

**IN THE MATTER OF THE THOMAS R. BRAIDWOOD, Q.C.,  
COMMISSIONS OF INQUIRY UNDER THE *PUBLIC INQUIRY ACT*,  
SBC 2007, c. 9**

Room 801  
Federal Courthouse  
701 West Georgia Street  
Vancouver, B.C.

May 4, 2009

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PROCEEDINGS AT  
HEARING (DAY 46)

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Commissioner:	T.R. Braidwood, Q.C.
Commission Counsel:	A. Vertlieb, Q.C.
Associate Commission Counsel:	P. McGowan
Counsel for Zofia Cisowski:	W. Kosteckyj, S. Whiteley, S. Parhar

(ii)

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Counsel for Vancouver Airport Authority:	D. Stewart, C. Friesen; B. Ergun
Counsel for B.C. Civil Liberties Association:	G. Pastine, S. Dubinsky
Counsel for Government of Poland:	D. Rosenbloom
Counsel for Corporal Benjamin Robinson:	R. Harris
Counsel for Constable Gerry Rundel:	T. Beaubier
Counsel for Constable Bill Bentley:	D. Butcher
Counsel for Constable Kwesi Millington:	R. Hira, Q.C.
Counsel for Public Service Alliance of Canada:	C. Buchanan, B. Matthews
Counsel for City of Richmond:	J. Goulden, M. Kleisinger, G. Trotter
Counsel for TASER International, Inc.	D. Neave, J. Spencer
Registrar:	L.N. Giles
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Transcriber:	P. Neumann

Vancouver, B.C.  
May 4, 2009

1  
2  
3  
4 THE REGISTRAR: Order. The hearing is now resumed.

5 THE COMMISSIONER: Good morning, everyone.

6 MR. VERTLIEB: Good morning, Mr. Commissioner. Mr.  
7 Commissioner, just a couple of issues I'd like to  
8 address. Number one, we intend to file all of the  
9 CBC and Global and CTV outtakes for Sgt. Lemaitre  
10 and Cpl. Carr, so we'd like those to be part of  
11 the record.

12 Secondly, the witness we wanted to start out  
13 with this morning, Superintendent Rideout, came by  
14 this morning and he brought some notes relating to  
15 the media issues and his briefing. Obviously just  
16 seeing those notes this morning, none of our  
17 colleagues and counsel for the various  
18 participants have seen those and they need some  
19 time to consider them. As well, when I sat with  
20 Superintendent Rideout, he informed me that there  
21 are some e-mails around this media issue that he  
22 did not bring with him. And I'm not criticizing  
23 him at all, but he didn't have them. And because  
24 of the importance of the area, I don't think it's  
25 appropriate that we start with Superintendent  
26 Rideout knowing he doesn't have the e-mail  
27 information that we require, and my friends have  
28 not had opportunity to see his handwritten notes  
29 that relate to a briefing that took place October  
30 15.

31 So what I'd like to do is just inform you  
32 that we've asked Superintendent Rideout to get  
33 those e-mails and collect them, and it may take  
34 him some time to bring them together. And so we  
35 don't wish to have him called as the first witness  
36 right now. We would like to have him come once  
37 that information is available and everyone's had a  
38 chance to see it.

39 Secondly in connection with this subject,  
40 you'll recall last week my friend, Ms. Roberts,  
41 made a submission to you about Superintendent  
42 Rideout's evidence. And I regret - and it's my  
43 error entirely - the request to speak to you by  
44 Ms. Roberts was sent to me by e-mail and never  
45 sent out to the to the other participants. And in  
46 the normal course, any of the requests that  
47 counsel have had, people have been present in the

1 courtroom and they would know it. And in this  
2 case, for example, Mr. Rosenbloom had no notice,  
3 didn't know it was going to happen, wasn't here  
4 because of it, and he's said that he'd like to  
5 make a submission to you on it. We accept that.  
6 That's totally because of our handling of it, or  
7 mishandling of it.

8 So Mr. Rosenbloom wants to speak to you about  
9 it. I'm not sure if Mr. Kosteckyj or others have  
10 any further comments to make. But the fact is  
11 that the lawyers other than Ms. Roberts and your  
12 counsel didn't really know that was coming.

13 THE COMMISSIONER: Well, certainly if there was no  
14 notice, we'll have to argue it again.

15 MR. VERTLIEB: And so we're happy if that be done now.  
16 I've told Superintendent Rideout that we're not  
17 going to call him at this point in time. And the  
18 only thing I did ask is that he await any ruling  
19 you might make concerning the case so that he will  
20 know to bring back all the necessary  
21 documentation.

22 THE COMMISSIONER: Yes. Well, all right. Thank you  
23 very much.

24 MR. VERTLIEB: Thanks, Mr. Commissioner.

25 THE COMMISSIONER: These things happen. We've moved  
26 along quite smoothly and I'm very pleased with the  
27 way everything has gone. But if there's no  
28 notice, of course, we'll have to hear this motion  
29 again.

30 MR. ROSENBLOOM: Hearing this motion again, Mr.  
31 Commissioner, does that mean you wish Ms. Roberts  
32 to speak first?

33 THE COMMISSIONER: Well, you have to know what you're  
34 answering.

35 MR. ROSENBLOOM: Indeed, I do.

36 THE COMMISSIONER: I guess so. Ms. Roberts, I'm sorry.  
37 I think we'll have to do it again.

38 MS. ROBERTS: For the record, Helen Roberts for the  
39 Government of Canada.

40 Mr. Commissioner, this was not an application  
41 and it's for that reason no notice was given.

42 This was simply asking for some guidance on what  
43 you felt was relevant to the proposed testimony of  
44 Superintendent Rideout. It was not my intention  
45 to mislead or leave anybody out. It was simply a  
46 request for guidance and that's all it was.

47 THE COMMISSIONER: Oh, nobody is suggesting that.

1 MS. ROBERTS: I'll just then go through the same  
2 submission more or less as I did on Thursday  
3 afternoon.

4 THE COMMISSIONER: Yes, please.

5

6 SUBMISSIONS FOR THE GOVERNMENT OF CANADA:

7

8 MS. ROBERTS: Thank you. Commission counsel has asked  
9 Canada to produce Superintendent Wayne Rideout,  
10 who was the officer in charge of the Integrated  
11 Homicide Investigation Team during the  
12 investigation of Mr. Dziekanski's death.

13 Commission counsel advised us they wish to  
14 question Superintendent Rideout about four  
15 matters. The first was the decision not to  
16 immediately correct some inaccurate information  
17 given by the media relations officers to media  
18 agencies. The second was the decision as to when  
19 Mr. Pritchard's video was returned to him. The  
20 third was the decision not to re-interview the  
21 four RCMP members about differences between their  
22 statements and the Pritchard video. The fourth  
23 was whether Superintendent Rideout was the person  
24 responsible for these three decisions.

25 Canada has a question as to whether you  
26 believe this evidence would be relevant to your  
27 mandate, which is focused on how Mr. Dziekanski  
28 died, not what RCMP members and officers did after  
29 the death.

30 Superintendent Rideout, as the officer in  
31 charge of IHIT, supervised all the IHIT teams,  
32 including the team that investigated Mr.  
33 Dziekanski's death. That team was led by Sergeant  
34 Attew. Superintendent Rideout did not interview  
35 any of the four RCMP members. He did not meet any  
36 of the four RCMP members. He did not attend the  
37 first briefing that IHIT had on October 14th,  
38 2007. He has no first-hand knowledge of the  
39 circumstances of Mr. Dziekanski's death.

40 With respect to the four proposed topics,  
41 first with respect to the media relations decision  
42 not to correct the inaccurate information.  
43 Corporal Dale Carr already testified that  
44 Superintendent Rideout made the decision not to  
45 have the media relations officers discuss the  
46 evidence, including not correcting some errors, in  
47 order to protect the integrity of the IHIT

1 investigation. You already have that evidence,  
2 and my submission was that having Superintendent  
3 Rideout confirm it would be simply repetitive.  
4 Inquiring further into the reasons for the  
5 decision, I respectfully suggest, does not fall  
6 within the mandate of the Commission.

7 The second topic that was proposed was the  
8 return of Mr. Pritchard's video. Superintendent  
9 Rideout already publicly addressed the return of  
10 Mr. Pritchard's video in a news conference on  
11 December 12th, 2008, right after the provincial  
12 Crown counsel announced their decision. The text  
13 of that press conference is available on the RCMP  
14 website and available to the public. During that  
15 press conference, Superintendent Rideout said the  
16 following.

17 There were two key reasons why the  
18 investigation team wanted to hold on to Mr.  
19 Pritchard's video. The first was because it  
20 contained valuable evidence. Our second reason  
21 for retaining the video was to protect the  
22 integrity of witness statements. It was important  
23 that their recollections be based on what they had  
24 actually observed, and not what they might have  
25 seen on the video. Three weeks after the video  
26 was obtained, the Coroner had declared that he had  
27 no further need of it. At this point in the  
28 investigation there was no statutory authority  
29 under the **Criminal Code** to keep the video and as  
30 such it was returned to Mr. Pritchard on November  
31 7th, 2007.

32 With regard to the third proposed topic, and  
33 that was the decision not to re-interview the four  
34 RCMP members, I advised you, Mr. Commissioner, on  
35 Thursday afternoon that I did not yet have  
36 instructions as I had only become aware of that  
37 proposed topic Monday last week. Given your  
38 ruling on Thursday afternoon, I did not follow up  
39 to get instructions on that topic and am still  
40 before you saying I have no instructions.

41 As for the fourth topic as to who made these  
42 decisions, I have confirmed that Superintendent  
43 Rideout was the person who was responsible for the  
44 decisions in question, that is the decision to  
45 stop the media relations officers from discussing  
46 the evidence and correcting any errors and the  
47 decision as to when Mr. Pritchard's video was

1 returned.

2 You will recall that I made a somewhat  
3 similar submission prior to producing Sergeant  
4 Lemaitre and Corporal Carr. At that time I  
5 believe you indicated you were uncertain as to the  
6 relevance of their testimony, and given that  
7 uncertainty you were unable to say that their  
8 evidence would not be relevant. When Sergeant  
9 Lemaitre and Corporal Carr testified, it is my  
10 recollection that on a number of occasions you  
11 indicated that it was difficult to see the  
12 relevance of certain testimony.

13 I appear before you to again question the  
14 relevance of any testimony about RCMP media  
15 statements, especially given that Superintendent  
16 Rideout would simply be confirming evidence that  
17 you have already heard.

18 As to the second topic, Mr. Pritchard's  
19 video, it is difficult to understand how the  
20 timing of the return of an exhibit could be  
21 relevant to determining the circumstances of Mr.  
22 Dziekanski's death. The RCMP, by way of  
23 Superintendent Rideout, already provided a public  
24 explanation. There doesn't seem to be any point  
25 in having them repeat that explanation.

26 With respect to the third topic, again I have  
27 no instructions. And with respect to the fourth  
28 topic, yes, Superintendent Rideout was responsible  
29 for these decisions.

30 Once again I stand before you to ask whether  
31 you believe this proposed testimony would be  
32 helpful to you in writing a report about the  
33 circumstances of Mr. Dziekanski's death, and once  
34 again I am here to tell you that if you say yes,  
35 Canada will voluntarily produce Superintendent  
36 Rideout to testify about the media relations  
37 officers and the Mr. Pritchard video return, and  
38 to identify himself as the person responsible.  
39 And that would all be in accordance with Canada's  
40 voluntary participation in the inquiry generally  
41 and its support for the inquiry's work.

42 And those were roughly the submissions that I  
43 made Thursday afternoon.

44 THE COMMISSIONER: Thank you very much.

45 MR. ROSENBLUM: Thank you very much, Mr. Commissioner,  
46 for affording me the opportunity to make a  
47 representation in respect to this matter.

Submission by Mr. Rosenbloom (for Government of the Republic of Poland)

1 SUBMISSIONS FOR THE GOVERNMENT OF THE REPUBLIC OF  
2 POLAND:

3  
4 MR. ROSENBLOOM: My friend and I have very differing  
5 views in respect to the relevance of the issue and  
6 we have very differing views as to your  
7 empowerment under your terms of reference to look  
8 into these issues.

9 Mr. Commissioner, Canadians have been very  
10 troubled by the actual incident at YVR. But  
11 they've equally been disturbed by the aftermath  
12 handling of this matter by the RCMP. And what I  
13 speak about when I speak of aftermath is the  
14 misinformation. I speak of the suppression of the  
15 video, and I will come back to that in a moment,  
16 of the release of the video. And I speak of the  
17 quality of the investigation that was carried out  
18 by the RCMP subsequent to the incident, and in  
19 particular I focus on the issue of the RCMP  
20 choosing never to show the video to the four  
21 attending officers so that they might reconcile  
22 the video with their statements as given right  
23 after the incident.

24 Now, in respect to your terms of reference, I  
25 see it very differently. As I read your terms of  
26 reference -- and I speak to paragraph 4(2) and it  
27 reads in part:

28  
29 The terms of reference of the inquiries to be  
30 conducted by the hearing and study commission  
31 under section 2(2) are as follows:

32  
33 (b) to make a complete report of the  
34 events and circumstances of and relating  
35 to Mr. Dziekanski's death, not limited  
36 to the actual cause of death  
37

38 I emphasize that you are empowered by the terms of  
39 reference, as I see it, to give a complete report  
40 to the Canadian nation in respect to events and  
41 circumstances of and relating to Mr. Dziekanski's  
42 death, not limited to the actual cause of death.

43 And that being the case, I suggest to you  
44 that it is well within the power of this inquiry  
45 to investigate not only the cause of death and the  
46 actual incident at YVR but the circumstances  
47 relating to the incident, and those circumstances

1 relating to the incident include the issues of  
2 misinformation, the issue of suppression of the  
3 video - as I allege it, and I will speak to this  
4 in a moment - and certainly as to the quality of  
5 the investigation carried out and signed off by  
6 the IHIT investigators.

7 Now, I drew to the attention of the  
8 Commission some time ago an affidavit that I had  
9 prepared for these proceedings in respect to the  
10 Pritchard video. That affidavit is an affidavit  
11 of Paul Pearson, a criminal lawyer in Victoria who  
12 represented Mr. Paul Pritchard shortly after this  
13 incident and after Mr. Pritchard was informed by  
14 the RCMP, according to Mr. Pritchard's affidavit  
15 filed in these proceedings, that he would not  
16 receive or have returned the video for  
17 approximately one and a half to two and a half  
18 years.

19 This was in spite of the fact that at the  
20 time that he voluntarily gave up the video at the  
21 scene of the incident, he had been informed by the  
22 RCMP he would get the video back within an hour or  
23 two.

24 He then retained counsel, Mr. Pearson. Mr.  
25 Pearson prepared an affidavit and I supplied this  
26 affidavit to Commission staff approximately a  
27 month ago. In any event, that affidavit was then  
28 circulated to all counsel and I assume everybody  
29 is familiar with it. And I will be seeking to  
30 file this affidavit as it speaks to the issue of  
31 the suppression of the video.

32 Mr. Pearson in his affidavit indicates that  
33 he sent a demand letter to the RCMP on October the  
34 19th, which is what, five days after this  
35 incident, demanding the return of the video; that  
36 on October 22nd, he was informed by Constable  
37 Mulhall that the video would be returned shortly.  
38 And then in a telephone call message left in his  
39 voice mail, Mr. Pearson attests to the fact under  
40 oath that Corporal Mulhall called back to say that  
41 the RCMP had changed their decision and that they  
42 were not returning the video.

43 That led to a writ being issued in the B.C.  
44 Supreme Court in the Victoria Registry on October  
45 the 25th, and the writ was served October 30th,  
46 which led to the video eventually being returned  
47 to the lawful owner, Mr. Pritchard, on November

1 the 7th.

2 This business of the video being retained by  
3 the RCMP -- let me make this very clear to you,  
4 Mr. Commissioner. I don't think anyone in this  
5 room denies the position that the RCMP takes that  
6 that video had material evidence on it. It's  
7 pretty obvious to all of us as we worked our way  
8 through this inquiry.

9 The issue isn't the seizure of the video. It  
10 wasn't seized. It was provided by Mr. Pritchard  
11 on consent, and that consent was based upon its  
12 immediate return after copies were made. The  
13 issue here which I invite you to consider for  
14 investigation at this inquiry, for review at this  
15 inquiry, is whether or not it was appropriate for  
16 the police to inform Mr. Pritchard at a point in  
17 time shortly after this incident that he would not  
18 have the tape returned for a period of one and a  
19 half to two and a half years.

20 This, I suggest to you, is a matter in the  
21 public interest. It is a matter for your  
22 consideration as to appropriate conduct by the  
23 RCMP in this regard, as much so as the issue of  
24 misinformation to the public, which is also a  
25 matter of -- an aftermath from the incident  
26 itself, as well as the issues of the quality of  
27 the investigation and the appropriateness of the  
28 RCMP to sign off on their IHIT report without ever  
29 approaching the four attending officers to review  
30 the tape and then reconcile what they saw on the  
31 tape with their statements.

32 I therefore make this application that the  
33 inquiry allow this aspect of the aftermath or the  
34 after-events of the incident to be reviewed in  
35 testimony and to afford counsel the opportunity to  
36 cross-examine Superintendent Rideout in respect to  
37 these matters.

38 I believe other counsel have comments to  
39 make. Thank you.

40 MR. KOSTECKYJ: I agree with my learned friend, Mr.  
41 Rosenbloom, and I won't add to his argument beyond  
42 this.

43 That restoration of faith in the justice  
44 system in respect to this matter: the RCMP were  
45 the first --

46 THE COMMISSIONER: I have to interrupt you. I have a  
47 great deal of trouble with the use of the word

1 "justice system."

2 MR. KOSTECKYJ: And I appreciate that. The point is, I  
3 guess, more simply this. That the RCMP are a  
4 valued organization in the Canadian fabric, that  
5 much has been tarnished based upon how the public  
6 perceives the dealing of the video and some of the  
7 other matters that involve the investigation.  
8 That in my respectful submission, I, along with  
9 Mr. Rosenbloom, believe that those matters ought  
10 to be examined and that the parameters that are  
11 set out in the terms of reference would allow  
12 that, as my friend has pointed out.

13 THE COMMISSIONER: Yes, Ms. Roberts.

14 MS. ROBERTS: I appreciate the concerns expressed by  
15 Mr. Rosenbloom and Mr. Kosteckyj about public  
16 questions about these matters, the return of Mr.  
17 Pritchard's video, how the investigation was  
18 conducted. However, I would like to remind them  
19 that there is ongoing an investigation by the  
20 Commission for Public Complaints Against the RCMP  
21 which will no doubt address these questions and  
22 produce a public report that will be distributed  
23 to Canadians and will be available to those in  
24 Poland as well. So it is not as if this is the  
25 only opportunity for the public to find out how  
26 those matters took place.

27 THE COMMISSIONER: Ms. Roberts, if I understood you on  
28 this point 3 - that is the failure to re-interview  
29 the four officers and to show them the video - as  
30 I understand your submission to me, Mr. Rideout  
31 had absolutely nothing to do with that.

32 MS. ROBERTS: Superintendent Rideout was in charge of  
33 all of IHIT. He was not the investigator on this  
34 file. He may have been consulted on that  
35 decision. He may not have. I do not have  
36 instructions on that. Normally the team commander  
37 would make decisions as to who is interviewed and  
38 when. And for that matter, none of the other  
39 witnesses were re-interviewed in view of the  
40 video. In other words, it just wasn't done in  
41 this particular case. That goes to how IHIT  
42 investigates matters.

43 MR. KOSTECKYJ: I know it's unusual to be allowed to  
44 rise again, but Superintendent Rideout was an  
45 active member of the investigation in the sense  
46 that we know that he attended to interview the  
47 witnesses in Poland. That would have required him

1 to review the file in order to be able to conduct  
2 those interviews. So my recollection is that  
3 Superintendent Rideout was the individual sitting  
4 in the investigation asking the questions. So he  
5 was an active investigator in respect to this  
6 matter.

7 MS. ROBERTS: That's in fact correct. I was speaking  
8 of the earlier stage that we were talking about,  
9 the return of Pritchard and the interviewing of  
10 the RCMP members.

11 THE COMMISSIONER: All right. I am very, of course,  
12 interested in the citation of my exact terms of  
13 reference. I don't have the words before me, but  
14 counsel has used the word "the circumstances of  
15 and relating to," and I think that is an important  
16 consideration.

17 I confirm my ruling on point 1.

18 With reference to point 2, the video release  
19 and its timing, now having heard these submissions  
20 and the term of reference pointed out, and indeed  
21 having regard to other evidence that has been  
22 called, I am of the opinion that I must change  
23 what I said before and allow cross-examination on  
24 point 2.

25 However, on point 3, I maintain what I  
26 thought before. I do not want to move into an  
27 investigation as to the conduct of the police in  
28 terms of their inquiry into this matter. That  
29 topic would know no borders and there would be no  
30 way to draw a line that makes any sense with  
31 reference to investigating how the RCMP  
32 investigated this matter. I do not think that  
33 that should be included in my terms of reference.  
34 And so I will not allow cross-examination on that  
35 part.

36 But I will on parts 1 and 2. And part 4 is  
37 pretty much irrelevant now. We have heard the  
38 fact that it was the superintendent's decision.

39 So Mr. Vertlieb, where does that leave us?

40 MR. VERTLIEB: I think what we'll try to do is see if  
41 we can get Officer Rideout back for Wednesday,  
42 which was a day we had for RCMP evidence on some  
43 policy issues. I'll speak with Ms. Roberts about  
44 that.

45 We have Dr. Lu, who was scheduled to be here  
46 for 11:30 to give evidence to you. We've asked  
47 him to come down as soon as he can.

1                   So we're pretty much on schedule. We'll lose  
2                   a bit of time. I'm sorry about that. But if we  
3                   could just stand down, and as soon as Dr. Lu is  
4                   ready to go, we'll let you know through Mr. Giles  
5                   and we'll start back.

6                   THE COMMISSIONER: Thank you very much.

7  
8                   (PROCEEDINGS ADJOURNED)  
9                   (PROCEEDINGS RECONVENED)

10  
11                   MR. VERTLIEB: Thank you, Mr. Commissioner. Dr. Lu is  
12                   here.

13                   Mr. Butcher, on behalf of his client and I  
14                   think for the other three RCMP, has asked that two  
15                   witness statements taken by the RCMP in Poland  
16                   also be marked, and we have no objection. These  
17                   are the two people that we would have -- that we  
18                   had thought about calling when we were doing the  
19                   Polish cases. So one person's father, I think,  
20                   had a stroke and so she couldn't come, and then  
21                   the other was the stepson and there was some  
22                   concerns about his health issue. But we have no  
23                   objection to those being marked.

24                   THE COMMISSIONER: Anybody have any problem with that?

25                   MR. VERTLIEB: Thank you.

26                   MR. BUTCHER: I'm going to bring copies of those  
27                   documents this afternoon. It's being brought up  
28                   at this point because Dr. Lu makes reference to  
29                   having reviewed those documents in his report.  
30                   There are some other documents that are reviewed  
31                   in his report that I might also ask to be marked,  
32                   but I'm going to discuss those with Commission  
33                   counsel over the break.

34                   MR. VERTLIEB: So next, then, is Dr. Shao-Hua Lu. Dr.  
35                   Lu, would you please come forward.

36                   THE REGISTRAR: Good morning, sir. Before you are  
37                   seated, do you wish to be sworn or affirmed?

38                   THE WITNESS: Affirm.

39                   THE REGISTRAR: Affirm.

40  
41                   DR. SHAO-HUA LU, a witness,  
42                   affirmed.

43  
44                   THE REGISTRAR: Would you state your full name, please.  
45                   A     S-h-a-o-dash-H-u-a, last name L-u.

46                   THE REGISTRAR: Thank you. You can be seated.  
47                   Counsel.

12

Dr. Shao-Hua Lu

In chief on qualifications by Mr. Vertlieb

1 MR. VERTLIEB: Thank you, Mr. Giles.

2

3 EXAMINATION IN CHIEF ON QUALIFICATIONS BY MR. VERTLIEB:

4

5 Q Dr. Lu, thank you for being here with us this  
6 morning. We have already filed your report that  
7 you prepared at the request of Corporal  
8 Brassington of the Integrated Homicide  
9 Investigation Team, and that's Exhibit 77.

10 Let me just take you through your background.  
11 You are a psychiatrist, and I know to be highly  
12 regarded in your field and practising here in  
13 Vancouver.

14 A Thank you.

15 Q Your background; just tell us where you studied  
16 your specialty training in psychiatry, and tell us  
17 what you do presently in our community.

18 A I am a psychiatrist. I have my initial internship  
19 training in Dalhousie University, completed my  
20 psychiatry residence in University of Ottawa. I  
21 also have one year clinical fellowship at Harvard  
22 for addiction psychiatry. I am currently on staff  
23 at Vancouver General Hospital. I specifically  
24 provide consultation, liaison, psychiatry care to  
25 medical and surgically ill patients. And I have  
26 treated patients with delirium, alcohol withdrawal  
27 and other types of medically related psychiatric  
28 condition for the past ten years.

29 Q And you're in active practice at Vancouver  
30 Hospital and you see people on a regular basis for  
31 clinical treatment?

32 A Yes.

33 MR. VERTLIEB: Thank you. I don't think there's doubt,  
34 Dr. Lu, about your credentials in the field of  
35 psychiatry, and we're going to ask you to provide  
36 some opinions.

37 I have nothing else, Mr. Commissioner, to  
38 take the doctor through.

39 THE COMMISSIONER: Well, I'd like to have him  
40 qualified. What do you suggest he's qualified, in  
41 what area?

42 MR. VERTLIEB: In the field of psychiatry, and in this  
43 case he's going to speak about Mr. Dziekanski's --  
44 his observations of Mr. Dziekanski based on some  
45 written material and observing the video. I don't  
46 know if there's any dispute about his  
47 qualifications.

1 THE COMMISSIONER: Ms. Roberts.

2 MS. ROBERTS: I have no questions about that, but is --  
3 his qualifications also indicate that he's an  
4 expert in addiction medicine, and I think there  
5 may be questions directed to that, so I would  
6 suggest he also be qualified as an expert in  
7 addiction medicine.

8 MR. VERTLIEB: I think he mentioned his background in  
9 that field.

10 THE COMMISSIONER: All right. I accept that the doctor  
11 will be accepted to qualify in those two areas.

12 MR. VERTLIEB: Thank you, Mr. Commissioner.

13

14 EXAMINATION IN CHIEF BY MR. VERTLIEB:

15

16 Q Dr. Lu, the RCMP asked you to provide an opinion  
17 in this case, and they gave you written material  
18 that's reflected in your report, Exhibit 77?

19 A Yes, and I list the documentations that were  
20 provided to me that -- and I have reviewed for the  
21 purpose of my report.

22 Q Okay. You have never spoken to any of the people  
23 involved as principal players in this event?

24 A No.

25 Q So all the material that you've had has been  
26 written material and that's outlined extensively  
27 in your report?

28 A Correct.

29 THE COMMISSIONER: Now, just a moment, not the video?

30 MR. VERTLIEB: I was going to come to that. That's  
31 fine, Mr. Commissioner.

32 Q So you've seen witness statements that were  
33 written down at different times --

34 A Yes.

35 Q -- and sent to you. You also, and I know your  
36 report's extensive, you watched what's known as  
37 the Pritchard video?

38 A Correct.

39 Q And you saw the three segments of Mr. Pritchard's  
40 video?

41 A Correct.

42 Q I don't believe, though, you saw any of the YVR  
43 videos that were taken, the Airport videos?

44 A If it's not listed in my report, then I have not  
45 seen it.

46 Q Right. We have had the benefit of -- and I don't  
47 think they were available to you then, the

14  
Dr. Shao-Hua Lu  
In chief by Mr. Vertlieb

1 Vancouver Airport has cameras at different  
2 portions of the airport and they have brought  
3 videos and we've seen those extensively. We  
4 recognize that everything you've seen is in your  
5 report.  
6 A Yes.  
7 Q Okay. And since writing your report, and it's  
8 dated April 9, 2008, you haven't done any further  
9 work on this case?  
10 A No.  
11 Q So you haven't been updated in any way with  
12 further information, further medical reports, you  
13 haven't been asked to reconsider any part of the  
14 opinion you gave; is that fair?  
15 A No.  
16 MR. VERTLIEB: Okay.  
17 MR. HIRA: There's a report dated July the 3rd, Mr.  
18 Vertlieb.  
19 MS. ROBERTS: There's also reference to the YVR video  
20 under point number 6 in his report.  
21 MR. VERTLIEB: Well, okay.  
22 A It's been over a year so I don't quite remember  
23 some of the --  
24 MR. VERTLIEB: That's fine, Dr. Lu, don't you worry  
25 about that. We will make sure --  
26 THE COMMISSIONER: Yes, I see that on page 4 under 6.  
27 A Yes, the July 3rd information -- yes, I review  
28 further information, that's right, from the  
29 witnesses listed on my July 3rd, 2008 report.  
30 MR. VERTLIEB:  
31 Q Okay. We just have that here, and this is to take  
32 into account some people who lived in Poland that  
33 were interviewed after your report?  
34 A That's right.  
35 Q Okay. We'll mark that, then, as the next exhibit,  
36 please. It's a report July 3, 2008, and that's  
37 taking into account five people who lived in  
38 Poland and had some commentary about Mr.  
39 Dziekanski; is that correct?  
40 A Correct.  
41 MR. VERTLIEB: Fine, okay.  
42 THE COMMISSIONER: All right, next exhibit.  
43 MR. VERTLIEB: Thank you.  
44 THE REGISTRAR: That will be marked as Exhibit number  
45 118.  
46 MR. HIRA: May I suggest 77A so you have them together.  
47 THE COMMISSIONER: Well, the difficulty is it puts the

15  
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1 book out. No, it will stay as mentioned.  
2 MR. VERTLIEB: 118, thank you, Mr. Commissioner.  
3

4 EXHIBIT 118: Dr. Lu letter to Cpl. Derek  
5 Brassington dated July 3, 2008  
6

7 MR. VERTLIEB:

8 Q Now, Dr. Lu, you had been given material and you  
9 relied on what you read, is that a fair summary,  
10 and relied on what you watched?

11 A Yes.

12 Q Now, I wanted to just to highlight just a couple  
13 of things in your report, and I want to leave time  
14 for my colleagues to ask you questions. Number  
15 one, the subject of DTs, delirium tremens, you'd  
16 addressed that in your report. Your conclusion  
17 about Mr. Dziekanski and the subject of delirium  
18 tremens, which we all know from as laypeople that  
19 that's dealing with alcohol, what's your opinion  
20 about that, sir?

21 A Based on the information that was provided, there  
22 wasn't sufficient information to really consider  
23 whether or not Mr. Dziekanski had delirium  
24 tremens.

25 Q Thank you. Now, let's just talk briefly about  
26 excited delirium while we have you here. You deal  
27 with that in your report. A number of times  
28 during this inquiry we've had the term "excited  
29 delirium" discussed. What's your view of that  
30 term? You're a psychiatrist. Tell us what you  
31 say about the term "excited delirium".

32 A I previously mentioned in the Phase 1 of the  
33 Braidwood Report that excited delirium is not a  
34 term that we use in a medical sense. Certainly  
35 excited delirium is not a term that we recognize  
36 in the DSM-IV, for example. Delirium is a medical  
37 syndrome. It's not a disease in and of itself.  
38 Delirium is a reflection of underlying  
39 physiological changes that individuals are  
40 medically ill might present, or may be acutely or  
41 in a more chronic sense. For most individuals  
42 with delirium, they often, not always, present in  
43 an agitated manner. So agitation can be  
44 considered part and parcel of delirium. But  
45 excited delirium as a disease entity is not  
46 something that I recognize or have been taught or  
47 practice in a clinical setting.

- 1 Q And you're saying then to the Commissioner that  
2 agitation may or may not be a symptom of the  
3 underlying problem, which may be delirium.
- 4 A For large, for most part, individuals with  
5 delirium demonstrate aspects of agitation during  
6 the course of that symptom.
- 7 Q Now, since you presented to Commissioner Braidwood  
8 last year on excited delirium, you've continued to  
9 maintain that view that you expressed to the  
10 Commissioner just a moment ago about the merit of  
11 the term "excited delirium"?
- 12 A Yes.
- 13 Q Are you then telling the Commissioner that you  
14 don't die from excited delirium?
- 15 A Well, people can die from the underlying cause  
16 that creates delirium.
- 17 Q Right.
- 18 A So to give an example, an individual with high  
19 fever as a result of an infection, dies from the  
20 infection, not from the fever. Fever is merely a  
21 symptom of the underlying infection. Delirium is  
22 the symptom of some underlying condition, whatever  
23 that condition might be. So one doesn't die from  
24 a fever, any more than one dies from delirium.  
25 But delirium is a reflection of an underlying  
26 medical dysregulation and function.
- 27 MR. VERTLIEB: Thank you. Now, just so we're clear,  
28 the translation prepared by Kris Barski, marked  
29 Exhibit 33, you did not have that. Mr. Giles,  
30 would you show that to the witness just so he can  
31 confirm it for us, Exhibit 3-3, sir.
- 32 Thanks, Mr. Giles.
- 33 Q Dr. Lu, you've had a chance to look at this  
34 shortly before coming to give evidence this  
35 morning?
- 36 A Yes.
- 37 Q And this information was not available to you at  
38 the time you prepared your reports?
- 39 A No.
- 40 Q Does this exhibit give you any sense of delirium,  
41 the existence of delirium on the part of Mr.  
42 Dziekanski? In other words, are his responses  
43 apparently appropriate?
- 44 A The responses provided certainly indicate an  
45 individual who is not happy with his situation.  
46 It's -- it does not help to rule out delirium, nor  
47 does it rule in delirium. It stands on its own.

Dr. Shao-Hua Lu

In chief by Mr. Vertlieb

Cross-exam by Mr. Kosteckyj (for Zofia Cisowski)

1           Certainly individuals who are in a state of  
2           delirium can respond to questions and respond in a  
3           similar fashion, but it does not necessarily show  
4           Mr. Dziekanski being disorganized.

5           Q     Delirium is a cognitive issue?

6           A     Yes.

7           Q     Okay. Your opinion is based on the information  
8           you were given?

9           A     Correct.

10          Q     You have not been paying -- you have not been  
11          reading the transcripts of the evidence as it's  
12          unfolded here at the inquiry?

13          A     No.

14          Q     Do you have a general -- have you been generally  
15          following it in the media in terms of what type of  
16          commentaries being made by witnesses here at the  
17          inquiry?

18          A     Actually, not really.

19          Q     Okay. All right. Well, then, that's very  
20          helpful. We have your opinion and, as I say, I  
21          want to leave time for others to question you.

22          Thank you very much, Dr. Lu.

23          A     Thank you.

24

25          CROSS-EXAMINATION BY WALTER KOSTECKYJ ON BEHALF OF

26          ZOFIA CISOWSKI:

27

28          Q     Doctor, my name is Walter Kosteckyj. I am counsel  
29          for Zofia Cisowski. Doctor, I take it that  
30          delirium is a difficult thing to determine that  
31          somebody has.

32          A     It can be; depends on the circumstance. In some  
33          circumstances fairly readily available in terms of  
34          the diagnosis. Sometimes it can be quite easily  
35          determined. If, for example, you know, when I get  
36          asked to go up to the medical surgical unit and,  
37          you know, somebody who is sort of post-cardiac  
38          surgery, if they behave in a certain way, the  
39          diagnosis of delirium can occur pretty rapidly.  
40          On the other hand, in this particular incident,  
41          the determination is not 100 percent  
42          straightforward.

43          Q     It's difficult to determine whether someone has  
44          delirium when you're not in a clinical setting; is  
45          that -- is that fair?

46          A     Well, yes, that would be a fair thing to say.

47          Q     All right. And now there are issues in respect of

1 Mr. Dziekanski that you have now become aware of?  
2 You were aware that he didn't have a chance to  
3 sleep for some period of time before he travelled?  
4 A That's one of the assumptions that I made.  
5 Q Right.  
6 A Based on the -- as the facts and assumptions that  
7 I lay out for my report.  
8 Q Now, people who don't sleep can be moody, correct?  
9 A Correct.  
10 Q They can be irritable?  
11 A Correct.  
12 Q They can act quite unreasonably sometimes.  
13 A And here is the -- the understanding of delirium,  
14 because delirium is not an on and off. It's not,  
15 you know, you are pregnant or not pregnant, which  
16 is either positive or negative, one can't be half  
17 pregnant, whereas delirium is a continuum of  
18 syndromes. Sleep deprivation, for example, for  
19 elderly individuals who have medical conditions,  
20 even brief sleep deprivation, because they have  
21 pain and surgery, can precipitate gradual onset of  
22 delirium. So if you keep somebody who is  
23 relatively healthy and they don't have sleep for,  
24 I don't know, 36, 48 hours, the mental change that  
25 you describe, that irritability, moodiness, can  
26 herald the beginning of delirium.  
27 Q But at the same time it doesn't mean you're  
28 delirious, either, if you're irritable, does it,  
29 sir?  
30 A It is -- it's not 100 percent, no.  
31 Q No. So if someone doesn't sleep for a long period  
32 of time they can be irritable, they could be  
33 difficult to deal with and they can even seem  
34 unreasonable, but it doesn't mean that they're  
35 delirious, does it?  
36 A Correct.  
37 Q All right. Now, for someone that's delirious, and  
38 would you expect that they'd be able to follow  
39 instructions?  
40 A Yes.  
41 Q All right.  
42 A Individuals -- again, it depends on the degree.  
43 So give -- to give you an excellent example:  
44 recently, as little as a week ago, it's a 77-year-  
45 old gentleman, post-cardiac surgery, who is quite  
46 delirious, believed that the nurses are trying to  
47 kill him, and that the doctors are trying to kill

1 him and that he is -- he is in some nefarious  
2 place. I went in there and talked to him, and but  
3 in a calm voice, he's able to follow directions,  
4 he's able to take his medications. So even for  
5 somebody who is in a highly agitated and clearly  
6 delirious state that is not in question, that  
7 individual can still follow directions, depending  
8 on the circumstance and their response. So  
9 somebody who is in a state of delirium doesn't  
10 completely render them incapable of following  
11 instructions.

12 Q Yes. But in this particular case, you didn't have  
13 any indication that Mr. Dziekanski thought people  
14 were trying to kill him before the time that the  
15 Taser was pulled out, correct?

16 A But that's not the question you asked me. You  
17 asked me is can somebody who has delirium follow  
18 directions, and I'm just responding --

19 Q Okay.

20 A -- to the questions that you posed to me, sir.

21 Q All right. But in terms of in this particular  
22 case with respect to Mr. Dziekanski, there was no  
23 evidence that he thought that people were trying  
24 to kill him before the Taser was pulled out?

25 A Well, no, not that I'm aware of.

26 Q No. And there was no evidence that you're aware  
27 of that he was confused as to where he was,  
28 correct?

29 A There is no direct evidence that I can see that he  
30 was disoriented to where he is.

31 Q No. As far as you knew, he at all times acted and  
32 understood that he was in an international  
33 airport.

34 A I don't know that.

35 Q Well, you don't have any evidence to the contrary.

36 A I don't have evidence to support that, either.

37 Q All right. Well, you have -- are you aware of the  
38 fact that when he went through Primary Customs he  
39 had to fill out a form and that he filled that  
40 form out and it's been an exhibit in these  
41 proceedings, in other words, a form for entering  
42 the country. Were you aware of that, sir?

43 A Those are -- those are the procedures that I'm not  
44 familiar with. So I would assume what you say is  
45 true, yes.

46 Q All right. Well, that's not an indication of  
47 someone that's delirious, is it?

- 1 A No.
- 2 Q Okay. And when he dealt with Immigration  
3 officials, you have no knowledge of any reason  
4 that he thought that they were anything other than  
5 Immigration officials, correct?
- 6 A Correct.
- 7 Q And when he dealt with the police officers, you  
8 have no reason to suspect that he thought they  
9 were other than police officers?
- 10 A No.
- 11 Q In fact, when he saw the police, he called out to  
12 them and said "*Policja*", correct?
- 13 A I don't know about that.
- 14 Q Well, I think it's in your report, sir.
- 15 A Can you point that out to me?
- 16 Q Yeah, paragraph 14 on page 9.
- 17 A Good.
- 18 Q Do you recognize that?
- 19 A Yes.
- 20 Q And you remember watching the tape and when the  
21 police arrived did you hear him calling the word  
22 "*Policja*"?
- 23 A You know what, I don't remember.
- 24 Q All right. Well, let's just assume for a second  
25 that when he saw the police he did call out  
26 "*Policja*".
- 27 A Yes.
- 28 Q That's not a delusion, that's not delusional, is  
29 it, sir?
- 30 A You know, one of the things that -- that's really  
31 difficult to explain in this scenario is that in a  
32 delirious state, individual can still recognize  
33 those -- in an individual with delirium can still  
34 be able to recognize police. It's again, going  
35 back to my patient who is post-cardiac surgery,  
36 who thinks the nurses are trying to kill him. I  
37 show up with my ID badge on. He's clearly able to  
38 say "You're a doctor." But the fact that Mr.  
39 Dziekanski is able to say "*Policja*", assuming that  
40 that means police, it doesn't take away the -- the  
41 possibility that he might have delirium. And I  
42 lay out the facts and assumptions that I made,  
43 that he -- and if those facts and assumptions that  
44 I made have changed in some way since my report,  
45 then my opinion can change. But what I'm saying  
46 is based on the information that was provided to  
47 me, that was still enough for me to make that

- 1 clinical determination.
- 2 Q I understand. But you keep going back to this  
3 example, and the example is that there is somebody  
4 who thinks that people are trying to kill them.
- 5 A No, but what I'm saying is even for as extreme of  
6 a case as that, one can still be able to maintain  
7 that degree of following instructions. Most  
8 individuals with delirium do not get to that  
9 degree where they think their cardiac surgeon is  
10 trying to kill them. But what I'm -- that example  
11 I made to say that in the most extreme case that  
12 you can find, which is somebody in the cardiac  
13 ICU, with that degree of significant clear  
14 delirium, they can still follow some degree of  
15 instruction. So I'm not equating that gentleman  
16 that I treated with Mr. Dziekanski. But what I'm  
17 saying is I'm just using that as an illustration  
18 that even in the most extreme example some degree  
19 of recognition and cognition is maintained.
- 20 Q You don't have any evidence, direct evidence that  
21 Mr. Dziekanski was delirious in the sense that he  
22 misunderstood where he was or the people -- or who  
23 the people were that he was dealing with, do you?
- 24 A Obviously there is no direct evidence, because you  
25 have to talk to the person, and short of that  
26 there is no one else can make that determination.  
27 And what the report I made is based on a series of  
28 facts and assumptions that I believe at the time  
29 to be accurate, in preparing for that. No one can  
30 make those determinations unless one actually have  
31 a chance to talk with Mr. Dziekanski.
- 32 Q Okay. But the point is that nobody in any of  
33 those reports said to you "He didn't understand  
34 that I was a Customs officer." No one -- you had  
35 no such evidence, correct?
- 36 A No.
- 37 Q You had no such evidence that somebody said "He  
38 didn't know that I was a police officer"?
- 39 A No.
- 40 Q You had no evidence that he didn't know that he  
41 was in an international airport?
- 42 A No.
- 43 Q Were you aware, sir, that while Mr. Dziekanski was  
44 standing in the doorway, where you watched him on  
45 the tape.
- 46 A Yes.
- 47 Q That two individuals walked by Mr. Dziekanski, one

1 a Mr. Dhari, who was a luggage cart attendant.  
2 A Mm-hmm.  
3 Q Were you aware of that, sir?  
4 A I remember if I -- watching the video, he let  
5 somebody past him, yes.  
6 Q And there was a second person, a Mr., I think it  
7 was Canzon, who was the janitor, who walked by  
8 him, quite a small gentleman. Do you recollect  
9 that information?  
10 A It has been close to year since I watched the  
11 video, so I -- I don't recall all of the  
12 scenarios.  
13 Q Okay. Now, fear of flying isn't very unusual, is  
14 it?  
15 A No.  
16 Q In fact, a lot of public officials and high  
17 profile people in the news, the media, and  
18 entertainment have a fear of flying?  
19 A That's not an unusual thing that happens.  
20 Q Yes. In fact, it's far from being unusual.  
21 A I don't know the statistic. I'm not an expert on  
22 that. But I would say it's not particularly rare.  
23 Q Right. Okay. And it's not really an indication  
24 of anything to do with a person's state of mind or  
25 whether or not they're delusional?  
26 A No.  
27 Q All right. Now, you were aware that there was an  
28 incident, and you describe it in paragraph 20 of  
29 your report, which is dated October the -- or,  
30 sorry, April 9th, 2008.  
31 A What page?  
32 Q It's on page 10.  
33 A Okay.  
34 Q This is a discussion about Mr. Meltzer, paragraph  
35 20.  
36 A Yes.  
37 Q You were aware, sir, that Mr. Meltzer, who has  
38 often been described as a chauffeur or driver, got  
39 into quite a heated argument with Mr. Dziekanski.  
40 Were you aware of that, sir?  
41 A My awareness is again based on what I read.  
42 Q Okay. Well, we've had evidence here that Mr.  
43 Meltzer admitted to the fact that he swore at Mr.  
44 Dziekanski. He has elevated his voice, he used  
45 four-letter words in respect of talking to Mr.  
46 Dziekanski, and was irritated with him and got  
47 into his face, within a foot or two of his face,

- 1 and it was after that, that Mr. Dziekanski got  
2 quite angry. That's not unreasonable or  
3 delusional, is it, sir?
- 4 A I wasn't there. I didn't see it. I have no idea.  
5 I can't really answer that one way or the other.
- 6 Q Well, if one person gets into an argument with  
7 another, it's not unusual for that person to  
8 respond, is it?
- 9 A No.
- 10 Q And to be responsive to that kind of verbal attack  
11 doesn't make you delusional, does it, sir?
- 12 A Again you are continuing to use the term  
13 "delusional" in a way that I don't intend to make  
14 it. And so let me perhaps answer it in this way,  
15 which is when somebody is -- if somebody has a  
16 form of delirium, they might respond more  
17 aggressively to challenges and verbal challenge.  
18 But on the other hand, as you said, if somebody  
19 started an argument and Mr. Dziekanski responded  
20 in kind, that would be perfectly normal.
- 21 Q Okay. And you wouldn't find anything unusual  
22 about that kind of response.
- 23 A No.
- 24 Q And if the person came back, the same person you  
25 had a verbal altercation with came back, and for  
26 you to demonstrate that for me to be agitated with  
27 that person, that would be normal, too, correct?
- 28 A No, it depends on the degree of agitation and, you  
29 know, it depends on how heated the argument is. I  
30 don't know --
- 31 Q Yes.
- 32 A -- I wasn't there. So some degree of adversarial  
33 interaction and -- and anger and display of anger  
34 probably would be appropriate.
- 35 Q Yes. Now, were you aware, sir, that when Mr.  
36 Dziekanski in the last minutes of his life, when  
37 -- or the last moments of his life, when he was  
38 faced with the Taser or had been -- immediately  
39 before being shot said something like, "Have you  
40 lost your minds?" or "Have you gone crazy?" That  
41 would be responsive to a threat, correct? Do you  
42 understand what I'm saying?
- 43 A I don't have those evidence. To -- it would be  
44 perfectly reasonable for an individual to respond  
45 to a threat with a statement like that.
- 46 Q Yeah. Did you understand that Mr. Dziekanski  
47 spoke no English?

Dr. Shao-Hua Lu

Cross-exam by Mr. Kosteckyj (for Zofia Cisowski)

Cross-exam by Ms. Roberts (for Government of Canada)\_

1 A It's my understanding that he does not speak  
2 English.

3 Q All right. Because in your report it talked about  
4 that he had some limited English, or I just wanted  
5 to make sure that you understood that he didn't  
6 have any working knowledge of English.

7 A Well, again, that the assumption I made is based  
8 on the information that was provided to me. It's  
9 not something that I made up. And in terms of  
10 whether or not he had no English or limited  
11 English, it depends on the information provided to  
12 me about whether or not he's able to interact with  
13 Customs agents, and if he's able to interact with  
14 Customs agents, to fill out forms and so on and so  
15 forth, my assumption is that he has at least a  
16 little bit of limited English in terms of  
17 responding to that.

18 Q All right. So did you work on the premise that he  
19 had some knowledge of English?

20 A Sure. I mean, but those -- doesn't really change  
21 my opinion.

22 Q It doesn't change your thought process to know  
23 that this man spoke absolutely no English?

24 A I don't think it makes a huge difference. My  
25 understanding is that Mr. Dziekanski, even if he  
26 has a bit of English, his ability to communicate  
27 with sort of general interaction in using English  
28 is exceedingly poor. So I didn't take it that he  
29 can actually carry on a regular conversation, but  
30 my understanding is that Mr. Dziekanski would have  
31 really limited English. And to the extent that it  
32 would be difficult for him to kind of respond to  
33 -- to normal conversation. So I do take it to --  
34 in my report that Mr. Dziekanski has really  
35 limited knowledge of English.

36 MR. KOSTECKYJ: Those are my questions, thank you.

37

38 CROSS-EXAMINATION BY MS. ROBERTS ON BEHALF OF THE  
39 GOVERNMENT OF CANADA:

40

41 Q Dr. Lu, my name is Helen Roberts. I'm counsel for  
42 the Government of Canada.

43 A Okay.

44 Q I have some questions for you. It appears from  
45 your report that you reviewed a large number of  
46 materials and videotapes in preparation for  
47 preparing an opinion?

1 A Yes.

2 Q Can you give us some idea of the time that you  
3 spent carefully reviewing these materials,  
4 considering the diagnosis and preparing your  
5 report?

6 A It was a long process, probably about a few hours  
7 just to go through everything in detail.

8 Q All right. And I presume you knew that this was  
9 important what your opinion would be used for?

10 A Yes.

11 Q All right. So you did this as carefully as you  
12 could?

13 A Yes.

14 Q All right. Now, one of the things that you're a  
15 specialist in is addiction medicine, as I  
16 understand it?

17 A Yes.

18 Q All right. And can you tell Mr. Commissioner what  
19 the effects of alcohol withdrawal are, or if  
20 somebody is addicted to alcohol?

21 A Alcohol -- alcoholism is a wide-ranging condition.  
22 It -- its impact on an individual really depends  
23 on the age of the person, their medical condition  
24 and their overall physical symptoms. And even for  
25 an individual who has an addiction to alcohol, the  
26 normal -- the amount of alcohol that he or she  
27 consumes over periods of time, all of that have a  
28 bearing. So it's -- perhaps you need to frame  
29 your question a little bit more specific for me to  
30 answer.

31 Q Well, we don't have a lot of information, but we  
32 do understand that Mr. Dziekanski did consume  
33 alcohol. There are findings on autopsy of chronic  
34 alcoholism, which seemed to confirm that evidence.  
35 And I believe we have evidence that he did not  
36 have any alcohol after he left Poland during the  
37 time of his travel to Vancouver. I don't know if  
38 that assists you. What I was actually looking for  
39 were sort of general symptoms of alcohol  
40 withdrawal.

41 A In terms of -- alcohol withdrawal is a process  
42 that can take place anywhere between -- it depends  
43 on how heavy the individual drinks, anywhere  
44 between eight to 72 hours after the last drink.  
45 For most individuals, the symptoms really begin to  
46 onset about 24 to 36 hours after last drink. The  
47 alcohol withdrawal again is a condition that have

1 a degree of severity from really mild alcohol  
2 withdrawal, just mild tremors, a bit of agitation,  
3 a bit of irritability without any changes in  
4 mentation. In the most severe alcohol withdrawal  
5 it can be potentially life threatening with the  
6 individual becoming disorganized, having seizures,  
7 blood pressure or heart rate imbalance that can be  
8 potentially life threatening. For -- it should --  
9 also should be noted that in terms of delirium,  
10 alcohol, regular alcohol use, even in the absence  
11 of significant addiction, and what I mean by that  
12 is even an individual who drinks fairly regularly,  
13 but not heavily, if they are exposed to sleep  
14 deprivation or -- and other factors that increases  
15 delirium risk, that regular alcohol use can be  
16 problematic.

17 Q All right. Are you also able to give us some  
18 general information about people going through  
19 nicotine withdrawal? We have evidence that Mr.  
20 Dziekanski, I believe, smoked a pack of cigarettes  
21 and then gave up two days before he departed  
22 Poland, and we assume did not smoke any cigarettes  
23 after that point in time. What would be the  
24 general kind of symptoms you might see of somebody  
25 going through nicotine withdrawal?

26 A Similar, or not as significant, and certainly not  
27 life-threatening compared to alcohol --  
28 potentially life-threatening, I should say, for  
29 alcohol withdrawal. Nicotine withdrawal mostly is  
30 one of irritability, increased frustration, sleep  
31 change, are all potential symptoms.

32 Q All right. We have evidence from Dr. Lee that he,  
33 as I've mentioned earlier, found signs on autopsy  
34 of chronic alcoholism, and he listed three things  
35 in his report: cerebellar atrophy, a fatty liver  
36 and dilated cardiomyopathy. I'm not sure if your  
37 specialty in addiction medicine permits you to  
38 comment. Does that sound like those would be the  
39 findings you would find on autopsy for chronic  
40 alcoholism?

41 A Yes. Particularly the finding of the cerebellar  
42 vermis atrophy. The cerebellum is what we call  
43 the smaller brain in the -- sort of in the back of  
44 the head here. The cerebellum degeneration is  
45 quite specific for alcohol, chronic alcohol use,  
46 and one of the really specific findings is  
47 something called atrophy in a central part of the

- 1 cerebellum called the vermis. That's quite  
2 unusual for other disease entity and fairly common  
3 for alcohol, chronic alcohol use. Fatty liver,  
4 particularly as described as fairly severely fatty  
5 liver, is common for alcohol users. In terms of  
6 alcohol-related liver disease progression, it's  
7 liver enlarged becomes fatty liver, which is a  
8 reversible process, until at which point one then  
9 get into more end stage alcoholism, where the  
10 liver becomes cirrhotic or becomes shrunken and  
11 hard. Cardiac myopathy or dilation of the heart  
12 is a common feature associated with the impact of  
13 alcohol on the musculature within the heart  
14 muscle. So cardiac myopathy is also fairly  
15 common, but not always indicating alcohol.
- 16 Q All right. We had evidence from a pathologist  
17 named Dr. Butt who said that with atrophy of the  
18 cerebellum vermis, he would expect to see some  
19 difference in the walk of the person. Is that  
20 something that you would agree with, and then I  
21 was going to take you to some parts of your  
22 report.
- 23 A I don't -- because most of those findings are  
24 autopsy findings, and for most individual with  
25 alcoholism, one cannot directly correlate the  
26 percentage of shrinkage in that part of the brain  
27 to certain gait. There might be that general  
28 expectation, however, from a clinical standpoint  
29 one really can't make that determination. He  
30 could, but it's not necessary a result. So I  
31 can't comment on it, either way. But it certainly  
32 increases the possibilities that somebody walks in  
33 a sort of wide-based gait.
- 34 Q All right. Do you have your first report there.
- 35 A Yes.
- 36 Q Can I ask you to turn to page 7, and at paragraph  
37 4 you've recounted some evidence from the security  
38 guard, Mr. Arora.
- 39 A Yes.
- 40 Q And in that paragraph you noted that towards the  
41 end Mr. Dziekanski, when he lifted the chair, lost  
42 his balance and wobbled.
- 43 A Yes.
- 44 Q And that he seemed wobbly, like he was drunk on  
45 something.
- 46 A Yes.
- 47 Q So you made a notation there about his balance or

1 his walk. And then in paragraph 5 on that page,  
2 you've recounted the evidence of another security  
3 guard, Mr. Rudek.

4 A Yes.

5 Q That when Mr. Dziekanski was throwing things he  
6 looked as though he'd fall over.

7 A Yes.

8 Q And he kept tripping over himself.

9 A Yes.

10 Q And on page 8 at the very top you noted some  
11 evidence from a Customs officer, Mr. Chapin, who  
12 noted that Mr. Dziekanski stumbled on exit trying  
13 to steady himself with the luggage cart.

14 A Yes.

15 Q On page 14 of that report in the second full  
16 paragraph, you talked about:

17  
18 Mr. Dziekanski had psychomotor agitation  
19 typical of delirium.

20  
21 A Yes.

22 Q That:

23  
24 More than one individual noted he had poor  
25 balance.

26  
27 A Yes.

28 Q And then you say:

29  
30 In the Pritchard video Mr. Dziekanski could  
31 be observed to have wide-based gait.

32  
33 A Yes.

34 Q Going back, the poor balance, were those the two  
35 references I've pointed out to you earlier?

36 A Yes.

37 Q And with regard to the Pritchard video, is that  
38 something you watched and observed?

39 A Yes.

40 Q Is that the wide-based gait that you said you  
41 sometimes see with atrophy of the cerebellum  
42 vermis?

43 A Wide-based gait is -- can occur in a number of  
44 situations. Wide-based gait is basically when we  
45 walk, we -- it's actually fairly mechanically  
46 amazing that humans can walk the way we do with  
47 our feet fairly close to each other. When a

- 1 person gets tired, a person gets sleep deprived or  
2 they're drunk or they are on medication, they  
3 might sort of spread their legs a little bit wider  
4 to steady themselves. So, for example, you know,  
5 a typical scenario is, for example, if somebody  
6 wants to be in the combative stance, they want to  
7 widen their gait to give them more balance. So  
8 that sort of widening of gait is -- can occur on a  
9 number of different scenarios. In terms of  
10 alcohol withdrawal, for somebody alcohol  
11 withdrawal, or have chronic alcoholism, we  
12 certainly see that more often than not. So having  
13 a wide-based gait in and of itself doesn't  
14 necessarily tell me everything, but in the context  
15 of the other information, wide-based gait gives  
16 some information that Mr. Dziekanski wasn't as  
17 steady as he probably would be in that time.
- 18 Q So it may or may not be a sign of this atrophy of  
19 the cerebellum vermis?
- 20 A It could be.
- 21 Q The atrophy of the cerebellum vermis, is that  
22 something that might predispose someone, or create  
23 a risk of delirium?
- 24 A No -- yes, and no. That part of the brain is not  
25 really directly linked to possibility of cognitive  
26 change. However, the changes in the cerebellum  
27 vermis give some indication of more chronic and  
28 more globalized brain vulnerability, and that  
29 increases -- vulnerability increases the risk of  
30 an individual developing delirium. So it is a --  
31 that in and of itself does not increase the risk,  
32 but it is an excellent marker of more global  
33 cognitive changes and deficits that likely have  
34 occurred as a result of chronic alcohol use, which  
35 increases the likelihood of delirium. Does that  
36 make sense?
- 37 Q Thank you. Now, you've testified that excited  
38 delirium is not a recognized disorder. Is  
39 delirium a recognized disorder?
- 40 A Yes.
- 41 Q All right. And I understand from reading your  
42 report that there are a number of different causes  
43 for delirium.
- 44 A Yes.
- 45 Q And that these can be physical, emotional,  
46 chemical, or a combination of those three?
- 47 A Yes.

- 1 Q Your opinion is, as I read it, was that there was  
2 a high degree of certainty that Mr. Dziekanski was  
3 in a state of delirium prior to the police  
4 incident in his death, and that's from page 12, is  
5 that correct?
- 6 A Correct. And I lay out the reason that I -- that  
7 I come up with that particular opinion.
- 8 Q All right. And as I understand it, your evidence  
9 this morning was that delirium is a sign of  
10 something else going on in the body. There's  
11 always an underlying cause for it?
- 12 A Correct.
- 13 Q And as I understand your report at pages 14 and  
14 15, you've set out what you believe the underlying  
15 causes were for Mr. Dziekanski's delirium?
- 16 A Yes.
- 17 Q And one was prolonged sleep deprivation?
- 18 A Yes.
- 19 Q All right. Now, we've had evidence that he told  
20 people in Poland he hadn't slept for two nights  
21 before his departure. How long would it take  
22 before sleep deprivation became a factor?
- 23 A Generally speaking, 36 hours of continuous non-  
24 sleep will begin to affect an individual's  
25 judgment. Beyond that, 48 hours is sufficient to  
26 cause impaired judgment. By the time an  
27 individual gets to about three days with no sleep,  
28 cognition can be significantly affected. So, for  
29 example, you know, there is -- recently there is a  
30 law passed in New York that forbids medical  
31 residents from working more than 36 hours at a  
32 time, which probably is a good thing, so because  
33 an individual's judgment becomes impaired after  
34 periods of prolonged sleep.
- 35 Q Okay. One of the other underlying cause you  
36 identify is dehydration and electrolyte imbalance.
- 37 A Yes.
- 38 Q We have evidence that Mr. Dziekanski appeared to  
39 be thirsty and asked for and was provided some  
40 water by Border Services agents. In terms of  
41 food, we have evidence from autopsy that there  
42 were minimal stomach contents. The bladder was  
43 empty, but that can of course be for other  
44 reasons. We know from the exhibit list that Mr.  
45 Dziekanski still had the airline breakfast in his  
46 pocket. Can you tell us a bit more about how much  
47 dehydration or how much lack of food would be

1 required to cause delirium, or how that works?  
2 A And that's a really tricky, tricky answer. In  
3 that individual with chronic alcohol use, and  
4 again they don't even have to be massive amount of  
5 alcohol use. Chronic alcohol use can lead to  
6 dehydration because alcohol is a diuretic, meaning  
7 it -- for example, if a person drinks a glass of  
8 beer, or wine, certainly -- and I'm not even  
9 counting any more harder alcohol, they pee out  
10 more than they drink, because alcohol dehydrates.  
11 So if a person drinks a glass of beer, they end up  
12 peeing, generally speaking, more than a glass of  
13 beer. And so what that does is, alcohol does not  
14 replenish the individual's fluid, and over time  
15 there is a relative deficit, particularly if in  
16 alcohol withdrawal state and they don't have  
17 fluid.

18 And one of the major treatment for alcohol  
19 withdrawal, sometime even in the absence of  
20 medication, by replenishing fluid itself will  
21 substantially decrease symptoms associated with  
22 alcohol withdrawal. An individual can be, as an  
23 average size individual, so I don't know, five-ten  
24 - it's hard for me to talk about average because  
25 I'm so small - five-ten, 170 pound individual, if  
26 they're in alcohol withdrawal, they can be as much  
27 as five to six, if not more, litres of fluid  
28 behind. And so that would be the equivalent of a  
29 gallon and a bit of fluid, IV fluid that can go  
30 into the body.

31 And electrolyte is also similar kind of a  
32 scenario, where most individual with alcohol  
33 withdrawal will have some -- particularly  
34 significant ones, significant alcohol withdrawal  
35 will have some electrolyte imbalance. And  
36 interestingly a lot of those imbalances will  
37 normalize itself after death. And so in the  
38 electrolyte imbalance, particularly in an acute  
39 setting, rather than chronic over many, many,  
40 many, many weeks, in autopsy settings, those  
41 electrolyte can normalize because the body's  
42 natural fluid balance will take place.

43 Q All right. So in terms of causation, we have the  
44 sleep deprivation, the dehydration, the  
45 electrolyte imbalance, and is alcohol withdrawal  
46 one of the underlying causes to the delirium, or  
47 not, in your view?

1 A In this particular scenario when I laid out that  
2 the -- the report, it is a combination, you can't  
3 say, ah-ha, that one thing caused it. In my  
4 understanding of just the entire process, here you  
5 have somebody who has sleep deprivation, lightly  
6 dehydrated, and his language and in an unfamiliar  
7 place also plays a huge role, because it -- for  
8 somebody who is delirious, again I want to give  
9 clinical example of that. So it's not infrequent  
10 that I get called to see somebody who is quite  
11 agitated and delirious in the medical unit and is  
12 a little, you know, a little old Chinese lady who  
13 doesn't speak a word of English. And I go in and  
14 I say "Hi" in Cantonese. It calms them right  
15 down. And that ability to communicate directly  
16 makes a world of difference, because they wake up  
17 in the middle of the night, they don't really know  
18 where they are. They're in an unfamiliar place in  
19 the hospital. They have nurses talking to them in  
20 English and they can't really communicate. So all  
21 of those factors are -- have bearing on the  
22 experience of delirium and not really sure, and  
23 that degree of agitation that one might -- that  
24 one sees.

25 Q I'd like to ask you a bit about onset. You've  
26 talked about acute delirium, you've talked about  
27 chronic delirium, what can you say about the onset  
28 of delirium in the context of Mr. Dziekanski's  
29 case?

30 A And when I talk about chronic, it's usually I'm  
31 talking about in terms of weeks. The onset of  
32 delirium doesn't happen like this. It's a gradual  
33 process, even for acute ones. So meaning somebody  
34 who will have acute illness, gradually onset over,  
35 you know, the course of about 12 to 24 hours or  
36 so.

37 Q All right. We have evidence that Mr. Dziekanski  
38 was afraid of flying to the extent where he was  
39 holding on to a radiator and very upset in Poland.  
40 We have evidence that he had sleepless nights in  
41 Poland, that he hadn't been eating particularly,  
42 he'd given up cigarettes. Is it possible that the  
43 delirium started in Poland, or is this something  
44 that you think would have developed later in his  
45 case?

46 A You know, I don't think I can comment on that, and  
47 I don't think I can even comment on when -- when

- 1           that occurred. I can only really comment on what  
2           I see, based on the video.
- 3        Q     All right. Once someone is delirious, do they  
4            remain at the same level of deliriousness, or does  
5            it generally increase, or can it decrease, or what  
6            is the pattern?
- 7        A     One of the hallmarks of delirium is fluctuation  
8            that -- and a person doesn't remain delirious  
9            continuously until they are quite, quite ill. The  
10           fluctuating level of consciousness, fluctuating  
11           response, is a hallmark. So they're better  
12           sometimes, they're worse others. So it's not  
13           infrequent to have periods of, you know, four to  
14           five hours where an individual seems pretty good,  
15           and then many hours later they worsen. That  
16           sleep/wake cycle, the loss of sleep/wake cycle is  
17           a big part. So it's not infrequent that again  
18           looking at my clinical practice load, that an  
19           individual looks pretty good in the daytime,  
20           because the sun is shining, they can have access  
21           to that eternal stimuli, but then as the sundown,  
22           you know, toward the end of the evening, they  
23           become much more agitated, much more aggressive.  
24           And that's a well-known phenomenon called  
25           sundowning. And in this particular case, you  
26           know, having been in Vancouver International  
27           Airport so many times, that complete loss of  
28           daytime/daylight cycle available to Mr. Dziekanski  
29           probably wasn't helpful for him.
- 30        Q     You watched the video taken by Mr. Pritchard, and  
31            I presume you saw the segment before the police  
32            arrived, as well as the other segments?
- 33        A     Yes.
- 34        Q     And in that segment Mr. Pritchard (sic) was  
35            shouting and sweating and throwing things? You  
36            know the segment?
- 37        A     Mr. Dziekanski.
- 38        Q     Mr. Dziekanski, I'm sorry.
- 39        A     Yes.
- 40        Q     Was throwing things. You remember that segment?
- 41        A     Yes.
- 42        Q     Is it your opinion that he was suffering from  
43            delirium at that time?
- 44        A     It's one of the bases that help me formulate the  
45            opinion. There are a couple of things that  
46            particularly struck me. One was a time when he  
47            was standing in the doorway of the automatic door

1 where it was kind of closing in on him a few  
2 times, and it doesn't seem to kind of bother him.  
3 The other part is his moving of the chair, before  
4 he threw it, you know, move it a couple of times.  
5 That doesn't seem to be entirely purposeful.  
6 Those are the kinds of sort of purposelessness,  
7 psychomotor agitation that one tends to observe  
8 for patients in a state of delirium.

9 Q And that was before the police arrived?

10 A Correct.

11 Q Is delirium a serious condition?

12 A Yes.

13 Q And is there a risk of death if the delirium and  
14 the underlying cause is not treated?

15 A Generally in -- in the hospital setting, when an  
16 individual has delirium, we identify them and we  
17 treat them. So I really can't answer that  
18 question.

19 What I can say is by and large for an  
20 otherwise healthy individual, even if they have  
21 alcoholism, and with some of the changes that are  
22 described, in a state of delirium or dehydration,  
23 it's unlikely that a person would die  
24 spontaneously from those features. That if they  
25 -- if an individual were to suffer, it's usually  
26 because of dehydration and electrolyte changes  
27 that increases the demand on the heart and other  
28 demands on the heart that lead to heart attack or  
29 other kind of precipitating factor that can lead  
30 to. So, for example, let's say in alcohol  
31 withdrawal, what kills individuals in alcohol  
32 withdrawal are generally a number of things:  
33 intractable seizure, heart attack, cardiac  
34 arrhythmia, meaning the dysregulation of the heart  
35 rhythms, and sort of what we call cardiovascular  
36 collapse, where the heart simply gives out because  
37 the demand on the body is too much, because  
38 there's lack of fluid, lack of electrolytes and so  
39 on and so forth.

40 Q And so in the state that Mr. Dziekanski was in  
41 prior to the police arrival, given what we now  
42 know from autopsy, given your diagnosis of  
43 delirium.

44 A Mm-hmm.

45 Q Given that he was possibly going through alcohol  
46 withdrawal, was he at risk of a heart attack even  
47 then?

Dr. Shao-Hua Lu

Cross-exam by Ms. Roberts (for Government of Canada)\_

Cross-exam by Mr. Butcher (for Cst. Bill Bentley)

1 A I cannot comment on that. It -- what I can say is  
2 he is more vulnerable than the average individual.

3 Q Given the state that Mr. Dziekanski was in, would  
4 it be important for him to get medical treatment  
5 for the dehydration and the other things going on  
6 in his body?

7 A Absolutely.

8 Q And is it sometimes necessary, even in hospital  
9 settings, to physically restrain people so that  
10 you can give them treatment?

11 A Yes.

12 MS. ROBERTS: Sorry, Mr. Commissioner, I'm just  
13 checking my notes.

14 Thank you, those are all my questions.

15 MR. BUTCHER: Mr. Commissioner, I'm going to be a  
16 while, probably half an hour. If you want me to  
17 start...

18 THE COMMISSIONER: Well, if you can start, go ahead.

19

20 CROSS-EXAMINATION BY MR. BUTCHER ON BEHALF OF CONSTABLE  
21 BILL BENTLEY:

22

23 Q The first thing that I want to do, Doctor, is have  
24 you identify some extracts from what you know as  
25 DSM-IV.

26 A And you are -- sorry?

27 Q I am David Butcher. I'm counsel for one of the  
28 police officers.

29 First of all, can you tell the Commissioner  
30 what DSM-IV is.

31 A The DSM-IV is a textbook that is a compilation of  
32 how psychiatry generally make diagnosis of  
33 psychiatric conditions. Most, if not all  
34 psychiatric illness lacks laboratory results that  
35 indicate, for example, what depression and what  
36 schizophrenia is. In order to have a way for  
37 individuals to make communication between one  
38 party to another, one psychiatrist in, you know,  
39 North Carolina to Vancouver, one has to set up a  
40 series of criteria to make the determination of  
41 that disease. Because we all have depressing  
42 times, that times when we may feel sad or  
43 depressed, but that does not make depression, for  
44 example. And so the DSM-IV lays out a series of  
45 criteria and one has to meet those criteria before  
46 the diagnosis of a specific psychiatric condition  
47 is made. And so the DSM-IV is a relatively

- 1 generally agreed on textbook for laying out those  
2 criteria, so one can have the same lexicon  
3 regardless of location and time. So when we talk  
4 about depression, it's generally agreed on that an  
5 individual with major depression would likely have  
6 all of those criteria, and so when one party from  
7 one location talk about depression, it's the same  
8 as someone else 500 miles away.
- 9 Q It's because one pathologist may be able to very  
10 readily explain to another pathologist a  
11 particular finding that they've made that would be  
12 defined in medicine, but that's more difficult in  
13 psychiatry?
- 14 A Correct.
- 15 Q Is that what you're trying to say. And the term  
16 DSM-IV actually stands for Diagnostic Statistical  
17 Manual of Mental Disorders.
- 18 A Yes.
- 19 Q And the fourth edition that I've handed to you is  
20 the current version?
- 21 A Correct.
- 22 Q And I see that it's prepared by the American  
23 Psychiatric Association. Is it accepted as the  
24 basic textbook in Canadian psychiatry as well?
- 25 A Correct.
- 26 Q And as I understand your evidence to date, the  
27 task of a psychiatrist being presented with a  
28 cognitively disturbed person would be first to  
29 assess whether or not they suffered from delirium  
30 or were in a state of delirium, and second to try  
31 to determine the cause of that delirium?
- 32 A Yes.
- 33 Q The delirium is the symptom, the cause is the  
34 disease?
- 35 A Yes.
- 36 Q What are the symptoms that DSM-IV recognizes for  
37 -- or requires for a diagnosis of delirium? And  
38 the chapter begins at page 135 in this collection  
39 of excerpts. Perhaps you can help us with  
40 identifying what you would look for before you  
41 would want to make a diagnosis of delirium.
- 42 A The diagnosis of delirium is based on a series of  
43 diagnostic features. The most important is  
44 recognizing that delirium is a disturbance of the  
45 cognition and consciousness. So one looks for  
46 features to go along with that particular  
47 constellation of features, such as disorientation,

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Cross-exam by Mr. Butcher (for Constable Bill Bentley)

1 disorganized speech, and speech impairment,  
2 language impairment, memory impairment and  
3 cognitive distortions. Those are all features  
4 generally associated with delirium.

5 Q There is a table --

6 THE COMMISSIONER: Well, I think we'll take the break  
7 now. Two o'clock.

8 THE REGISTRAR: The hearing is now adjourned until 2:00  
9 p.m.

10

11 (WITNESS STOOD DOWN)

12

13 (PROCEEDINGS ADJOURNED FOR NOON RECESS)

14 (PROCEEDINGS RECONVENED)

15

16 DR. SHAO-HUA LU, a witness,  
17 recalled.

18

19 MR. BUTCHER: So everybody is aware, I've provided Dr.  
20 Lu with a copy of Exhibit 105, which is the  
21 "Circumstances" prepared by Commission counsel.  
22 I'm going to be -- he, at the moment, is reading  
23 that document.

24 Actually, Doctor, I'm going to ask that we  
25 come back to that in a moment. I was hoping you'd  
26 be able to get to it before we started, but if  
27 you've not, that's fine.

28

29 CROSS-EXAMINATION BY MR. BUTCHER ON BEHALF OF CONSTABLE  
30 BILL BENTLEY, continuing:

31

32 Q I think before the break I was just trying to ask  
33 you to explain what the diagnostic criteria of  
34 delirium are.

35 A So basically, the criteria is quite simply laid  
36 out in the DSM-IV. That is, a disturbance of the  
37 consciousness, meaning reduced clarity of  
38 awareness of the environment, with reduced ability  
39 to focus sustained, and to shift attention.  
40 Changes in cognition, such as memory deficits,  
41 disorientation, language disturbance, or  
42 possibility of perceptual disturbance - perceptual  
43 disturbance meaning development of hallucinations  
44 and so on - and that the disturbance develop over  
45 short periods of time, usually hours or days, and  
46 tend to fluctuate throughout the course of the  
47 day.

- 1                   And that the -- and here is an important  
2 part: That the delirium, there is evidence that  
3 it's caused by some physiological consequence of a  
4 medical condition. So that's what delirium is.
- 5       Q       Those are the points listed on page 143.
- 6       A       Yes.
- 7       Q       In the little summary chart --
- 8       A       Correct.
- 9       Q       -- on that page. And if you go back in the DSM-IV  
10 text to page 136, this is written under the  
11 heading "Delirium". The disorders in the  
12 "Delirium" section share a common symptom  
13 presentation of a disturbance in consciousness and  
14 condition, but are differentiated based on  
15 etiology. Etiology means "cause"?
- 16      A       Yes.
- 17      Q       And then there are four different etiologies  
18 listed: delirium due to a general medical  
19 condition; substance-induced delirium, including  
20 medical side effects; delirium due to multiple  
21 etiologies; and delirium not otherwise specified.  
22 Have I read that correctly?
- 23      A       Yes.
- 24      Q       And is that last category one in which the  
25 psychiatrist has been able to identify delirium  
26 but not been able to identify the cause?
- 27      A       Yes.
- 28      Q       And certainly alcohol withdrawal is one of the  
29 known causes of delirium.
- 30      A       Correct.
- 31      Q       Now, I am going to ask you now to read and digest  
32 Exhibit 105, please.
- 33      A       I've finished.
- 34      Q       I'm going to ask you as well to assume that the  
35 assumptions that you made in paragraphs 16, 17 and  
36 18, of your report of April the 9th are true.
- 37      A       Okay.
- 38      Q       Namely, that the Provincial Toxicology Centre --  
39 toxicology report dated October 25th, 2007,  
40 indicates no drugs or alcohol detected in blood or  
41 vitreous fluids with final notation that no  
42 alcohol, prescribed medication or elicit drugs  
43 were detected.
- 44                   The coroner's report by Dr. Lee does not  
45 indicate intracerebral injuries or other  
46 significant pathology, but the fatty liver was  
47 noted. Sorry, those are the two that I'm asking

1           you to consider, as well. The rest of Dr. Lee's  
2           autopsy report generally, I'm also going to ask  
3           you to ignore. In page -- in the first paragraph  
4           in the fourth line, the word "social" --  
5        A     Which -- which --  
6        Q     Sorry, in the circumstances --  
7        A     -- part are you --  
8        Q     In Exhibit 105.  
9        A     Okay.  
10       Q     I'll just ask you to assume that --  
11       THE COMMISSIONER: I'm sorry, which page are you on?  
12       MR. BUTCHER: Sorry, page 1.  
13       A     Page 1.  
14       MR. BUTCHER: Of the circumstances, the very first  
15           paragraph.  
16       A     Uh-huh. Assume -- take out the word "social"?  
17       Q     Yes. In the -- he was a regular drinker -- sorry,  
18           a regular smoker and drinker --  
19       A     Okay.  
20       Q     -- "who was generally in good health." I'm now  
21           going to -- what I'm going to do now, Doctor,  
22           since -- is show you again the video that you've  
23           not seen for a year, and ask us -- ask you to tell  
24           us two things: Firstly, whether you see any  
25           indicia of delirium in Mr. Dziekanski, and  
26           secondly whether, based on the circumstances and  
27           the other assumed facts, you're able to provide a  
28           psychiatric diagnosis, or whether you would  
29           require more information --  
30       A     Okay.  
31       Q     -- to do that. Do you understand that --  
32       A     I do.  
33       Q     -- task? Thank you.  
34       MR. BUTCHER: If we can play Pritchard video 1, please.  
35       A     And should I ask you to stop at points?  
36       Q     Yes, please. Ask us to stop when you see things  
37           that -- perhaps if you could imagine that you'd  
38           been called to the scene and you were being asked  
39           to assess this patient from a distance, or this  
40           man from a distance, whether you are able to see  
41           indicia of dementia as you observed his behaviour.  
42       MR. LUNN: Would you like to start from the beginning?  
43       MR. BUTCHER: Start at the beginning. Sorry, I should  
44           have said "delirium", not "dementia".  
45       Q     Because indeed, Doctor, as the tape's being lined  
46           up, those two things are quite different, aren't  
47           they?

1 A Yes.

2 Q And, as well, being delirious does not equate  
3 directly to being in delirium.

4 A They're not the same thing.

5 Q Thank you. What is the difference?

6 A Dementia, you say, stable condition, a progressive  
7 worsening of cognition over periods of time.

8 Delirium is a fluctuating clinical course that, in

9 an individual who is otherwise healthy, can be in

10 a delirious state and -- and if the underlying

11 medical condition, you treat it, they can return

12 to full normal cognitive health. Whereas in an

13 individual with dementia, that is the state that

14 they -- he or she is in.

15 Q Is there a difference between delirium and being  
16 delirious?

17 A No.

18 MR. BUTCHER: If we can have the tape played, please,  
19 and at various times I'm going to try to tell you  
20 what Mr. Dziekanski is saying in Polish.

21

22 (VIDEO BEING PLAYED)

23

24 MR. BUTCHER: We can stop it at the 00:30.

25 Q At this point, Mr. Dziekanski says, in Polish:

26

27 I will trash this office.

28

29 MR. BUTCHER: If you can continue to 00:40, please.

30 Q At this point, Mr. Dziekanski says, "Fuck off".

31 MR. BUTCHER: To 1:11.

32 A And I just want you to stop there one sec. You  
33 notice when he -- just go back. Okay, right  
34 there. After he threw the computer, there's a  
35 moment of -- if I can sort of mimic. He threw  
36 the computer and the body kind of wobble a little  
37 bit there. That is a little bit different from  
38 what one would see if somebody's acting out in  
39 aggression, anger. Throw something, stand back.  
40 Because you can see that there is sort of a wobbly  
41 body position there. I just want to highlight  
42 that.

43 Q Uh-huh, and what significance did that have for  
44 you?

45 A Again, it's just that overall clinical decision of  
46 seeing -- because delirium doesn't just impact the  
47 cognition. For a lot of individuals in a state of

1 delirium, the motor coordination is impaired.

2 That impairment, again, has a range.

3 Q And you thought you were seeing a symptom of motor  
4 impairment at that point?

5 A Put it all together, and there's more examples of  
6 that later.

7 MR. HIRA: And the time count of that observation?

8 MR. LUNN: 1:08.

9 MR. HIRA: Thank you.

10 MR. LUNN: Continue?

11 MR. BUTCHER: Yes, please. Stop it there.

12 MR. LUNN: (Indiscernible - not at microphone).

13 MR. BUTCHER:

14 Q At this point, Mr. Dziekanski says:

15

16 I will smash the glass and I will smash the  
17 glass here and you will see.

18

19 MR. BUTCHER: You can go to 1:32, please.

20 Q At this point, Mr. Dziekanski says:

21

22 What did you say? You will not let me.

23

24 MR. BUTCHER: And then to 1:38.

25 Q At this point, Mr. Dziekanski says:

26

27 You will not let me.

28

29 MR. BUTCHER: To 1:44, please?

30 A Now, one of the assumptions that I make, and one  
31 of the facts and assumptions that has been sort of  
32 continuing to be on my mind when I make my medical  
33 opinion is that Mr. Dziekanski was sweating, and  
34 that was noted throughout the course. Sweat,  
35 prolonged sweating, in and of itself, can lead to  
36 electrolyte problems and increases the risk of  
37 delirium because it can lead to electrolyte loss  
38 and fluid loss. Both of those are possibilities.  
39 So, you know, the gesture and the brow again is  
40 consistent with that.

41 MR. BUTCHER: Okay. If we can go to 1:44.

42 MR. LUNN: We're there now.

43 MR. BUTCHER:

44 Q At this point, Mr. Dziekanski says:

45

46 For fuck's sake, I will sue you and everybody  
47 else.

- 1 Now, at this point, you've seen the behaviours of  
2 the throwing of the objects and the creation of  
3 the barrier of chairs preventing people from going  
4 in or out of the doors there. Do they have any  
5 significance to you medically?
- 6 A Yes, it does. What I -- what I don't see is a  
7 really angry, purposeful, someone who is enraged.  
8 What -- you know, the throwing of the chair and  
9 then picking up the computer and then putting it  
10 down, moving the chair, and you can see later on  
11 he moves it back out. It's more -- it doesn't  
12 seem to serve a real purposeful -- a real  
13 purposeful anger, or directed at anyone. He's not  
14 -- notice the two security guys out -- just  
15 outside the door. He's not directing any of that  
16 towards those guys. And in rage, when somebody is  
17 actually in anger and in rage because they're  
18 pissed right off at somebody, one likes to direct  
19 that anger towards a specific individual.  
20 Whereas, what I see in Mr. Dziekanski, in the  
21 aggression is more purpose -- is not so much  
22 purposeful. What I see in my experience working  
23 with individuals with delirium often is that non-  
24 purposeful aggression. I call it defensive  
25 aggression because they are frightened, they're  
26 scared, and some of those actions are meant to  
27 kind of put people away, rather than to hurt  
28 somebody.
- 29 Q To protect them by a real or imaginary screen,  
30 that sort of concept?
- 31 A Yes. Yes.
- 32 Q I should have asked this earlier when you -- you  
33 interrupted. What significance does the potential  
34 for electrolyte loss or fluid loss have?
- 35 A Again, it's another one of those things that  
36 increases the risk of delirium.
- 37 Q Do we know why?
- 38 A What do you mean?
- 39 Q Why does that increase the risk?
- 40 A Oh, because the body's function is dependent on  
41 proper balance of electrolytes and fluids, and the  
42 loss of those is a major cause of delirium. So  
43 you can take an otherwise healthy individual and  
44 if you induce a state of electrolyte imbalance or  
45 fluid imbalance, you will induce a state of  
46 delirium in -- just by changing the electrolyte on  
47 an otherwise healthy individual.

1 MR. BUTCHER: If we can go forward, please, to 1:54.

2 Q At 1:54, I'm going to ask you to assume that Mr.  
3 Dziekanski says this:

4  
5 Fine, fine. We're in a different country,  
6 so...

7  
8 MR. BUTCHER: Carry on to 2:13.

9 A And if that's the case, then I won't have to ask  
10 the question who he's speaking to. "We're in a  
11 different country," and if I take the assumption  
12 is he talking to somebody, or is he talking to  
13 somebody imaginary? I don't know.

14 MR. BUTCHER: 2:13, please.

15 A And again, here, at this point, he moved the chair  
16 back and unfortunately the pillar blocks the view.  
17 I'm not really sure what he was doing with the  
18 chair, and again, that goes to that non-purposeful  
19 movement that I was talking about.

20 MR. BUTCHER: And the time frame?

21 MR. LUNN: We're at 2:13.

22 MR. BUTCHER:

23 Q Fair to describe it as disorganized and irrational  
24 behaviour?

25 A Disorganized. I don't know whether or not there  
26 is a rationale behind it. I can't talk to him, so  
27 I can't make that distinction.

28 Q From a cognitive perspective --

29 A Yes.

30 Q -- it's disorganized.

31 A From what I can observe, it -- I don't see a  
32 purpose being served. There might be one; I don't  
33 know. I can't say.

34 MR. BUTCHER: On to 2:13, please.

35 MR. LUNN: Yes, we're here.

36 MR. BUTCHER: Sorry.

37 Q At this point, Mr. Dziekanski says:

38  
39 I will smash the entire desk. I will smash  
40 the entire desk.

41  
42 And then says something that's indecipherable  
43 followed by the word "trouble".

44 MR. BUTCHER: If we can go on to 2:20, please?

45 Q At this point, Mr. Dziekanski says:

46  
47 Leave me alone, everybody. Go away, I said.

Dr. Shao-Hua Lu

Cross-exam by Mr. Butcher (for Constable Bill Bentley)

1 MR. BUTCHER: We'll now carry on to 2:32.

2 MR. LUNN: 2:32.

3 MR. BUTCHER:

4 Q At this point, Mr. Dziekanski says:  
5 For fuck's sake.

6

7 MR. BUTCHER: Can you carry on, please, to the end of  
8 the tape? Let's stop it right there.

9

10 (VIDEO STOPPED)

11

12 MR. BUTCHER:

13 Q That's as far as I want to take you with this  
14 tape. I'm going to ask you whether you've seen  
15 any further indicia of delirium in the pieces of  
16 the tape that we've seen?

17 A No. The last little bit doesn't -- doesn't add  
18 any more to the --

19 Q Provide you with any assistance.

20 MR. BUTCHER: We have a problem, Mr. Commissioner. The  
21 tape being shown is coming up as Pritchard 1, but  
22 it is in fact Pritchard 2. I didn't realize that  
23 until we saw --

24 THE COMMISSIONER: Well, are you going to show more  
25 tape?

26 MR. BUTCHER: Yes. I'm now going to show him Pritchard  
27 1 as well, I think. The problem is that I put to  
28 him the words from Pritchard 1.

29 THE COMMISSIONER: You put the wrong words?

30 MR. BUTCHER: I put the words from Pritchard 1,  
31 thinking this was Pritchard 1. It's showing up as  
32 Pritchard 1, and so I'm going to go back to  
33 Pritchard 1 now.

34 MR. LUNN: Sorry, Mr. Commissioner. I might just need  
35 a moment to make sure that I have the right file  
36 before we continue.

37 THE COMMISSIONER: Go ahead.

38 MR. LUNN: Okay. We do have the right -- this is  
39 Pritchard.

40 MR. BUTCHER: Let's play this video and I'm going to  
41 give you the same language quotes as this video is  
42 played. Can you go to 00:30.

43 MR. LUNN: Do you want to play it through, or just...?

44 MR. BUTCHER: No, just go to 00:30.

45

46

(VIDEO BEING PLAYED)

47

Dr. Shao-Hua Lu

Cross-exam by Mr. Butcher (for Constable Bill Bentley)

1 A And you notice he's quite laborious in his  
2 breathing.

3 MR. BUTCHER:

4 Q What significance does that have?

5 A Again, in alcohol withdrawal, delirium, that  
6 laborious breathing often is a sign of either  
7 dehydration or what we call autonomic instability.  
8 Autonomic instability is the technical term for  
9 physiological changes in the body when there is  
10 increased heart rate, increased respiratory rate  
11 and -- and increased or changes in blood pressure.  
12 All of those signs have physiological changes that  
13 increase the risk of delirium or as a result of  
14 having delirium.

15 MR. BUTCHER: Okay. Can we go to 0030, please?

16 MR. LUNN: We just passed it.

17 MR. BUTCHER: Okay.

18 Q Well, at 00:30, Dr. Lu, Mr. Dziekanski said:

19

20 I will trash this office.

21

22 MR. BUTCHER: Then if we can go to 00:40, please.

23 MR. LUNN: 00:40

24 MR. BUTCHER:

25 Q And at that point -- it was at that point that Mr.  
26 Dziekanski said, "Fuck off." Now, did you notice  
27 that he was shaking his hand -- right hand?

28 A Yes.

29 Q Does that have any significance to you?

30 A The problem with that is it's -- yes and no.  
31 Tremor is often a sign of alcohol withdrawal and  
32 possible delirium, but those kind of movement can  
33 be what we call "cross tremors" (phonetic), and it  
34 doesn't necessarily -- it -- that, in and of  
35 itself, I cannot just look at that and say that's  
36 the type of tremor typical of alcohol withdrawal.  
37 I can't say that. But in my --

38 Q It might be and it might not be.

39 A But it may or may not be. So I don't put a whole  
40 lot of significance on that. But sort of as an  
41 overall picture.

42 MR. BUTCHER: We can go to 1:11, please.

43 MR. LUNN: That was 1:11.

44 MR. BUTCHER:

45 Q Okay. And at this point, Mr. Dziekanski says:

46

47 I will smash the glass.

1 A And actually I want you to play through --

2 Q

3 I will smash the glass.

4 A -- play through this a little bit. Because this  
5 is a -- in my mind, an interesting vignette.

6 MR. LUNN: Just play through?

7 A Yes.

8 MR. BUTCHER: Stop at 1:32, please.

9 MR. LUNN: That's just there.

10 MR. BUTCHER: Okay.

11 Q At this point, Mr. Dziekanski says:

12

13 What did you say? You will not let me.

14

15 Have you seen any observations?

16 MR. BUTCHER: Keep going to 1:38, please.

17 MR. LUNN: That's 1:38.

18 MR. BUTCHER:

19 Q At that point, Mr. Dziekanski says:

20

21 You will not let me.

22

23 MR. BUTCHER: To 1:44, please.

24 A You notice the door kind of swinging back and  
25 forth behind him? For most people, if they have  
26 full awareness of what's happening, that can be  
27 really disturbing. Where somebody with delirium,  
28 that -- they tend to ignore those kind of stimuli.  
29 It's -- it's odd. It's really unusual to see  
30 that.

31 MR. BUTCHER: To 1:44 --

32 A There might be a little bit further evidence of  
33 the door actually hitting Mr. Dziekanski and him  
34 ignoring it. I don't remember fully, but I  
35 believe it's in this tape.

36 MR. BUTCHER: Okay. 1:44, please.

37 MR. LUNN: That's it.

38 MR. BUTCHER:

39 Q At this point, Mr. Dziekanski says:

40

41 For fuck's sake, I will sue you and everybody  
42 else.

43

44 MR. BUTCHER: To 1:54, please.

45 Q He says:

46

47 Fine, fine. We're in a different country,

1                   so...

2

3       MR. BUTCHER: To 2:13.

4       A     So he actually was talking to somebody at that  
5            point, because initially when he made that  
6            statement, I thought he was by himself and making  
7            that comment. So he actually was conversing with  
8            people, so he wasn't talking to somebody who was  
9            imaginary.

10      MR. BUTCHER: To 2:13, please.

11      MR. LUNN: That's 2:13.

12      MR. BUTCHER:

13      Q     At this point, he says:

14

15                   I'll smash the entire desk. I will smash the  
16                   entire desk.

17

18      MR. BUTCHER: To 2:20.

19      MR. LUNN: That's 2:20 to 2:21.

20      MR. BUTCHER:

21      Q     At this point, he says:

22

23                   Leave me alone. Everybody go away.

24

25      MR. BUTCHER: To 2:32.

26      MR. LUNN: 2:32.

27      MR. BUTCHER:

28      Q     At this point, he says, "For fuck's sake."

29      A     And you notice how he moves? Kind of shuffling.

30            That's what we mean by wide-based gait.

31      MR. BUTCHER: Carry on to the end of this tape, please.

32      A     See, that's what I mean by the door not hitting  
33            him, but the door was impeded by his presence and  
34            he really wasn't paying any attention to this.

35      MR. LUNN: That's the end.

36

37                   (VIDEOTAPE STOPPED)

38

39      MR. BUTCHER:

40      Q     And what I should tell you is said, simply at  
41            different times, before the police come in the  
42            second tape in time, which is the first tape we  
43            watched, is simply right at the beginning. Mr.  
44            Dziekanski said:

45

46                   How long do I still have to wait?

47

1 Then after two minutes, he said:

2

3 So you'll not let me go, you'll not let me  
4 out of here.

5

6 And then at three minutes, he said:

7

8 Police. Police.

9

10 And then just before he was tasered, he said:

11

12 Leave me alone. Leave me alone. Did you  
13 become stupid or are you out of your mind?

14

15 So those are the things that the translator has  
16 been able to hear and translate from the tape.  
17 Having seen the tape, having heard the words  
18 spoken by Mr. Dziekanski, having read the  
19 circumstances of the case, Exhibit 105, and having  
20 read Dr. Lee's report, are you able to tell us  
21 whether, in your opinion, this person is in a  
22 state of delirium? Are you able to provide that  
23 medical opinion?

24

A I think with all the information that's available  
25 to me, with the facts and assumptions that are  
26 laid out for me and the observations and the  
27 translation available, it is still, in my opinion,  
28 that it's more likely than not that Mr. Dziekanski  
29 was in a state of delirium during the Pritchard  
30 video was taken (sic).

31

Q Now, I think we've heard you say that delirium is  
32 not a steady state.

33

A No.

34

Q And you made reference earlier to a case in which  
35 you'd been able to go in and speak to a Cantonese-  
36 speaking elderly woman and calm her down.

37

A Yes.

38

Q There is evidence here that the police were able  
39 to calm Mr. Dziekanski down briefly. Is -- does  
40 that become a stable situation when somebody who  
41 is in a delirious state calms down, or does it  
42 remain an unstable state, or can you help us with  
43 that at all or is it just too variable to say?

44

A I think if you know what you're doing, and you go  
45 in and you understand the language and you're able  
46 to communicate with the individual and you  
47 recognize that they are in a state of delirium and

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1           you're able to make a degree of intervention and  
2           calming gestures, support, own language, providing  
3           -- asking the right questions, you can maintain a  
4           degree of calmness over periods of time.

5           Q     But that's something you, as a trained  
6           psychiatrist, can do.

7           A     Yes. Not all the time, but, you know, sometimes  
8           you can.

9           Q     Have you see this document, Exhibit 105?

10          A     Which document?

11          Q     It's the circumstances.

12          A     Mr. Vertlieb provided that to me earlier today and  
13                I have a chance to glance through it, and I've  
14                obviously a chance to read through it just now.

15          Q     Until today, you had not seen it?

16          A     No.

17          MR. BUTCHER: Thank you. Those are my questions.

18

19          CROSS-EXAMINATION BY MR. HIRA ON BEHALF OF CONSTABLE

20                KWESI MILLINGTON:

21

22          Q     Doctor, my name is Ravi Hira. I represent  
23                Constable Kwesi Millington.

24          A     Okay.

25          Q     I first have some series of general questions  
26                regarding delirium and then I wish to deal with  
27                your report which has been marked as an exhibit.  
28                Would you agree with the statement that delirium  
29                can have a profound effect on someone's strength?  
30                In other words, they can appear and act a lot  
31                stronger.

32          A     Yes. Again, delirium has a range of severity.  
33                Not necessarily all delirium, but there are  
34                circumstances where some individuals in a state of  
35                delirium can exhibit greater strength than one  
36                would anticipate.

37          Q     Thank you. Would you agree with this proposition,  
38                that delirium causes physiological responses such  
39                as instability, rapid breathing, sweating,  
40                increased heart rate, unstable blood pressure.

41          A     That's an inaccurate statement. Delirium is a  
42                physiological response to an underlying medical  
43                condition. In that condition, often, in addition  
44                to having changes in cognition leading to  
45                delirium, that underlying medical condition can  
46                also cause unstable autonomies such as heart rate,  
47                blood pressure and so on. So the delirium doesn't

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1           cause it. It is associated with it.

2           Q     Yes, thank you. I worded it wrongly. And also,  
3                 that it -- that these -- these are physiological  
4                 responses. Those are the unstable blood pressure,  
5                 increased heart rate, rapid breathing, sweating,  
6                 et cetera, to changes in perception.

7           THE COMMISSIONER: I think you're putting it all  
8                 backwards. This is all backwards, isn't it?

9           MR. HIRA: Well, let's deal with it another way. I  
10                have a transcript of your evidence given during  
11                the study session, and I'm actually paraphrasing  
12                from page 6, line 42, going on to page 7, line 3.  
13                Maybe I should just put that before you and read  
14                it to you because then it won't be backwards.

15                And I have an extra copy for Mr.  
16                Commissioner.

17           Q     You gave evidence on -- during the study session  
18                 on May 13, 2008. Starting at line 42 at page 6,  
19                 you said [as read]:

20                         Delirium is a medical physiological response  
21                         to external insults.

22                           
23                           
24           A     Yes.

25           Q                         Almost always, patients with delirium will  
26                         have what we call autonomic instability:  
27                         rapid breathing, sweating, increased heart  
28                         rate, unstable blood pressure. Those are the  
29                         physiological responses to the changes in  
30                         perception.  
31                           
32                         

33           A     Yes.

34           Q     And that is your evidence today as well.

35           A     Yes.

36           Q     Thank you. Now, you also noted during the study  
37                 session, that long -- that you've seen instances  
38                 with -- in long-haul flights, people flying a full  
39                 day, having prolonged sleep deprivation, getting  
40                 into a state of delirium.

41           A     There's an increased risk of that.

42           Q     Thank you. And, as I understand it, the sudden  
43                 onset of delirium may be a warning of potential  
44                 life-threatening metabolic changes.

45           A     Correct.

46           Q     And people that are in this condition are unable  
47                 to understand basic instructions, such as putting

1 an object down.

2 A They might not be able to. Not always. Like I  
3 described to you -- sorry, I've -- Mr. Kosteckyj,  
4 that the -- there is a degree. Some individuals  
5 can, some people can't. Depends on really the  
6 circumstances and the instruction provided.

7 Q All right. Let's just deal with that in terms of  
8 the questions and answers that you gave on May the  
9 18th to Mr. Vertlieb. If I could have you turn to  
10 page 13 of the transcript, and I'm going to read  
11 the questions and answers from line 17 to the next  
12 page, line 6, page 14, line 6 [as read]:  
13

14 Q What about in a police setting, when the  
15 police attend and give basic instruction.  
16 Give an example of what -- where a person  
17 might not be able to comprehend.

18 A Yes.

19 Q You mention putting up -- putting your hands  
20 up.

21 A Putting your hands up, put down a certain  
22 object.

23 Q So if a person was in a state of --  
24

25 Sorry.  
26

27 So if a person was in that state, a simple  
28 command or whatever you might want to call  
29 it from the police might not be understood.

30 A May not be understood or may be  
31 misinterpreted in ways that they might not  
32 have understood, but they might not perform  
33 due to their internal confusion and thought  
34 process.  
35

36 Firstly, those questions and answers -- you were  
37 asked those questions and you gave those answers?

38 A Yes.

39 Q And they continue to be accurate today?

40 A Yes.

41 Q Continuing on. Mr. Vertlieb asked:  
42

43 Q Now, then, you also went on to say that a  
44 person could appear more aggressive. Just  
45 expand on that for a moment.  
46

47 And you answered:

1           The individual, as I say, often is in a  
2           frightened state. Again having seen close to  
3           1,000 delirious patients, I probably have  
4           seen only two individuals to have happy  
5           delirium and the rest are frightened, scared.  
6           And when you're frightened and scared, it's a  
7           fight or flight response. It's a basic --  
8           that is basic to human nature, and in that  
9           state, aggression is not uncommon.

10

11

You were then asked:

12

13

Q       So are you saying to the Commissioner that  
14       the person could appear to be aggressive, but  
15       in fact not really at their core, aggressive.

16

A       No, no, no. They can be aggressive, not just  
17       appear aggressive, but they are aggressive.

18

19

You can have both in the sense that, for  
20       example, this is a perfect example: A  
21       patient believes that somebody is going to  
22       kill them. In the middle of the night,  
23       they're going to leave here, and if you're  
24       going to stop them, you're going to be  
25       aggressive, and they don't just appear  
26       aggressive. They will be aggressive.

26

27

And you were asked those questions and gave those  
28       answers?

28

29

A       Yes.

30

Q       And they continue to be accurate today?

31

A       Yes.

32

Q       So a person in a delirious state is not -- does he  
33       appear to be aggressive, but is aggressive. Would  
34       you agree with that proposition?

33

34

A       Can be.

35

36

Q       Thank you. Now, you were -- would you agree with  
37       the proposition that in a situation where a person  
38       is in a delirious state and appearing to be  
39       aggressive, that communication doesn't work? De-  
40       escalation doesn't work as the patient is simply  
41       in an agitated state.

36

37

38

39

40

41

A       Well, it depends on how agitated they are and what  
42       state they are. Sometimes de-escalation works,  
43       sometimes it can't. There are times when trying  
44       to reason with somebody who is in a significant  
45       state of delirium, it may not be possible.

42

43

44

45

46

Q       All right. And in fact the Commissioner asked you

47

1 the following question at page 18, and I'm at line  
2 44. I'm going to go to page 19, line 32. But  
3 would you be able to --

4 A Page 19 or it's page 18?

5 Q We're starting at page 18, line 44.

6

7 But would you be able to say whether or not  
8 there could be a state reached where  
9 something as severe as a Taser could be used?

10

11 And you answered:

12

13 And I will say yes for a couple of reasons.  
14 Number one, again, delirium is presented in a  
15 disorganized, agitated state. I cannot tell  
16 -- for example, let's say if I were to see a  
17 patient, I don't think I can tell whether or  
18 not in, let's say, a brief two minutes or 15  
19 seconds, if they have that information, you  
20 know. Somebody who's really agitated --  
21 let's say I drive down the street and  
22 somebody, whether or not they're in a  
23 delirious state, in a severe psychotic state,  
24 in a drug-induced state, I don't think one  
25 can tell. And, in that case, necessary force  
26 to help control the situation. Don't forget,  
27 if a patient is in a delirious state, they  
28 can really harm themselves, and they can  
29 really harm themselves again. Not because  
30 they mean to, but because they have become  
31 disorganized, run out in traffic and other  
32 things.

33

34 In hospital, again, I can really speak about  
35 hospital setting. There are times when,  
36 really, it's heart-wrenching for a family to  
37 see three security guards go in to pile onto  
38 an elderly individual. But, you know,  
39 sometimes that's the only way to have the  
40 situation controlled. And so translating  
41 that scenario into the community setting, I  
42 can certainly see scenarios where attempt at  
43 communication doesn't work, attempt to de-  
44 escalate doesn't work, and the patient is  
45 simply in an agitated state. In that case,  
46 weapon use or whatever restraint necessary to  
47 get the individual in a safe environment is

1                   perhaps necessary.

2

3                   You gave that answer, and do you continue to  
4 believe it's accurate?

5           A        Yes.

6           Q        Thank you. Now, dealing with your report, Exhibit  
7 77. The purpose of the report was to provide your  
8 best estimate or opinion on Mr. Dziekanski's  
9 mental status based on the information that you  
10 were provided and had available at the time; is  
11 that correct?

12          A        Correct.

13          Q        And while you didn't have the translation that you  
14 now have that is Exhibit 33, and the assistance of  
15 the translation on the video as Mr. Butcher  
16 provided, you certainly had a translation of the  
17 video provided to you by the RCMP; is that  
18 correct?

19          A        Yes.

20          Q        And you note that, at page 4 of your report,  
21 paragraph 6, the third-last bullet in paragraph 6  
22 is a translation of Polish video by Constable  
23 Visic (phonetic)?

24          A        Yes.

25          Q        And you had the words of that translation that  
26 you've set out at page 9, paragraph 14.

27          A        Yes.

28          Q        And then you proceeded to express your medical  
29 opinion starting at page 12.

30          A        Yes.

31          Q        You've already been taken to the first paragraph  
32 of your opinion by Ms. Roberts. In the second  
33 paragraph you opined that -- that the state of  
34 agitated delirium, that there was no other  
35 potential medical psychiatric condition that could  
36 better account for Mr. Dziekanski's behaviours and  
37 mental status.

38          A        One of the things that's important to note is  
39 somebody, let's say with bipolar effective  
40 disorder in a manic state, or somebody with an  
41 acute brain infection, for example, or somebody  
42 who's on crystal methamphetamine can behave much  
43 in the same way that I observe for Mr. Dziekanski.

44                   What I make in the assumption is that none of  
45 those things happened, that he's not on drugs,  
46 that he is -- he doesn't have a pre-existing  
47 psychiatric condition, that he doesn't have a

1 brain tumour to account for this, that he doesn't  
2 have dementia. He doesn't have any of those  
3 medical conditions that can cause this, and so one  
4 ends up with what can possibly lead to this degree  
5 of mental status? If I make the assumption that  
6 Mr. Dziekanski does not have bipolar effective  
7 disorder, that there's no psychiatric condition,  
8 that he does not use any drugs, no previous pre-  
9 existing psychiatric conditions, and that there  
10 are no autopsy reports to find, let's say, adrenal  
11 gland that's out of whack, then the -- the medical  
12 opinion of delirium is made based on that.

13 Q So it's based on eliminating a number of  
14 physiological and psychological factors.

15 A Correct.

16 Q And you continue at the bottom of page 12 in the  
17 second-last -- sorry, the third-last sentence,  
18 talking about excited delirium but saying,  
19 basically, that delirium is often understood --  
20 and I'm reading from the third line from the  
21 bottom:

22  
23 ...as individuals with agitation, cognitive,  
24 perceptual and thought disturbances.

25  
26 Correct?

27 A Yes.

28 Q And so in terms of thought disturbances,  
29 perceptual and thought disturbances, would that be  
30 consistent with an individual when approached by  
31 the police arming himself with a stapler?

32 A If all of those assumptions are made, then I would  
33 say the individual would then just, generally  
34 speaking, grab whatever is present as a defensive  
35 measure. So I'm not too sure, you know, that the  
36 statement of specifically grabbing a stapler is a  
37 purposeful action or just it happens to be there.  
38 I can't tell. That's not unusual.

39 Q Just grabbing something regardless --

40 A Yes.

41 Q -- is not unusual.

42 A Yes.

43 Q And what about grabbing something and then  
44 clenching it tightly in a fist, both fists  
45 clenched?

46 A Yes.

47 Q That's something you would expect to find?

- 1 A Correct.
- 2 Q And sort of grabbing a stapler about chest-high,  
3 clenched in the fist, the other fist clenched and  
4 advancing towards the police. That's something  
5 that you wouldn't find unusual?
- 6 A I mean, in those kind of circumstances, we're  
7 speaking really right now almost in hypothetical  
8 fashion. In terms of the actual -- I can't really  
9 say from the videotapes, but what I can say is  
10 when -- if an individual -- an assumption is made  
11 the individual is in a delirious state, then the  
12 grabbing on of some inanimate object as a way to  
13 kind of protect oneself would be an expected  
14 action.
- 15 Q Okay. You also note that defensive aggression and  
16 agitation is common in delirium. That's at the  
17 top of page 13.
- 18 A Yes.
- 19 Q And that delirium is a serious medical condition  
20 that negatively affects all aspects of general  
21 brain function.
- 22 A Yes.
- 23 Q And you note at the bottom of page 13, and this  
24 appears to be based on the video footage. Looking  
25 at the first sentence of the last paragraph, that  
26 he demonstrated:  
27  
28 ...classical features of delirium, especially  
29 based on the Pritchard video.  
30
- 31 I gather that continues to be your opinion, even  
32 after having read the circumstances?
- 33 A Yes.
- 34 Q You've already commented on barricading as -- and  
35 aggressive behaviour as delirious  
36 misinterpretation of the external environment,  
37 something that's common in such patients.
- 38 A Yes.
- 39 Q And that's at page 14?
- 40 A Yes.
- 41 Q You noted from, I gather, the YVR, the Customs and  
42 airport video and the Pritchard video that there  
43 appeared to be a rapid onset of the agitation.
- 44 A Yes.
- 45 Q Which further reinforces your view that he was in  
46 a state of delirium?
- 47 A It's one of the factors.

Dr. Shao-Hua Lu

Cross-exam by Mr. Hira (for Constable Kwesi Millington)

Cross-exam by Mr. Neave (for TASER International)

1 Q And you note that at page 14 of your report?

2 A Yes.

3 Q And you conclude at the bottom of page 15 that the  
4 Pritchard video provides an excellent  
5 documentation of his mental status, and it is  
6 sufficient to establish a clear clinical picture  
7 of his mental status before death, going on to  
8 page 16.

9 A Yes.

10 Q And that is, that he was in the syndrome of  
11 delirium.

12 A Yes.

13 Q And in those circumstances, he would have great  
14 difficulty understanding, responding, dealing with  
15 his environment, and particularly the police.

16 A Well, particularly given the fact that Mr.  
17 Dziekanski doesn't speak English, or really  
18 limited English. The lack of language is  
19 particularly frightening for an individual who is  
20 in a state of delirium.

21 Q Yes. And as you've noted earlier, this state is  
22 difficult to detect for an ordinary person,  
23 somebody who isn't a trained practitioner like  
24 you.

25 A Yes.

26 MR. HIRA: Thank you. Those are my questions.

27 THE COMMISSIONER: Mr. Neave, would it be convenient to  
28 have a break?

29 MR. NEAVE: I'm in your hands, Mr. Commissioner. I  
30 have one question.

31 THE COMMISSIONER: Oh, go ahead. Go ahead.

32 MR. NEAVE: I'll be brief. For the record, David Neave  
33 for TASER.

34

35 CROSS-EXAMINATION BY MR. NEAVE ON BEHALF OF TASER  
36 INTERNATIONAL:

37

38 Q Doctor, I just want to ask you a single question,  
39 and that's with respect to your opinion on  
40 cognitive disturbance that we've been speaking  
41 about and these factors, and get your view on  
42 them, please. We know from the evidence that Mr.  
43 Dziekanski arrived in the Customs hall at  
44 approximately four o'clock in the afternoon, and  
45 he was there until approximately midnight. We  
46 know from the evidence that he had -- he had money  
47 with him. He had his mother's phone number. He

Dr. Shao-Hua Lu

Cross-exam by Mr. Neave (for TASER International)

Cross-exam by Mr. Kosteckyj (for Zofia Cisowski)

1 had a bank card. He had a cell phone that could  
2 make emergency calls. He had a strawberry Danish  
3 with him --

4 MR. KOSTECKYJ: With respect, I don't think there's any  
5 evidence that he had a cell phone that could make  
6 emergency calls. I don't know where that evidence  
7 comes from.

8 THE COMMISSIONER: Well, I'll let Mr. Neave go ahead  
9 and the premises, we'll later see whether they're  
10 proven.

11 MR. NEAVE: I understand it's from Mr. Hoivik's  
12 evidence.

13 Q And he had a Polish-English dictionary. How do  
14 those factors influence, if any, your opinion.

15 A I don't know if they make a whole lot of  
16 difference in my opinion. It just seems  
17 surprising that an individual, after a large  
18 number of hours, to not take that step to seek --  
19 directly seek support and using translation  
20 language. On the other hand, you know, he hasn't  
21 slept for a few days, or a number of hours, he  
22 might be tired, and he's in a highly unfamiliar  
23 environment. So he's anxious.

24 Q Do you those -- do those factors -- or do they  
25 indicate some level of cognitive disturbance in  
26 your view?

27 A Just those information in themselves, no.

28 MR. NEAVE: Thank you, Mr. Commissioner, those are my  
29 questions.

30 THE COMMISSIONER: Anybody else?

31 MR. KOSTECKYJ: Something that arose out of Mr.  
32 Butcher's video statements.

33 THE COMMISSIONER: Yes, go ahead.

34

35 CROSS-EXAMINATION BY MR. KOSTECKYJ FOR ZOFIA CISOWSKI,  
36 continuing:

37

38 Q First of all, you talked about the fact that my  
39 friend, Mr. Hira, asked you about the rapid onset  
40 of agitation. Do you recollect that, Doctor?

41 A Yes.

42 Q And you indicated that's one of the signs of  
43 delirium or can be.

44 A It can be.

45 Q And, now, you remember the first tape that Mr. --  
46 tape 1 that Mr. Butcher showed you. That's when  
47 he told you --

Shao-Hua Lu

Cross-exam by Mr. Neave (for TASER International)

Cross-exam by Mr. Kosteckyj (for Zofia Cisowski)

1 A The police -- the one that police arrived?

2 Q Before the police arrived.

3 A Okay.

4 Q When the swearing was taking place.

5 A Yes.

6 Q If I told you that right before that he had had an  
7 argument with this gentleman, the chauffeur --

8 A Yes.

9 Q -- that's an explanation for why he would have  
10 become -- rapid onset of agitation as well,  
11 correct?

12 A No. I -- I would have a tough time with that,  
13 because the holding the chair, the putting those  
14 two sort of -- I guess this kind of armchair into  
15 the doorway, not really as aware, those types of  
16 behaviour are more typical of what one would see  
17 in what I call defensive aggression, more -- less  
18 -- a lot less purposeful. Whereas if somebody is  
19 angry and they just -- they're still angry a  
20 couple of hours later, and there's just -- you  
21 know, 30 minutes later they just have a earlier  
22 argument with somebody and they just got them  
23 really riled, and they're still hot (sic).

24 And having worked with drug-addicted patients  
25 all the time, you know, I also see the other side,  
26 which is regular, good old-fashioned anger. I  
27 don't see Mr. Dziekanski in a really mean angry  
28 state. What I see is more of a frightened,  
29 scared, but yet at the same time -- and I use the  
30 word defensive aggression to go along with the guy  
31 is scared. He was -- it is quite evident to me,  
32 working with this, seeing those behaviours, a  
33 person who is scared and also frightened.

34 Q And if that is a response to someone that was just  
35 threatened by somebody, or felt threatened, is  
36 that not a reasonable response? If he had just  
37 been --

38 A Being frightened and being scared, yes, it would  
39 be a reasonable response. But the purpose -- the  
40 non-purposeful action that he demonstrates are not  
41 typical responses.

42 Q Okay. I'm just going to take you to the second  
43 tape. It's the part where you see -- yeah, and  
44 there's a third individual there with him.

45 MR. KOSTECKYJ: I think it was something like 2:10 or  
46 something you said. Just a little bit further.  
47 Yeah, just go there, start there. Just go back.

1           Yeah.

2

3

(VIDEO BEING PLAYED)

4

5       MR. KOSTECKYJ:

6       Q     Do you see there are three individuals here now?

7       A     Yup.

8       Q     There's two security guards and another man.

9       A     Yup.

10      Q     All right. That's just -- for the record, that's  
11           Mr. Meltzer, he was here earlier.

12      MR. KOSTECKYJ: Just play it forward.

13      A     Which one's Mr. Meltzer?

14      Q     He's the man in the suit standing --

15      A     This guy?

16      Q     Yes.

17      A     On the far left corner on the --

18      Q     Right. Do you see the arrow onto him now?

19      A     Yup. Yup.

20      Q     All right. Now, did you see that he just took his  
21           phone and he walked away from the area?

22      A     Mm-hmm.

23      Q     Okay. Just before that, did you notice that after  
24           he walked away, that Mr. Dziekanski came towards  
25           the doors and moved the chair away from himself?

26      A     You know what? I did not understand the context  
27           of that.

28      Q     All right. Well, in the -- does it fit into this  
29           context that when Mr. Meltzer, the man who -- he  
30           had had an argument with, left the scene, he no  
31           longer felt threatened and he moved the chair away  
32           from himself. Does it fall into that  
33           understanding to you, sir?

34      A     When I take the whole scenario into an entire  
35           piece, that's my opinion. If you were just to  
36           look at that one snippet and just based on that  
37           one snippet, that would make sense.

38      Q     Okay. Well, that's all I'm asking you, is in the  
39           context of that motion, that movement where Mr.  
40           Meltzer leaves the scene and within a few seconds,  
41           Mr. Dziekanski comes to the doors and pushes the  
42           chair away that's in front of him.

43      A     No, but he's pushing it towards the door, isn't  
44           he?

45      Q     Well, let's just go back for a second.

46      MR. KOSTECKYJ: Back it up. Go forward.

47      Q     Do you see him pushing it away?

Dr. Shao-Hua Lu

Cross-exam by Mr. Kosteckyj (for Zofia Cisowski)

1 A Good.

2 Q Do you see that, sir?

3 A Yes.

4 Q So that's consistent with someone who is -- now  
5 feels that the threat is away, I'm going to move  
6 the chair out of the way.

7 A And so one also -- you know, looking at it from  
8 the delirium standpoint again, if Mr. Dziekanski  
9 have delirium and is frightened and scared, got  
10 into an argument with Mr. Meltzer, his  
11 misinterpretation of that interaction becomes  
12 heightened. The perceived threat of Mr. Meltzer  
13 walks away, he feels more comfortable. That also  
14 makes sense.

15 Q Yeah, but it also makes sense whether he was  
16 delirious or not, doesn't it?

17 A Absolutely.

18 MR. KOSTECKYJ: All right. Thank you.

19 THE COMMISSIONER: That's everybody?

20 MR. VERTLIEB: I think that's the end, then, for Dr.  
21 Lu.

22 THE COMMISSIONER: Dr. Lu, once again I must thank you  
23 very much for your time and trouble.

24 A You're welcome.

25

26 (WITNESS EXCUSED)

27

28 MR. VERTLIEB: I'm sorry, Mr. Butcher has something.

29 MR. BUTCHER: Dr. Lu is finished on --

30 THE COMMISSIONER: Oh, thank you, Doctor.

31 MR. BUTCHER: Further to the discussion that we had  
32 this morning, I have copies of the statements of  
33 Dibon and Ms. Czernel and I'd ask to be marked as  
34 the next two exhibits.

35 THE COMMISSIONER: Yes, all right. They'll be the next  
36 exhibits.

37 MR. VERTLIEB: Now, just to update, Mr. Commissioner,  
38 we've completed Dr. Lu this morning and this  
39 afternoon, so that's good. Tomorrow we have the  
40 two witnesses from CBSA, Canadian Border Services  
41 to talk about their policy. We will have some  
42 questions about the policy that was in place at  
43 the time, October '07, concerning the delivery of  
44 information if someone phoned and wanting to know  
45 where their relative was. There's a question  
46 about rovers who go through the Customs Hall, but  
47 we won't be too long in chief, but we've scheduled

1 those two because of the discussion we've had with  
2 Mr. Brongers. We've scheduled those two people  
3 for the day. It's very difficult to understand  
4 what questions our friends may have, but we want  
5 people to feel comfortable as we've done  
6 throughout in having the time they think they  
7 need. So that looks after Tuesday for the  
8 Commission.

9 Wednesday morning we'll have Superintendent  
10 Rideout back, and then with him is Officer  
11 Lightfoot - I believe it's Inspector - and he came  
12 a year ago in May and spoke to you about RCMP  
13 policy on Taser use. He's been mentioned as one  
14 of the policy witnesses that Ms. Roberts wants to  
15 have come and speak with you, so he's scheduled in  
16 that Wednesday slot.

17 We have YVR policy changes and we've  
18 restricted that to one full day, which should be  
19 ample. I think YVR will be on the Thursday only  
20 for one day. They've done a number of things they  
21 want to discuss with you.

22 Friday is the only Friday we're sitting, and  
23 that's for Dr. Tseng. Now, Dr. Tseng is trying to  
24 get his report to us this evening so we can  
25 distribute it to our colleagues here in time for  
26 him to be here.

27 Now, just while I'm taking a moment, if I  
28 may, just to take you through, then, the last week  
29 of our evidentiary phase. You're going to hear  
30 from Corporal Gillis. That's -- if you recall,  
31 Mr. Butcher could not be with you and so we've  
32 accommodated Mr. Butcher's schedule and we're  
33 happy to do that; it's important. So we have  
34 Gillis, and then we have Dr. Noone, a psychiatrist  
35 whose opinion may be of some assistance to you.

36 Then the rest of the week we have Dr.  
37 Webster, the psychologist on the use of force and  
38 how the event unfolded. We have another gentleman  
39 that, at the request of Mr. Kosteckyj, a Mr.  
40 Nichol (phonetic) who is a former police officer,  
41 an instructor on use of force. Mr. Kosteckyj has  
42 asked us to call him, and as with other requests  
43 we've had, we've accommodated.

44 Then we have Dr. Chambers. We still have not  
45 been able to sort out Dr. Ho's apparently  
46 incredibly busy schedule. If we can get Dr. Ho in  
47 this week, we could call him on the Thursday, the

1 7th, which would work -- or even tomorrow  
2 afternoon. We don't anticipate that he's going to  
3 fly in. We could do him by video. If worst comes  
4 to worst and we can't have him appear because he  
5 seems to have an almost impossible schedule, then  
6 perhaps it's just a matter of filing his report  
7 and letting it sit that way. But maybe -- we'll  
8 see if Mr. Neave or Ms. Spencer can help us.

9 But it seems that we're still on track to  
10 finish the evidence by next Thursday, which is the  
11 scheduled date, which then leaves all of the  
12 participants opportunities to work on their  
13 written submissions and deal with closing argument  
14 the last week of May.

15 THE COMMISSIONER: Is everybody content with the order  
16 I've -- not the order, but the procedure I've set  
17 out for written submissions? I've tried to be  
18 generous, but I don't want everybody to take too  
19 long.

20 MR. NEAVE: Mr. Commissioner, David Neave for the  
21 record. The only thing that hasn't been built  
22 into the schedule is the ability to reply. I  
23 suspect that the various arguments that are going  
24 to be put before you, Mr. Commissioner, are going  
25 to have some contentious issues in them, and I  
26 would anticipate a reply will be required, and we  
27 don't seem to have an order of how that might  
28 work. I'm in your hands on that issue. I'm just  
29 not -- just not sure if we built that in or what  
30 your thoughts are with respect to those issues.

31 THE COMMISSIONER: I've changed my mind on a few things  
32 a few times, but was not the written submissions  
33 to be in on the Thursday? Yes. Written  
34 submissions were to be filed and exchanged.

35 MR. NEAVE: Okay.

36 THE COMMISSIONER: I hope I said that. Exchanged on  
37 the Thursday and that, then, would give time to  
38 consider the reply.

39 MR. NEAVE: Thank you.

40 THE COMMISSIONER: And then the reply can be oral in  
41 the next week. It could be incorporated in your  
42 main submissions --

43 MR. NEAVE: Yes.

44 THE COMMISSIONER: -- as far as that goes.

45 MR. NEAVE: Yes. Fine. Thank you.

46 THE COMMISSIONER: We'll be a little flexible there.

47 MR. NEAVE: Thank you.

1 MR. BUTCHER: I wonder if -- frankly, if this might  
2 make some sense. I imagine that there may be some  
3 things that Commission counsel and Mr. Kosteckyj  
4 and Mr. Rosenbloom and perhaps Ms. Pastine might  
5 say that might be similar. There may be some  
6 things that the police witnesses might say -- are  
7 going to say in reply to all of that, and I wonder  
8 if the -- if we could arrange an order so that our  
9 submissions on behalf of the police witnesses were  
10 in response to Commission counsel's, Poland's, and  
11 the family's submissions.

12 THE COMMISSIONER: Well, I don't think so. I think the  
13 way these procedures have gone, and having regard  
14 to the ability and experience of counsel, I think  
15 everybody here knows the subjects that are going  
16 to be addressed. I'd be very much surprised if  
17 there was a surprise. But if there is, we'll  
18 handle it and give time.

19 MR. BUTCHER: Thank you.

20 THE REGISTRAR: Mr. Commissioner, if I may mark those  
21 two documents now? The first document marked  
22 "Task 0364" will be marked as Exhibit 119. The  
23 document marked "Task 0365" will be marked as  
24 Exhibit number 120.

25  
26 EXHIBIT 119: Translation Task #0364 for  
27 Aneta Czernel

28  
29 EXHIBIT 120: Translation Task #0365 for  
30 Wojciech Dibon

31  
32 THE COMMISSIONER: Yes, that's fine. All right.  
33 Tomorrow at 10:00.

34  
35 (EXCERPT CONCLUDED)

36  
37 (PROCEEDINGS ADJOURNED TO MAY 5, 2009 AT  
38 10:00 A.M.)  
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