubstance abuse plus mental health issues.
A Yes.
Q Would the use of marijuana as a drug be considered polysubstance abuse? Is that one of the substances that makes it a complex patient?
A Yes.
Q You also said that there was a number of patients you'd see with drug-induced psychosis.
A Yes.
Q What does drug-induced psychosis look like, in your experience?

THE COURT: Sorry, I don't understand. Do you mean physically, the manifestations of it? Is that what you're asking?
MR. REID: Yes.

Q So a patient with drug-induced psychosis, how does that patient typically present?
A They can be -- they're not in control of their behaviour, they're not in control of their movement. They can be aggressive, usually it's not because of -- they're not intending, they're just -- they might be hallucinating, they might see us as something that we're not. They generally need to be sort of contained and restrained and sedated until they clear.
Q So in the course of working at St. Paul's emergency you've seen many patients presenting like that?
A Yes.
Q Responding to hallucinations, aggressive such to the point they need to be restrained?
A Yes.
Q Dealt with violent patients before?
A Yes.
Q I understand the term is "four-pointed"?
A Yes.
Q Perhaps you can explain what that means.
A Those are limb restraints, so patient is

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restrained, wrist and ankles, to a stretcher.
Q And you've dealt with patients who had to be restrained in that manner?
A Yes.
Q Patients who spit?
A Yes.
Q Yell?
A Yes.
Q Threaten you?
A Yes.
Q Are there patients as well in your experience who you just have a sense about; they're not doing anything that's outwardly aggressive, but because of your experience you think this patient might be trouble in the future?
A Yes. Sort of, yeah. I'd say yes.
Q You sort of get a feeling for the patients who are troubled patients.
A Yes.
Q To your recollection did you have any such concerns about Mr. Osuteye when he was there?
A At the time I saw him, no.
Q I'd like you to turn to tab 14, page 18. This is the CTAS information gathered by the triage when Mr. Osuteye came in. Under "MH065," it's got "bizarre paranoid behaviour, harmless."
A Yes.
Q Is that something that you would typically see in a note, the note "harmless"?
A It's part of the CTAS scoring. So the CTAS are the Canadian triage scores, so it's a national standard, so these are not modifiable. That's -- if you want to assign someone the 4, if that's what you see, that coding automatically comes up.
Q And what does "harmless" mean?
A Harmless means no threat.
Q To who?
A Themselves, others.
Q We've already gone over Mr. Osuteye, at the time of admission, had a GCS of 14?
A Yes.
Q Communicated he lost points, 4 out of 5, as a result of he was disoriented and conversed -- says "converses" but --
A Disoriented, yes.
Q Have you seen many psychiatric patients, in your experience, with a lower GCS score than 14?

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A Yes.
Q And have you seen a patient's GCS score change over time during the course of their admission?
A Yes.
Q I'd like to take you then to tab 21, page 2.
A Yes.
Q This is the nursing note that's maintained throughout the course of Mr. Osuteye's admission that day; correct?
A Yes.
Q And under "GCS" at the bottom, there's a number of scores. The first one is a score of 13?
A Yes.
Q Do you know if you wrote any of these or you don't know?
A I did not.
Q Looking at the first entry there where there's 13, it looks like he gets a 3 on eyes. And what does a 3 mean?
A A 3 means his eyes were not spontaneously open, that he had to be stimulated to open his eyes. So it could be that he was just resting with his eyes closed and the nurse said "Open your eyes," and he opened his eyes.
Q So someone who is resting with their eyes closed would have a score of 3?
A Yeah.
Q Looking at later on, on that same one, later at 3:50, it looks like he's assessed again and those checkmarks, I take it, means that he gets a full score at that point?
A Yes.
Q And that's why there's 15 at the bottom there?
A Yes.
Q And then later at 6:02, there's a note that says "asleep"?
A Yes.
Q So that means the nurse didn't perform a GCS assessment at that time because Mr. Osuteye was sleeping?
A Correct.
Q And then finally at 7:20 he again has a perfect 15/15.
A Yes.
Q You testified that Mr. Osuteye was placed in bed 14. Can you describe where bed 14 is in relation to the emergency department?

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A Bed 14 is part of Acute 2, so if you -- the emergency department has a main acute nursing desk in the middle, stretchers 1 to 13 -- or 1 to 12 on the left, 13 to 20 on the right, but the main nursing station you can't see stretchers 13 to 20. There's a wall, there's a washroom, so if you wanted to see it, you would have to get up and actually walk around the corner. In front of those stretchers there's an exit door into the main hallway of the hospital, which is right -- 17 to 20 is here, there's a corridor that goes that way, there's a corridor that goes down the other way past the trauma bay out to the ambulance bay onto Burrard Street.

Q So bed 14 is one that can be easily seen by the nurses at the nursing station?

A Yes.

Q At the time of your initial assessment of Mr. Osuteye, you took his personal belongings?

A Yes.

Q Did he object or oppose that in any way?

A No.

Q Have you had psychiatric patients who have?

A Yes.

Q And what does that look like?

A That would generally involve security going hands on and possibly having to restrain the patient. And in that case, we may sedate first and take the clothing off after the fact.

Q You were also able to do a physical examination of Mr. Osuteye?

A Yes.

Q We went through that already?

A Yes.

Q And there was no indication that Mr. Osuteye was resisting or opposing that?

A No.

Q Calm and co-operative throughout?

A Yeah, he wasn't paying any attention to me at all. I was just there, you know, but he was following my commands, my direction.

Q He was compliant with what you were telling him?

A M'mm-hmm. Yes.

Q Aside from -- sorry. And you testified Mr. Osuteye was responding to internal stimuli --

A Yes.

Q -- throughout. Are there different degrees of

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responding to internal stimuli, or does it always look the same in every patient?

A It looks the same depending on -- I guess there's different levels of engagement. He was mumbling. He was quite quiet. Some people are louder. But it's typically the same. Like, they're not really inter -- or engaging with the people that are physically present.

Q Are there patients who are responding to internal stimuli such that you can't even get them to take their clothes off or do a physical examination? They're just not paying attention at all?

A Yes.

Q You testified that at some point late at night you gave Mr. Osuteye Ativan to assist him in sleeping and calm him down?

A Yes.

Q Was that an unusual step that you took or is that pretty standard?

A No, I asked -- I reported to Dr. Pourvali that he was still mumbling, still pulling the blanket over his head, talking, laughing, and asked him if he wanted to give him some sedation. And he was standing at the computer at 13 to 16 so could see him and ordered the Ativan.

Q Is Ativan -- was the amount that was ordered unusual?

A No, it's very standard.

Q Are there other sedatives that are used in the emergency department with psychiatric patients?

A Sedatives, not really. Ativan, pretty much. I mean, for extreme agitation they will give a medication called midazolam, but that's usually -- that's an injectable medication for people that are really, really unable to control their behaviour at all.

Q And, in your experience, are there sedatives that are administered against the patient's will and it's necessary to control them?

A Yes.

Q And that wasn't the case with Mr. Osuteye?

A No.

Q And after he got Ativan, he went to sleep?

A Yes.

Q You indicated one of the reasons was you wanted him to sleep prior to being assessed later on?

A Yeah.

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Q In your experience, had you seen patients with psychiatric issues improve after sleeping?

A It doesn't hurt, yeah. He'd been up for the previous, he reported, 19 or 20 hours. I don't know how accurate that was. I suppose it could have been. That's the reported number.

Q At tab 21, on page 6, there's a note at 4:20:

Patient not acting differently.

A Yes.

Q In your experience, have you seen patients act differently from the time of admission throughout their course in the emergency department, as in have you seen changes in patient behaviour?

A Yes.

Q And is that something that you see frequently in patients with polysubstance or psychiatric, those complex patients?

A Yes. I mean, if they're under the influence, the farther out they are from the time of ingestion they tend to clear. So mental-health-wise, a little bit hard to say. That's, like, purely psychiatric, but if there is substance involved, the longer away they are from the ingestion the more clear they become.

Q At the -- on that same page at the time of discharge there's a checkmark that says "Referred to SW." What does that mean?

A Social work.

Q So there's a social worker available in emergency department?

A Yes.

Q So that would mean that the fact that it was checked means that Mr. Osuteye, on discharge, went to a social worker?

A It looks like "Referred to social work for Safe Ride," so referred to get a ride back to his accommodation.

Q And that's so he's just not set out -- right out the doors of the emergency department.

A Yeah, no, he would have -- but I don't know. I mean, it just says "for Safe Ride," so, I mean, we do have that. Social work just literally gets them a ride. I don't know if they had any contact. I wasn't there so...

Q This court has heard a recording of Mr. Osuteye

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as he was the following day on December 7.

A Yes.

Q I understand you've listened to that recording?

A Yes.

Q At any time when you assessed Mr. Osuteye, did he present to you the same way as he did on that recording?

A No.

Q Have you experienced patients who presented similar to that recording?

A Yes.

Q And what are your experiences, your involvement in the care of those patients?

A A patient that would present like that would likely be placed in our trauma bay and restrained and sedated, maybe offered oral sedation at first, but we wouldn't give them a lot of time to decline. We would restrain and control the behaviour urgently or emergently.

MR. REID: Thank you. Those are my questions.

MS. KOVACS: My Lord, just one question in redirect. I'll just stay here for that.

RE-DIRECT EXAMINATION BY MS. KOVACS:

Q My friend had asked you about a feeling or a sense that you get when someone might be a "troubled patient."

A M'mm-hmm.

Q Do you remember that question?

A Yes.

Q And you said you didn't have that sense about Mr. Osuteye when you saw him.

A Yeah.

Q Were you concerned that you might get that sense if you didn't give him the Ativan and if he didn't sleep?

A Possibly.

Q Escalation was your concern?

A Yeah, just based on not knowing very much about him, so...

Q Because, as my friend said in cross-examination, behaviours can change.

A Yes.

Q They can get better and they can escalate and get worse; isn't that right?

A Yes.

MS. KOVACS: Those are my questions in redirect.

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Thank you, Ms. Jordan.
THE COURT: Nurse, thank you so much.
THE WITNESS: Thank you.

(WITNESS EXCUSED)

MS. KOVACS: My Lord, I note the time. We have two witnesses this afternoon.

(JURY OUT)

THE CLERK: Order in court. Court is adjourned until 2:00 P.M.

(PROCEEDINGS RECESSED AT 12:27 P.M.)
(PROCEEDINGS RECONVENED AT 2:02 P.M.)

THE CLERK: Order in court.
THE COURT: You were going to speak about transcripts. We won't finish today with the witnesses, or if we do that issue is only for tomorrow morning for read-ins.
MS. KOVACS: Yes.
THE COURT: And I'm just wondering, did you have a chance to talk about that or will that be overnight?
MS. KOVACS: It will be overnight.
THE COURT: Thank you.
THE SHERIFF: The jury, My Lord.

(JURY IN)

MS. KOVACS: My Lord, the plaintiff calls her next witness, which is Constable Mike Dewar.

MICHAEL DEWAR, a witness called for the plaintiff, affirmed.

THE WITNESS: I am a retired Vancouver police constable 1436.

EXAMINATION IN CHIEF BY MS. KOVACS:

Q Thank you, Constable Dewar. And I see that you are standing as is the custom of most police officers. You prefer to stand?
A Sure, thanks.

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Q All right. So you've already told us you're a retired Vancouver Police Department officer; is that right?
A That's right.
Q And your badge number was 1436?
A Yes.
Q When did you join the VPD?
A January of 1989.
Q 1989?
A Yeah.
Q When did you retire?
A September of 2016.
Q Now I understand that you were one of the responding officers to the events involving Mr. Osuteye on December 7th of 2012?
A Yes.
Q Do you have a clear recollection, independent recollection of those events?
A I have some recollection. It's been a while, so it's foggy.
Q So I understand you have some documents and notes before you?
A Yes.
Q What are those documents and notes?
A It's my copy of my report that I wrote that day; a copy of my partner, Constable 2375 Brad Cook's report; copy of PC or Constable 2725 McCracken's report; 2816 Wells; and I have my -- a copy of my notes that were -- that I made that day.
Q Just to be -- so that we understand, you said McCracken, Wells, Cook were the three police officers' names that you mentioned?
A Yes.
Q Were they all at the scene with you?
A Yes.
Q Observing the same events?
A Yes.
Q So reading those documents and those notes, have those refreshed your memory to some degree?
A Yes, absolutely.
Q And to your recollection, corresponding with your independent recollection, is what's recorded in those notes, do those accurately reflect what you remember happening at the scene?
A Yes.
Q All right. Now, your partner at the time you've mentioned was Constable Brad Cook; is that right?

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A Yes.
Q And how long had you been partners with Constable Cook?
A I want to say that we'd been partners for about a year at that time. I can't say for sure.
Q So when we talk about police partners, you're in the same patrol car?
A Yes, correct.
Q So tell me about how it came to be that you were at the scene of this event.
A Constable Cook and I were working patrol division at that time, and we were working in an area called district 1, which -- best description I think would be to say Cambie Street from the water all the way down to I'll say False Creek and then west to Stanley Park, all inclusive. That's district 1.
Q So downtown?
A Downtown core, excluding what people would call the skids area.
Q The Downtown Eastside?
A Downtown Eastside, yeah.
Q That's what the VPD refers to it as?
A Downtown Eastside, yeah.
Q Colloquially, "the skids." Now where did you respond to and what was happening along the way?
A Well, there was a call on the radio about some assaults that had been going on and, from what I recall, just information about witnesses that had followed the suspect and that he was now down by BC Place stadium, so off of Pacific Boulevard. So one way is Pacific Boulevard on the stadium, the other way is Expo Boulevard. So we were coming in from the west going eastbound on Pacific Boulevard so --
Q It might help us to orient, actually, ourselves by looking at a map. So if I can get you to -- there's a big binder in front of you, it's Exhibit A. And tabs 30 and 31 may assist us to explain where exactly you were and where you were headed at the time that you responded to the call. So we look at tab 30, which is Exhibit 27, and tab 31, which is Exhibit 28. So you can see in tab 30, Exhibit number 27, you can see BC Place is the round figure and then there's "700 Pacific Boulevard" written across that. Do you see that?

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A Yes, that's right.
Q Are you able to direct us to the area in which you responded to the call and actually came to a stop with your patrol car?
A It actually looks like it's right where that bubble is that says "JW Marriott."
Q The Park Vancouver Hotel?
A Yeah, that wasn't -- that wasn't there when this happened, so...
Q That wasn't there when this happened?
A No, it was being built.
Q I see.
A Or was built later on.
Q So is that roughly the area where you came to encounter Mr. Osuteye?
A Yes.
Q So 700 Pacific Boulevard is a short distance away; is that right?
A Short distance?
Q Away. Just a short walk around BC Place?
A Yes.
Q Can you tell me, in your own words, what you saw when you arrived at the scene?
A As we approached, there was a witness -- and I can't remember his name, it's in my notes -- he was on the -- I think it was the -- call it the south side of Pacific, and he was pointing towards what we call the west airlock of BC Place stadium, it's on Terry Fox Boulevard. So it's basically the ground level entrance for BC Place stadium, and he was pointing in that direction. And at that point we saw Mr. Osuteye. Am I saying that name right?
Q Mr. Osuteye.
A I hope so. There, and he was right down to his underwear.
Q Right down to his underwear?
A Yeah, he was just wearing his white underwear.
Q Now it's December 7th. Do you have any idea of what the temperature was that day?
A It was cool. And from reading my report, it did start to rain heavily right after, so you could feel it coming.
Q So the rain clouds were coming in?
A Yeah.
Q Had you ever encountered arresting someone in their underwear before?

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A I have arrested people that have been in their underwear, have been naked running around when they're under -- when they're using drugs and that, cocaine and that sort of thing. I've never arrested somebody that's stripped themselves down to their underwear and stood and waited for us.
Q "Stood and waited for us"?
A Yes.
Q So when you saw Mr. Osuteye for the first time, what was he doing?
A He was standing on the sidewalk, and as we pulled up, he started to move towards us.
Q And you're raising your hands --
A Yeah, I think he put his hands up and kind of walked out into the middle of the road, so we came to a stop in the middle of the road.
Q What happened next?
A We directed him to get down on the road, so he laid down on the road, listened to what we told him to do, laid down on the road. We just handcuffed him. There was no problem at all. And he was picked up and brushed off and sat on the curb.
Q He listened to what you told him to do?
A Yes.
Q Totally co-operative?
A Yes.
Q Laid down on the ground face first?
A M'mm.
Q Asphalt?
A Yes.
Q Hands behind his back?
A That's where they ended up. I don't know where he put them.
Q You ended up handcuffing him with his hands behind his back. Is that accurate?
A That's where he -- yeah.
Q What happened next?
A So in the process of things, he would -- he was brushed off, sat down, and then he was read his charter rights.
Q What does that mean?
A By Constable Cook. So that's when the police officer arresting you tells you why you're being arrested or detained, gives you a lawful reason for it, tells you that you have the ability to speak to a lawyer, provides you with legal aid

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information, offers a phone number, and gives you an official statement of caution, basically says, "You don't have to say anything to us, but anything you say we can give as evidence."
Q So you recall him being chartered by your partner?
A Yes.
Q And you were present for that?
A Yes.
Q Do you recall what his reaction to being chartered was?
A No, I don't recall.
Q At some point, though, you were prompted to go and get a recorder or something of that kind; is that right?
A Yes.
Q How did that come about?
A Mr. -- I'll call him "Nicholas." Nicholas, how's that? He started talking. He was talking a lot. So rather than try to take notes and try to get the most accurate recording of what happened, Brad asked me, Constable Cook asked me to grab our digital recorder from the car. So back to my briefcase, got a digital recorder, brought it back, and gave it to Brad.
Q And you pressed record, or someone did?
A Push record, yeah.
Q Now we've heard that audio. It's a 37-minute-long audio recording.
A Yes.
Q Is your voice -- and you've listened to that in advance of your testimony here today?
A Yes.
Q Is your voice heard on that recording?
A Several places, yes.
Q Can you recall and tell us where your voice is heard on that recording?
A Well, I kind of -- I'll just look at some notes I made when I was listening to it. I think Brad mentions me on the tape initially, and then 3:38 into the recording, I respond with something about "they're being paged." Somebody asked me -- MCS major crimes was being called out, so I could hear my voice saying "They're being paged." And then 6:52 I hear my voice say "The west airlock," describing where we are. 8:39 I'm talking to him, Nicholas, about getting him sort

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of wrapped up in the blanket because I wanted to get him to sit on the blanket because the cement was wet and he was in his underwear, cold.
Q Before we move on from that, can you just turn to tab 34 in you binder? Exhibit 24 in these proceedings, tab 34. And you talk about giving him a blanket. This has already been identified as a photograph of Mr. Osuteye at the scene with what appears to be an blanket around his shoulders. Is that something you gave him?
A Yeah, what I remember is that we got it from Fire, I believe. I can't remember which person brought it over, but we got him wrapped up in it. So I can't say for sure.
Q So you got him wrapped up in it, someone did.
A Yes.
Q Why?
A Because it was cold. He seemed like he was rattled. So we just try to be nice to people.
Q Fair enough. And back to your notes of where your voice turns up in the recording, what else can you tell us was said by you in that recording?
A Where else am I on there?
Q M'mm-hmm.
A 20:43 into the recording I can hear myself giving my badge number to somebody. And at 21:45 I'm on tape and he's talking about -- I can hear myself on tape and he's talking about spending his money, where he can spend his money.
Q Now during the course of that 37-minute audio and during the course of your arrest of Mr. Osuteye, did you at any point feel that he -- feel threatened by him?
A No.
Q You didn't feel threatened by him at all?
A I didn't feel threatened by him, no.
Q Why not?
A He was very -- first off, he was very compliant with us right off the get-go, so he did everything we asked him. And after that he was handcuffed, and he's just very easy to deal with. We had him seated, he wasn't flailing about, he wasn't kicking, he wasn't -- nothing like that. Just very easy to deal with.
Q Now earlier you talked about district 1 and district 2 and other districts. I guess the

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Vancouver Police Department is divided up into different districts; is that right?
A The city is divided up into four districts.
Q I see. Now you and Constable Cook were first on scene. Was there someone right behind you?
A Yes, the other two members, Ms. McCracken and her partner. I can't remember who that was. Mazloum, M-a-z-l-o-u-m.
Q Were they district 1?
A I believe they're district 4. So that would be south West Vancouver.
Q How did they get to the scene? Do you know?
A Well, a lot of times -- the district -- when I say it's divided up into four districts, if you're driving along the border of a district, so say I'm driving along Cambie Street, I'll often turn one of radios -- one of our three radios in the car to that district that's next to us, so district 2. Because often something will be going on and you're the closest person. So it's possible they were coming over the bridge to go to court or something and they flipped on channel 1, or they were close to the bridge and decided to come over and help out.
Q So they were right behind you on scene?
A Yes.
Q And when we looked at that map that was at tabs 30 and 31, and you said district 1 did not include the Downtown Eastside; is that right?
A That's right.
Q What district was that?
A District 2. So they would be operating -- district 1 works on channel 1, district 2 works on channel 2 on the radios.
Q But certainly police officers respond to happenings in the other districts if they're tuned into that radio.
A Oh, absolutely.
Q In fact, you understood that there was a previous incident involving Mr. Osuteye in district 2?
A I don't believe we were aware of that initially, but it had started to filter through. This had started in district 2, I want to say around Columbia Street, but I'm not sure.
Q What had started in district 2?
A That there had been another assault in district 2. I want to say assault of a female,

but I'm not positive.
Q But that had filtered through to you?
A Eventually it did, yeah, at some point.
Q So this suspect had moved from district 2 to district 1?
A As far as I know, yes, makes sense.
Q And just to clarify as well when we're looking at the map, for example at tab 30, district 1 includes all of the downtown peninsula including the West End and St. Paul's Hospital; would that be accurate?
A Yes.
Q Now tell me about what happened after Mr. Osuteye's arrest. I understand you were involved in gathering some of the evidence?
A Yeah. So there was some clothes that were flung about on the street, and we could see that it was going to start raining pretty quickly, so to make sure we didn't lose DNA or anything else, shoes and whatnot, we left Brad with Mr. Osuteye and then we -- I grabbed some bags from my patrol car, took his shoes, socks, and I think a package of cigarettes off the roadway. I think I said they were about 20 feet from where he'd been initially standing. And then one of the other members, I think it's PC McCracken, grabbed his clothing and bagged that as well and then turned that over to me.
Q So Constable McCracken helped gather the evidence and then gave it all to you?
A Yes. Sorry, the purpose for that too is that we'll take -- one person will try to deal with the exhibits as best we can. So if it's something that there's going to be a whole bunch of exhibits entered, then give it to me, I'll enter them all, tag them all, and there's just one member that has to come and give that evidence; right?
Q And you want to make sure one person has custody over the evidence?
A Yes.
Q Now if I can have you turn to tab 39, we have three photographs here which were taken at the jail afterwards, or the police station, and it was already marked as Exhibit 18 in these proceedings. Can you tell me, looking at the first photo, is this consistent with what you

gathered at the scene?
A So this stuff would have -- this clothing I believe was gathered by PC McCracken who then turned it over to me. Now I don't have an absolute memory, but I've read over her notes and it makes total sense. She's described it -- she's handed it to me bagged, and then I've eventually turned it over to Ident person.
Q The Ident person?
A Yes.
Q Who's that? And what is Ident?
A Forensic identification unit, fingerprints, DNA, that kind of thing. Photographs. They're responsible for processing all of our exhibits that need to be printed. Smock for DNA, sent off to the lab. And of course they do all the photos and things for us. So if there's -- if this sort of evolves into something bigger than what we are initially doing with this, oh, there's going to be three scenes, and, oh yeah, there's going to be blood in that, so they'll look for their exhibits, take the shoes, whatever, swab them if they need to, send the exhibits off -- or send those off to the lab.
Q As one might assume, there were a number of photographs taken, and we have but three here, but you mentioned shoes. You collected shoes at the scene as well?
A Yes.
Q Those aren't depicted in these photographs?
A No.
Q Do you remember what those shoes looked like?
A I think I said they were black Nikes. Oh, sorry, two black running shoes and they're Reeboks.
Q Do you recall inspecting those shoes, at any point?
A No, I bagged them.
Q Did you inspect the contents of the bags that Constable McCracken gave you?
A Yeah, we had a look at them and found a couple of items that we thought should be noted and sent with him to the jail as well.
Q So some evidence was given to Ident and some evidence went with him to jail?
A Correct.
Q What went with him to jail?
A Medication and a hospital -- hospital form --

hospital discharge form maybe is what it's called. I'm not sure.
Q So you found a hospital discharge form and medication amongst Mr. Osuteye's belongings?
A Yes.
Q And both those items went with him to jail?
A Right.
Q So they're not shown in this photograph at tab 39.
A Right. The reason for that is anytime that we take a -- if we have a prisoner that's been transported for treatment to the hospital and has to go back for jail or somebody that has medication for an ongoing problem, it goes to the jail with him, so the jail nurse can use it if she needs it. And if they've been to the hospital, she needs a copy of the report, so she can see what she's dealing with.
Q And so correct me if I'm wrong, the purpose then of sending those items along is to make sure that he has the right health care.
A Correct.
Q Do you remember looking at those items?
A Yes.
Q What did the pill boxes look like? How many were there, first of all?
A I think I noted -- my notes here that they were four packages of risperidone, I think it's called. So in my notes I wrote he has multiple packs of risperidone, one milligram, and there's four full blister packs of 10 pills, 40 pills, no pills missing from the packs.
Q No pills missing from the packs?
A Yeah.
Q And you saw that yourself?
A Yes.
MS. KOVACS: Those are my questions. My friend may have some questions for you in cross.

CROSS-EXAMINATION BY MR. REID:

Q Thank you, Constable Dewar. I'm going to start by asking you about your evidence regarding the pills, package of pills that Mr. Osuteye had with him. Do you recall, or is it in your notes whether or not those pills in the package was crushed or was it intact?
A I don't recall.

Q You indicated you were primarily in division 1, that was the area that you worked --
A District 1.
Q District 1?
A Yes.
Q In that role, did you often come in contact with people in district 2 and the Downtown Eastside as well?
A Yeah, well of course they move back and forth between districts.
Q So you've dealt with people, interacted with people with mental health issues?
A All the time. District 1 is full of them as well.
Q As well as those with addiction and drug issues?
A Absolutely.
Q And a combination of the two: polysubstance abuse and mental health issues?
A Absolutely.
Q You indicated you've arrested people who were in their underwear before, when they were on drugs, meth or other --
A Yeah, correct.
Q In terms of those patients with -- not those patients -- those individuals you come in contact with with mental health issues, some of them presumably are people who have committed crimes, theft, things like that?
A Yes. Yeah. People with addictions -- say people with addictions and mental health issues unfortunately are often committing a lot of small crimes to support their habits.
Q What about as victims of crimes? Do you see that often, people with mental health issues, people in the Downtown Eastside --
A I think people with mental health issues are often preyed on. That was one of our biggest complaints when they closed down, say, Riverview and that. They put everybody with mental health issues down in the skids, told them they could live in the community, and then they became preyed on and developed drug addictions, multiple drug addictions.
Q With respect to those people you come in contact with -- some of them are victims, some of them committed crimes -- people with mental health issues that you've come across as a police

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officer, you don't arrest them all and take them all in, do you?
A Sorry. So if they've committed a crime, or if we're dealing with them just as a mental health issue.
Q Well, yes, I'll come to that. So there are circumstances where you come in contact with someone who's got a mental health issue.
A Correct.
Q But you're not going to arrest them or take them in or take them to hospital.
A Not every one of them, no.
Q For example, if someone has committed a crime, you may, but if they haven't committed a crime, if they're a victim of a crime, you may not.
A Right.
Q And you're familiar with section 28 of the *Mental Health Act*?
A Yes.
Q What is that?
A It's our -- if somebody is suffering from a mental health issue and is a danger to themselves or a danger to others, then we will take them in for assessment at the hospital. We'll take them into custody.

For our part -- for our part we use that mostly when it comes to suicidal people. So people we're taking off the bridges and people that are phoning in, they're going to commit suicide, people that attempt suicide, that's what it's used for mostly for us.
Q Presumably for people you come across who have mental health issues who are very disruptive, running, and screaming in the streets?
A If they're a danger to themselves or others. So if somebody is obviously suffering from a mental health problem and they're running through traffic and they're going to get run over, certainly we'll take them into custody.
Q And if someone is suffering from mental health and not obviously a danger to himself or others, muttering to themselves, walking around the Downtown Eastside?
A No, we won't take them into custody.
Q In addition to police officers, are you familiar with the Assertive Community Treatment Program?
A No. I know they have programs at the hospital.

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I don't know what they are, though.
Q What about Car 87?
A Yes.
Q What is Car 87?
A Car 87 is a -- I want to say a psychiatric nurse that works with a police officer. We have a couple of them on the road. We'll bring them in to -- they'll get contacted by, say, other agencies or the hospital to say, "Can you check on somebody for us? We haven't seen him in a while. He's missed his meds." That kind of thing. They'll go check on that. If people, family members call in and say "My family member is having a problem, can you go check on him," they'll go check on him. If there's not a Car 87 available, then we'll go. If we need them, we'll call them.

MR. REID: Thank you. Those are my questions.
MS. KOVACS: No redirect.
THE COURT: I've got no questions either, Mr. Dewar. Thank you. Thank you very much, sir.

(WITNESS EXCUSED)

MS. KOVACS: My Lord, we had a bit of a mix-up with our next witness in terms of timing and bringing him down. I wonder if we might stand down for a moment just so I can see if he is outside. Either that or we can call him. But we've been trying to track him down and hoping that he's going to be here shortly.
THE CLERK: Why don't we have Madam Clerk have him paged? You're welcome to step out. Are you ready to proceed if he were here? Would you need a few minutes --
MS. KOVACS: I think it would be good to have a few minutes with him.
THE COURT: We'll stand down for few minutes.
MS. KOVACS: Thank you, My Lord.

(JURY OUT)

THE CLERK: Order in court. Court stands down.

(PROCEEDINGS RECESSED AT 2:30 P.M.)
(PROCEEDINGS RECONVENED AT 2:36 P.M.)

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THE CLERK: Order in court.
THE COURT: We had talked about doing that application tomorrow afternoon. Am I able to tell the jury that they'll be excused at the noon hour or at the 12:30 break?
MS. KOVACS: Or sooner, because we only have one witness tomorrow morning.
THE COURT: And the read-ins.
MS. KOVACS: Oh, yes, the read-ins. Should we do the read-ins tomorrow?
MR. MEADOWS: You can.
MR. REID: Without seeing them, I don't see any issue.
MS. KOVACS: Yeah, I think --
THE COURT: And the question I have is the afternoon is ample time for the expert report application, is it? I just want to make sure you don't run out of time.
MS. KOVACS: I think the afternoon will be ample time. We're hoping to narrow some of the issues this evening.
THE SHERIFF: The jury, My Lord.

(JURY IN)

THE COURT: Just to ensure I don't forget to tell you this, I've spoken to counsel and the morning will be occupied with various things, but you'll be free for the afternoon. Counsel and I will be dealing with a legal issue, that will take the afternoon. You won't be required for that, so you can plan tomorrow accordingly. You'll be here for 12:30 or sometime shortly before that, and then you'll be free for the afternoon.
MS. KOVACS: My Lord, the plaintiff calls her next witness, which is Mr. Michael Jacko, who is already in the witness stand.

MICHAEL JACKO, a witness called for the plaintiff, affirmed.

EXAMINATION IN CHIEF BY MS. MACKOFF:
Q Mr. Jacko, how old are you?
A 37.
Q And you are a resident of Vancouver?
A Yes.
Q I understand you witnessed some attacks in

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Vancouver on December 7th, 2012?
A Yes.
Q What were you doing on the morning of December 7th, 2012?
A I was harvesting arugula in the Pacific Concord parking lot. I sold food farms, urban farm.
Q Sold food, urban farms, you said?
A Yes.
Q And where is that farm located?
A It's not there anymore, but it was at the Pacific Concord parking lot along Pacific Boulevard.
Q If you can, in the white binder in front of you, turn to tab 31. It's a map taken from Google Maps. Is the location of the farm you were at depicted on this map?
A No, the farm -- the farm is not on the map.
Q Sorry, where the farm used to be. Are you able to identify where that would have been on the map?
A Yes.
Q Can you describe relative to other things on the map?
A Yes. Although there appears to be a laneway that's not on there, but that's where it would have been next to, kind of.
Q So is it near the Plaza of Nations where that --
A Yes.
Q Could you describe what that farm looked like when it existed, how large it was, where it was relative to the road?
A It was right along Pacific Boulevard just on the west side of Carrall Street which -- or I think it turned into a lane -- Carrall Street turned into a laneway which went right to the water, but just on the west part of that parking lot. It's kind of hard to describe. It was a really big area which is why they had an urban farm there, but there was a lot of boxes there with -- we had soil in there. We were growing organic plants. We got there relatively pretty early, try to beat the sun.
Q Was there anything in between the farm and the road?
A There were two barriers: one was a construction barrier, and then there was a fence, which was a normal fence, just to keep pedestrians from walking into the parking lot. It had, like,

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really pointy metal at the top, so you're not supposed to climb it.
Q You mentioned that you were harvesting arugula that morning?
A Yeah. I remember cutting it with the -- with my blade when I heard a scream.
Q When you heard the scream. Was that what first alerted you to the events that were happening on the street?
A It was one of the -- one of the sounds or incidents -- I can't remember if it was the first or second incident that made me look. Something alerted me at first and then actually there was a second -- and I can't remember if that was a scream now because it was a while ago.
Q So something alerted you to events that were happening on the street that seemed unusual?
A Yes.
Q And what did you do when you became aware that something was happening?
A I threw my knife down and I told my coworker that I -- what I just saw and that I was going over there real quick.
Q What is it that you saw?
A I saw a man stomping an individual's head, like full force.
Q And you said you dropped your knife and ran towards the man?
A Yeah. I immediately put down the knife. And I couldn't really explain to my coworker because it looked pretty urgent, so I threw the knife down and went between those plants or boxes we had and I took down the construction barrier, which I was familiar with, so I just ran through there real quick, threw it aside, and then I ran over to the fence. And on my way I started, kind of, like, yelling, trying to divert the attacker's attention away from that person he was attacking, and a bit it, kind of, helped him from being harmed further.
Q So you ran towards the fence and you scaled the fence?
A Yeah. I saw the pointed metal on top, but obviously the state of the victims was more concerning at that time, so I just jumped that fence right away as quickly as I could.
Q And you said "victims" plural. How many

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individuals did you see that were victims?
A There was two -- two -- two people.
Q Two people. And where were the people located relative to the fence?
A They were right on the sidewalk if I -- yeah, they were right on the sidewalk. And I couldn't tell if they were men or women at first because their faces were so swollen.
THE COURT: Because of what? I'm sorry, I just didn't hear you.
THE WITNESS: Their faces were swollen. I could only tell by -- I tried to identify them, and I just looked at the size of their feet, and then that's when I could tell that they were women.
Q Could you please turn to tab 37 of that binder? Do you recognize this document?
A Yes.
Q What is it?
A Those little ugly boxes there, like where our planter boxes were, and where that X is, the one that says "MJ," that's where I was harvesting arugula with my coworker.
Q Did you draw this diagram?
A Yes.
Q And the handwriting at the top says "December 7th," either 2:28 or 7:28 P.M. Do you remember whether it was in the afternoon or in the evening that you drew this diagram?
A I recall it happened in the morning, but my chicken scratch looks like a 2, but I think --
Q Is that your signature beneath the "2012"?
A Yes.
Q And so I understand that you -- this is from the Vancouver police file, and you drew this diagram for the police?
A Yes.
Q And the letters "MJ" point towards the X, which I believe you mentioned was in the planter boxes?
A Yes.
Q And that's where you were when -- at what point -- is that where you were?
A Yes.
Q Sorry, I ruined that question. You were located where that X is in the MJ?
A Yes.
Q And at what point was that? Was that early on when you first heard the events that that was

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your location?
A Yes, I was standing right there with my coworker. She was kneeling down and we were just talking about whatever, regular stuff.
Q And there's another X with the writing "second victim." Do you see that?
A Yes.
Q And was that where one of the victims was on the ground?
A Yes.
Q And there seems to be another X to the left and an arrow saying "first victim unconscious"?
A Yes.
Q And that would have been the second individual you're talking about?
A Yes.
Q And I believe in your description of the events, you had just gotten to the point where you had scaled the fence; correct?
A M'mm-hmm. Yes.
Q What happened after you climbed over the fence? What was going on on the road?
A There wasn't really a lot of people, and I didn't know what street I was on. I never really had to go there because there's nothing really there except the casino, which I don't gamble so -- I was just appalled at the state of the victims so I was -- I just looked at the first one who was on the side of the fence, and I remember just being in shock and I was just like -- and then I looked over at the other person, I walked over, and I was like holy -- pardon my language -- "holy shit." And I tried to identify -- and I can't remember if I called police right at that moment, or if I tried looking for that guy.
Q Where was the attacker when you were looking at the victims on the ground?
A I'm not sure right at that moment because I had -- I just -- my attention just turned to the victims, like if these people were going to live or not, so I wasn't really looking -- I knew he headed westward on Pacific Boulevard.
Q Did you follow the attacker?
A Yes.
Q Did you get close to the attacker at any point?
A I tried to maintain distance. He seemed quite dangerous.

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Q What makes you say that he seemed dangerous?
A Just the violence that I had witnessed and the fact that he was attacking two women who were older and smaller and at such full force. I don't think I've ever really witnessed violence that was that extreme, like somebody who was -- you know, it just wasn't fair. That's what -- he seemed to overpower them quite easily.
Q So you kept your distance, but you did follow the attacker?
A Yes.
Q What did you see him do next?
A He approached the car that was stopped at a red light, and he had his hands in his pocket, and he appeared calm. And then when he got close to the vehicle, because they seemed to be speaking or communicating somehow, and then that was when he began to try to break the window with his foot. He stomped that window really hard, just as hard as he did to the victim's head. So he looked like he was trying to attack that woman driver. And then, I believe, at that time the police began to show up.
Q Did you watch where the attacker went after kicking the car?
A Not too far. He began taking off all his clothes and lit a cigarette and he was just in his underwear before the police apprehended him.
Q Did you see when the police apprehended him?
A Yes. I remember he got down on the ground on his stomach, and he was throwing his hands up in the air as if he wasn't -- no harm. I remember that. That's what I saw.
Q How would you describe his behaviour while he was being apprehended?
A Well, at the time I thought he was -- I didn't know he had mental health problems, and I thought it was cowardly of him to appear as if he was no threat, because he had just committed such acts of violence against two older people who couldn't really defend themselves against him, and he expected to be treated in a different manner so -- but he didn't appear as any threat, though, when he was being apprehended. He gave up, co-operated with the police.
MS. MACKOFF: My Lord, before moving on I'd like to mark tab 37 as the next exhibit.

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THE COURT: Mr. Meadows, that's fine. Yes?
MR. MEADOWS: Yes.
THE COURT: Madam Clerk.
THE CLERK: Exhibit 33, My Lord.

EXHIBIT 33: Common Book of Documents, tab 37: 1 page, hand drawn map, 1st and 2nd victims, Vancouver Police Dept. File 12-195734, date Dec 7 2012

MS. KOVACS:
Q Mr. Jacko, could you please turn to tab 32 of that binder. What we have here are some photographs from the Vancouver police file. On page 1, do you recognize the area depicted in this photo?
A Yes.
Q Can you describe any events that happened within this area depicted?
A Yes.
Q What happened here?
A On the left side of the page under the billboard sign in the background there appears like a -- this white -- there's a bunch of polyurethane plastic over these boxes. You can't see the boxes too well, but that's what that white plastic stuff is. I was in that area when I heard -- I became aware of the violence. You can kind of see the barriers there. Like you can see the poles, the upright poles which -- so I had to dismantle a section there, which I did relatively quickly before I made my way over to the fence closer to where it says "Event Parking sign."
Q And where it says "Event Parking sign," there seems to be a yellow cone on the ground. Do you see that?
A Yes.
Q Do you know what that cone would indicate or what happened at that spot?
A I believe that was where one of the victims was lying.
Q And across the street there seems to be a series of other yellow cones. Does that indicate anything to you?
A The other victim.
Q If you flip the page, photograph -- the second

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page, photograph number 2, is that the same area that we're looking at?
A Yes.
Q And the same thing, as the cones indicate, where the two victims were?
A Yes.
Q And the third page, also the same spot where one of the victims was located?
A Yes.
Q If you flip back to your hand-drawn map at tab 37, do those yellow cones match up with where your Xs indicate the victims were?
A Yes.
MS. MACKOFF: My Lord, I'll ask that the photographs at tab 32 be marked the next exhibit.
MR. MEADOWS: No objection, My Lord.
THE COURT: Exhibit 34.
THE CLERK: Exhibit 34, My Lord.

EXHIBIT 34: Common Book of Documents, tab 32: 3 page, 1st page photograph of a Vancouver Police vehicle stopped at the exit of a parking lot and 2 Police Officers on either side of the vehicle, colour copy

THE COURT: It's not clear to me, maybe to the jury, but Mr. Jacko has described what caused him to look up and what he did, but it's not clear to me where the attacker was and which of the two victims was being attacked that he saw. I don't know if you will lead that evidence but you seem to have gone by it.
You understand what I'd like to know. I want to know what it is that you saw. You've got two victims identified. It appears from what you said that you saw one of the attacks, or did you see both?
THE WITNESS: What my brain can remember from the incident several years ago was when the -- I remember -- it looked like boxing or something. I thought it was two friends. You know how guys like, whatever, right, spar, or whatever. And I just seen somebody backing up against the car, and I just looked over and I peered -- I don't know how I was able to even notice something like that from such a distance, but I saw that, and I didn't think too much of it. I continued talking

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to my friend, and then I heard the scream, and then I looked I saw someone's head being stomped. And so when I -- when I removed the barriers, and I went over quickly, and then I saw the person through the fence, I jumped over and -- again because it's been such a long time, but I believe they were wearing a red jacket. And they were just on the ground. I would think that was the first person that I saw. It was not the first victim, it was the second victim, because I didn't even notice there was another person there because she was already lying down. I guess she was already unconscious when I was witnessing the attack. But I guess he walked over, and then he stomped that other lady, but I --
MS. MACKOFF:
Q I don't want to interrupt, but, Mr. Jacko, from your location in the farm, you said you looked up and saw the attacker punching one of the victims?
A Yeah, the punches were first.
Q And based on your map, would that be the first victim or the second victim?
A That would be the second victim.
Q And then you said you -- by the time you were scaling the fence and you looked back, he had returned to the first victim on your map?
A Yes. Let me see if I can describe that again because now it's becoming -- the time line is -- I saw the punches first, I didn't think anything. And then I guess when I was harvesting arugula again, talking to my friend, I guess that was when he probably knocked her out. And then when I looked -- I looked over and then he -- I saw him walking over to the next victim, and then he stomped her, and that was when I became alerted that there was a very violent crime that was occurring. And then that's when I made my way over.
Q Mr. Jacko, I'm going to play an audio recording. Before I get into the recording, did you call 911 at any point?
A Yeah, frantically.
Q At what point did you first call 911?
A I can't remember because at that time the intensity of the incident was just -- it just took over and then I was focussing on trying not to lose -- trying to look at the condition of the

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victims, and then trying not to lose sight of the attacker, so I can't quite remember exactly at what point I would have called 911.
Q I understand there were -- you made a couple attempts to call 911 and dropped your phone a number of times?
A Yes.
Q And at one point you did manage to get through with 911 and let them know what was happening?
A Yes.
MS. MACKOFF: Play the recording now.

(AUDIO RECORDING PLAYED)

MR. JACKO: Hello.
911 OPERATOR: It's the Vancouver Police.
MR. JACKO: Pardon.
911 OPERATOR: It's the Vancouver Police.
MR. JACKO: Yeah.
911 OPERATOR: You called 911.
MR. JACKO: Yeah.
911 OPERATOR: Okay. What's going on.
MR. JACKO: Some black dude just smashed in these people's faces at the Edgewater Casino --

911 OPERATOR: Okay. What did he do.
MR. JACKO: He beat the shit out of a couple of women, and then he attacked some traffic in the street.
911 OPERATOR: Do you know where he is right now.
MR. JACKO: He's with the police, yeah.
911 OPERATOR: Are you following him.
MR. JACKO: No, no, no. I'm walking the other way.
911 OPERATOR: Okay. Do you see the police there.
MR. JACKO: He's fucking dangerous.
911 OPERATOR: Do you know where the guy is.
MR. JACKO: Yeah, yeah, yeah.
911 OPERATOR: Where is he? Take a deep breath. Where is the guy.
MR. JACKO: He's over there. He's in his fucking underwear. He's a dangerous man.
911 OPERATOR: I know, but where is he? We are looking for him.

MR. JACKO: We need the cops right now.
911 OPERATOR: We have the police in the area. Can you tell me where this guy is? We're looking for him. Where is he.
MR. JACKO: He's in the (indiscernible) the stadium.
911 OPERATOR: He is -- is he there.
MR. JACKO: He's all (indiscernible) he's with the cops now.
911 OPERATOR: Do the police have him.
MR. JACKO: No, not yet.
911 OPERATOR: Okay. So can you tell me where he is exactly, sir.
MR. JACKO: Oh, whoa. He's surrounded now.
911 OPERATOR: He's surrounded.
MR. JACKO: They have him. They have him.
911 OPERATOR: Okay, perfect. All right. Thank you. Bye-bye.

(END OF RECORDING)

MS. MACKOFF:
Q Mr. Jacko, was that your voice on the recording?
A Yes.
Q And this phone call happened as events were unfolding?
A Yes.
Q And you hung up the phone once the attacker was apprehended?
A Yeah. Yes.
MS. MACKOFF: Those are my questions. My friend may have some questions for you.
MR. REID: No questions, My Lord.
THE COURT: Is there anything we're doing with that audio?
MS. KOVACS: We should mark the audio.
MS. MACKOFF: My Lord, if we could mark the audio as the next exhibit.
THE COURT: Exhibit 35.
THE CLERK: Exhibit 35, My Lord.

EXHIBIT 35: Black and silver USB plug, audio of 911 call of Michaeal Jacko, black felt markings

MS. KOVACS: My Lord, what I'm going to do is I'll bring a USB, if I could. We actually mistakenly

did not. It's of course on my digital mobile phone. But we'll bring it in for tomorrow morning.
THE COURT: That's just fine, yes. Thank you. Mr. Jacko, there's no other questions for you. Thank you for coming in today.
THE WITNESS: Thank you.
THE COURT: Thank you, sir.

(WITNESS EXCUSED)

MS. KOVACS: My Lord, we have one more eyewitness. Unfortunately, she's not scheduled until tomorrow morning, and because she is disabled we were not able to move her to today even though we do have a bit of time. So she'll be on first thing tomorrow at 10 A.M., and then we'll do some read-ins.
THE COURT: All right. We're done for the day. Thank you.

(JURY OUT)

THE CLERK: Order in court. Court is adjourned until Tuesday, September 10th, at 10:00 A.M.

(PROCEEDINGS ADJOURNED AT 3:04 P.M.)

REPORTER CERTIFICATION

I, Glaucia R. Fadigas de Souza, RCR, Official Reporter in the Province of British Columbia, Canada, do hereby certify:

That the proceedings were taken down by me in shorthand at the time herein set forth, and thereafter transcribed, and the same is a true and correct and complete transcript of said proceedings to the best of my skill and ability.

IN WITNESS WHEREOF, I have hereunto subscribed my name on this day, the 15th day of September 2019.

Glaucia R. Fadigas de Souza, RCR
Official Reporter