

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

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

May 21, 2009

PROCEEDINGS AT
HEARING (DAY 55)

COPY

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(ii)

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Counsel for Vancouver Airport Authority:	D. Stewart, C. Friesen
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
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Counsel for Constable Bill Bentley:	D. Butcher
Counsel for Constable Kwesi Millington:	R. Hira, Q.C.
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Counsel for City of Richmond:	J. Goulden, M. Kleisinger, G. Trotter
Counsel for TASER International, Inc.	D. Neave, J. Spencer
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Transcriber:	P. Kealy

Vancouver, B.C.
May 21, 2009

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4 THE REGISTRAR: Order. This hearing is now resumed.

5 THE COMMISSIONER: Yes. Good morning, all.

6 MR. VERTLIEB: Mr. Commissioner, today we have Dr. Paul
7 Janke. He will be the only witness today, and I
8 don't think we'll be all day, but obviously one
9 never knows.

10 Tomorrow we have Mr. Orv Nickel, who is a
11 gentleman who will be giving evidence about use of
12 force. He is in Quebec tomorrow, so we will have
13 to do his evidence by teleconference in some way.
14 And unfortunately for the timing, he's only
15 available tomorrow afternoon starting at one
16 o'clock Pacific daylight time. So we won't sit
17 tomorrow morning but we'll have to sit tomorrow
18 afternoon, just sit, with your leave of course, as
19 long as it takes to finish his evidence.

20 Just to give a window to next week, Monday we
21 have Mr. Fredericks, who will be available
22 starting at 10:00 a.m., and that evidence will be
23 led by Mr. Butcher in chief, and if Commission
24 counsel has any questions, we can deal with that
25 at the end. And Mr. Fredericks is organized for
26 that day.

27 I understand Mr. Rosenbloom has already
28 indicated to you that he may have some evidence in
29 answer to Mr. Fredericks, and we're awaiting
30 confirmation of that. And if so, that would be
31 Tuesday. And then that should be the end of the
32 evidence phase of the case.

33 As to the closing argument, it seems that
34 almost everyone is agreeable to starting on June
35 19th to accommodate a scheduling issue on the 22nd
36 for one of the participants. We can't confirm it
37 yet, but in all probability what we'd like to do
38 is start the first day of closing argument on the
39 19th, the Friday, then not sit on the 22nd and
40 then come the 23rd and 24th, just finish. As I
41 say, almost everyone is able to accommodate that
42 change but we'll confirm it in the next couple of
43 days.

44 THE COMMISSIONER: Counsel, those things are just fine
45 with me if they can be arranged.

46 MR. VERTLIEB: Thank you, Mr. Commissioner. We
47 appreciate your flexibility in our desire to

Paul Janke

In chief on qualifications by Mr. Vertlieb

1 accommodate the parties.

2 Now, I notice Mr. Neave is not here and I
3 don't know -- he hasn't told us he was going to
4 come or not come. Unless you think we should
5 stand down, I'm content to proceed.

6 THE COMMISSIONER: Oh, no.

7 MR. HIRA: Mr. Neave will not be attending.

8 MR. VERTLIEB: Thank you. So then if I may begin with
9 the evidence this morning, Mr. Commissioner, and
10 the witness for the morning is Dr. Paul Janke, a
11 psychiatrist.

12
13 PAUL JANKE, a witness,
14 affirmed.

15
16 THE REGISTRAR: Would you state your full name, please.

17 A Paul Gordon Janke, J-a-n-k-e.

18 THE COMMISSIONER: Good morning, Doctor. Thank you.

19 A Good morning. Thank you. My preference is to
20 stand, if I may. Thank you.

21 MR. VERTLIEB: Mr. Commissioner, Dr. Janke is a
22 psychiatrist and well recognized in our medical
23 community. He's prepared a report dated May 6,
24 2009, and attached to that report is his
25 curriculum vitae. They are one document, and I'm
26 going to ask that the report, May 6, 2009, with
27 attached curriculum vitae, be the next exhibit.

28 THE COMMISSIONER: Yes, next exhibit.

29 THE REGISTRAR: That is Exhibit 154.

30
31 EXHIBIT 154: Copy - Dr. Janke report dated
32 May 6, 2009, with attached Curriculum Vitae
33

34 MR. VERTLIEB: Dr. Janke, your report has been
35 distributed and there's a number of counsel here
36 and all of my colleagues are free to, of course,
37 question you. So what we've been doing here in
38 the proceedings with the medical evidence is
39 Commission counsel will take you through the
40 report in a brief way and then recognizing that
41 others may have questions that will go into more
42 detail. So we will not be going into your report
43 in any great length at this time.

44 THE REGISTRAR: Counsel, may I just take a moment to
45 attach a longer mike.

46 MR. VERTLIEB: Of course, Mr. Giles. Thank you, Mr.
47 Giles. That's helpful.

Paul Janke

In chief on qualifications by Mr. Vertlieb

1 EXAMINATION IN CHIEF ON QUALIFICATIONS BY MR. VERTLIEB:

2

3

Q Briefly tell us your background in medicine, where
4 you studied and how it is you came to be
5 specialized in the field of psychiatry.

6

A Yes. I actually got -- my first post-high school
7 degree was my medical degree and that was at UBC
8 in 1982. Following that I did a one-year rotating
9 internship at St. Paul's Hospital, after which I
10 was licensed to practise medicine in the Province
11 of British Columbia. I completed a year of
12 internal medicine, mostly at St. Paul's Hospital,
13 before entering the psychiatry program. I
14 finished the psychiatry program in June 1987, at
15 which time I became a Fellow of the Royal College
16 of Physicians of Canada, specialty in psychiatry.

17

Once I was in psychiatry, I always knew I
18 wanted to do forensic psychiatry, so as part of my
19 psychiatry training I did a rotation in forensic
20 psychiatry that, as it turns out, was primarily
21 under the supervision of Dr. O'Shaughnessy at
22 Youth Forensic Psychiatric Services.

23

Upon getting my fellowship, I entered into
24 private practice, which initially was a mix of
25 general psychiatry and forensic psychiatry, and
26 part time -- or half of my time was spent at Youth
27 Forensic Psychiatric Services. I've remained at
28 Youth Forensic Psychiatric Services until the
29 present time. I am now the regional clinical
30 director of South Burnaby Region. I have
31 responsibility for our in-patient assessment unit,
32 our out-patient department, and mental health
33 services in the Youth Custody Centre in South
34 Burnaby.

35

My private practice now is almost solely
36 forensic in nature. That is, I do assessments and
37 prepare reports for a variety of different bodies.
38 The civil courts, criminal courts, various
39 governing bodies have asked me to assess
40 individuals.

41

I have a small private practice in which I
42 treat patients on an on-going basis.

43

Q So you have an extensive and broadly based
44 practice in psychiatry here in our province?

45

A Yes. Yes.

46

MR. VERTLIEB: Thank you. Now, I don't know if there's
47 any question or issue about Dr. Janke's

4
Paul Janke
Ruling on qualifications
In chief by Mr. Vertlieb

1 qualifications, Mr. Commissioner. I see
2 everyone --

3 THE COMMISSIONER: No, the doctor will be qualified as
4 a forensic psychologist.

5 MR. VERTLIEB: Psychiatrist.

6 THE COMMISSIONER: Psychiatrist, I'm sorry, Doctor.

7 A Thank you. My psychology friends would be
8 offended.

9 MR. VERTLIEB: Thanks, Mr. Commissioner.

10 THE COMMISSIONER: I majored in psychology but that's a
11 long time ago and a long way from psychiatry.

12 A Thank you.

13
14 EXAMINATION IN CHIEF BY MR. VERTLIEB:

15
16 Q Dr. Janke, let's then deal with the assistance you
17 can give to the Commissioner concerning the issue
18 around the word "delirium" and its different
19 import. Tell us what delirium means.

20 A Delirium in its simplest definition is a clouding
21 of consciousness that occurs in the context of
22 other physical factors or illnesses. It's most
23 commonly seen in hospitalized patients who are
24 suffering from a variety of processes. They may
25 be related to the medications they're on, may be
26 related to infection, may be related to the
27 withdrawal from substances and the accompanying
28 effects of that on an individual's functioning.
29 The primary feature of delirium is a clouding of
30 consciousness, in other words, an impairment of
31 the ability to perceive and interact with the
32 environment.

33 A cardinal feature of delirium is that it is
34 a waxing and waning state. There will be periods
35 of time when an individual may be fully aware of
36 their surroundings and interact appropriately with
37 their surroundings, and other times when the
38 individual is not at all in touch with their
39 surroundings and will be responding totally to
40 internal stimulus, ideas within their head.

41 Q So generally it's associated with some kind of
42 underlying medical problem?

43 A Almost invariably, yes.

44 Q So you used the word "infection." Someone can
45 have an infection that can be severe enough that
46 the brain just stops working properly; is that a
47 simple way of --

5
Paul Janke
In chief by Mr. Vertlieb

- 1 A That's a simple way of putting it. Or the
2 individual has suffered severe injuries and has
3 multiple system failures, liver failure, kidney
4 failure, other kinds of failure that just impair
5 the ability of the brain to function.
- 6 Q We've heard that delirium is really centring
7 around the word "cognition."
- 8 A Yes. By definition, delirium is clouded
9 consciousness.
- 10 Q Is delirium something that you would have to be a
11 psychiatrist to diagnose or would this be
12 something that a family physician could come in
13 contact with in a day-to-day practice?
- 14 A I would expect a family physician who has patients
15 who are in hospital or has elderly patients will
16 come into contact with delirium not infrequently.
17 It's a common occurrence towards the end of our
18 lives because of multiple system failures and
19 other problems that we have.
- 20 Q As a psychiatrist, you would deal with it more
21 often perhaps than a family doctor; is that a fair
22 way of saying it?
- 23 A As a general psychiatrist, probably not. If you
24 have any kind of a hospital practice or deal with
25 patients in any kind of a custodial type of
26 circumstance, you're going to come into contact
27 with individuals who are both medically ill,
28 severely psychiatrically ill, or have ingested a
29 variety of substances. That could lead to a
30 delirious state. Psychiatrists who have a
31 hospital-based practice, consultation-liaison
32 psychiatrists, deal with delirium on a constant
33 basis.
- 34 Q So moving, then, to the issue at hand, namely the
35 state of Mr. Dziekanski --
- 36 A Yes.
- 37 Q -- certainly in the moments before his tasing by
38 the RCMP, let's deal with Mr. Dziekanski's state.
39 You've covered the documents and materials that
40 you reviewed at page 1 of your report?
- 41 A Yes.
- 42 Q You've spoken with no one else about this case?
43 You haven't spoken with any of the witnesses, for
44 example, or any of the parties to the event?
- 45 A No.
- 46 Q Tell us what your conclusion is about Mr.
47 Dziekanski's state, his cognitive state, at the

1 time he was dealing with the police, and then I'm
2 going to ask you to tell us why you have that
3 view.

4 A Well, at the time Mr. Dziekanski was dealing with
5 the police and for the period of time immediately
6 before it, the part that's captured on what's
7 referred to as the Pritchard videos, Mr.
8 Dziekanski is clearly agitated. He's clearly
9 distressed. At times he's clearly angry. What is
10 striking is that whenever there is an opportunity,
11 he interacts with the people around him. He's
12 responsive to his environment, responds to
13 directions, and is acting in a way that, in my
14 mind, rules out delirium but certainly indicates
15 that he was in a highly stressed and agitated
16 state.

17 Q What is it about the interaction with people and
18 the way he was with others that brings you to rule
19 out delirium?

20 A We see Mr. Dziekanski on several occasions in the
21 videos interacting with other people in the
22 airport area. He's talking to them. He's
23 listening to what they're saying. At times he
24 responds to direction. I can think of when he has
25 an article lifted up above his arms and people are
26 yelling "No," he puts it down as opposed to
27 carrying on with whatever thought he had in his
28 mind. More importantly, when the police arrive on
29 the scene, he clearly recognizes the police. He
30 calls out "Polizia, polizia" at least once or
31 twice. He responds to the police when they come
32 to him. He pays attention to what they're saying
33 to him. He appears to follow their directions.
34 In my mind, that all indicates an operating mind
35 that's interacting with the environment and
36 responding to the environment, in the context, in
37 an appropriate way.

38 Q You have seen Dr. Lu's report that comes to a
39 different opinion on this subject?

40 A I have.

41 Q And you know Dr. Lu to be a well respected
42 psychiatrist here in our community?

43 A I don't know Dr. Lu personally. I know that he
44 works in the -- has worked in consultation-
45 liaison. I know that he has training in addiction
46 medicine and I know that he has been doing
47 forensic work over the last four or five years

- 1 that I -- I want to make sure I'm not minimizing,
2 but I think it's been four or five years. I've
3 certainly been aware of his reports over the last
4 four or five years.
- 5 Q During these proceedings, a number of times there
6 have been references to the fact that Mr.
7 Dziekanski appears to have been sweating.
- 8 A Yes.
- 9 Q Tell us about your view of that comment and that
10 issue.
- 11 A Well, I would agree. On several portions of the
12 video it looks like he's sweating and it appears
13 there's been consistent descriptions of him
14 sweating. There's no doubt that Mr. Dziekanski
15 was anxious. There's no doubt that at times he
16 was quite agitated. There were times when he was
17 clearly quite angry. Those are all circumstances
18 in which human beings may sweat, some of us to a
19 greater or lesser degree. To me it speaks to his
20 agitation and his anxiety.
- 21 Q You read the document that was sent to you called
22 "Circumstances," which was a lengthy recitation of
23 events that have taken place here at this inquiry.
24 This was a typewritten document --
- 25 A Yes.
- 26 Q -- of some 10, 12 pages.
- 27 A Yes.
- 28 Q And in that is detailed the observations some have
29 made of Mr. Dziekanski from the time he landed in
30 Vancouver and was dealing with Border Services
31 people and his interactions with Customs,
32 Immigration, et cetera. You're familiar with
33 that --
- 34 A Yes, I am.
- 35 Q -- rubric of the case? You've given us your
36 opinion about his mental state during his time
37 immediately before the police interaction and
38 during the police interaction. Is there anything
39 that you notice in the other hours that he was in
40 Vancouver that's inconsistent with the opinion
41 you've given the Commissioner?
- 42 A No, no. I think that the other information we
43 have represents an individual who's agitated,
44 anxious, distressed, but when he has the
45 opportunity to interact with somebody, he appears
46 to interact appropriately. He's aware of his
47 surroundings and he responds to direction in a

8
Paul Janke
In chief by Mr. Vertlieb

1 manner that I think would be consistent with his
2 language abilities and the fact that he
3 undoubtedly was overtired, hungry, stressed,
4 anxious and agitated.

5 Q I just want to have a few terms defined while we
6 have the benefit of your evidence here. In your
7 report at page 4, you go through observations one
8 by one, and I'm looking right now, page 4,
9 number 3.

10 A Yes.

11 Q Tell us what you mean by "moderate to severe
12 psychomotor agitation." This is during the
13 Pritchard video.

14 A What I'm referring to is the fact that Mr.
15 Dziekanski facially looks like he's agitated. At
16 times he's yelling and gesticulating in what
17 appears to be an angry fashion. He is moving --
18 not constantly but almost all the time he's in
19 some form of movement. This is what is referred
20 to as psychomotor behaviour, and because of the
21 nature of his actions, I agree that it's
22 psychomotor agitation.

23 Q You made comments in paragraph 6 of your report
24 about the chairs and the automatic door. Some
25 others have watched that video and made comments
26 about it. Your commentary is viewed from the same
27 perspective, namely watching the video and
28 watching Mr. Dziekanski standing there while the
29 doors appear to open and close?

30 A Yes.

31 Q Tell the Commissioner your impression, watching
32 him with your trained eye, so to speak, and what
33 you observed and the significance of that.

34 A I saw Mr. Dziekanski standing in the doorway. He
35 appears to be aware that the door is opening and
36 closing behind him but he's focusing on other
37 people or other circumstances at the time. So
38 he's simply -- he's aware of it but ignoring it,
39 which is not quite the same as being unaware of
40 it, obviously. To a certain degree this is
41 obviously speculation. We don't have Mr.
42 Dziekanski here. We don't have the opportunity to
43 actually interact with him, to know what his
44 thoughts and processes are. So to a certain
45 degree we're all speculating when we look at the
46 video and say, this is what was going on in his
47 head.

1 Q And when you say "We're all speculating," you mean
2 "we" from the standpoint of the medical people?

3 A The medical people for sure, and anyone who
4 attempts to interpret what was going on in his
5 head at that time.

6 Q It may be self-evident, but just briefly tell us
7 why the diagnosis of delirium would be one where
8 you'd want to have an actual visit or assessment
9 of the patient.

10 A Well, to diagnose delirium, you have to know that
11 the person is not oriented to their environment,
12 that they are not fully aware of where they are,
13 what the time is, what's going on, who the various
14 people are that they're dealing with. That's
15 simply not possible in this kind of a video where
16 there's nothing like that kind of interaction, not
17 that detail that's there.

18 It's also important in diagnosing delirium to
19 have the opportunity to either assess the person
20 repeatedly - in other words, you get to see them
21 at different times when their state of
22 consciousness may vary - or be able to review
23 materials that tell you that the person's
24 consciousness or awareness has varied over time.

25 Q So the result of your assessment is that you rule
26 out delirium in this case of Mr. Dziekanski?

27 A I think that when I look at the video and when I
28 review the circumstances, which is what I based my
29 opinion on, we have an individual who on repeated
30 occasions interacts appropriately, appears to be
31 aware of his surroundings, aware of his
32 circumstances. These are all inconsistent with
33 and contradict a diagnosis of delirium. When I
34 view the video in particular, I see multiple
35 instances where he is interacting with his
36 environment and responding to his environment.
37 That's not consistent with delirium.

38 MR. VERTLIEB: Thank you, Dr. Janke.

39 MS. ROBERTS: Dr. Janke, my name is Helen Roberts. I'm
40 counsel for the Government of Canada.

41 A Yes.

42 MS. ROBERTS: I have some questions for you.

43
44
45
46
47

1 CROSS-EXAMINATION BY MS. ROBERTS ON BEHALF OF THE
2 GOVERNMENT OF CANADA:

3
4 Q First, what exactly were you asked to do for the
5 Commission?

6 A I was asked to review Dr. Lu's report and to offer
7 my opinion with respect to the diagnosis of
8 delirium.

9 Q And were you given any additional information
10 apart from what you've listed on page 1, either in
11 written or verbal form?

12 A No.

13 Q Now, as I read your report, you disagree with
14 Dr. Lu on two primary things. One is the
15 sufficiency of the evidence for a diagnosis of
16 delirium?

17 A That's correct.

18 Q And the second is the diagnosis of delirium
19 itself?

20 A Yes.

21 Q All right. Now, you had a chance to look at
22 Dr. Lu's report?

23 A Yes, I did.

24 Q And he listed a great number of materials that
25 he'd reviewed on pages 2 to 6 of his report?

26 A Yes, he did.

27 Q And you'll agree that you didn't have all of that
28 information?

29 A No, I didn't.

30 Q For instance, you had a very abbreviated form of
31 circumstances whereas he had full statements from
32 a lot of witnesses?

33 A Yes.

34 Q And in outlining your practice, am I correct in
35 thinking your clinical practice relates to seeing
36 people for appointments in your office?

37 A I have two aspects in my practice. One is my
38 private office forensic practice where I'm doing
39 assessments. The other half of my scheduled time
40 is with Youth Forensic Psychiatric Services, where
41 I am seeing individuals who've been admitted to
42 the in-patient assessment unit for assessment for
43 court purposes or I'm following people who are in
44 the custody centre for psychiatric needs or I'm
45 seeing people in the out-patient who are being
46 seen for ongoing treatment and/or assessment.

47 Q And I think you made the distinction -- you talked

- 1 about psychiatrists who practise in a hospital
2 setting probably see more delirium than you do in
3 your clinical practice?
- 4 A Yes, they would.
- 5 Q And would it be fair to assume that you might have
6 more time during an appointment than they might
7 have as they do rounds and have to see a whole
8 number of patients during their day?
- 9 A It's possible, yes. But if you -- you take as
10 much time as you need to make an accurate
11 assessment and diagnosis.
- 12 Q Fair enough. I'm just wondering if those
13 psychiatrists who practise in a hospital setting
14 are more used to making a quicker diagnosis just
15 because of the time constraints and the nature of
16 their work.
- 17 A That would be true when we compare it to my
18 private office practice but not to my practice in
19 Youth Forensic Psychiatric Services, where I have
20 clinics where I'm seeing six to ten youth over the
21 course of a morning and would have at least the
22 same if not less time than most consultation-
23 liaison psychiatrists would have available.
- 24 Q I take it you don't have any issue with the fact
25 that Dr. Lu would be qualified to diagnose
26 delirium?
- 27 A Oh, I would expect a first-year psychiatric
28 resident to be able to diagnose delirium. So no,
29 I have no difficulty with that.
- 30 Q Okay. And ultimately it would be up to each
31 psychiatrist to decide whether he or she had
32 sufficient information to make a diagnosis?
- 33 A That's as an individual making a diagnosis. When
34 we're operating in the field of forensic
35 psychiatry where we're offering independent
36 medical opinion, the standard is expected to be
37 higher. You're expected to meet an acceptable
38 level of investigation and review of material.
- 39 Q All right. But having said that, Dr. Lu had
40 access to more material than you did and he
41 evidently felt that he had sufficient information
42 to make a diagnosis.
- 43 A Clearly he did.
- 44 Q In terms of diagnosis, I understand that
45 psychiatrists are governed or practise according
46 to the *DSM-IV*, which is the *Diagnostic and*
47 *Statistical Manual of Mental Disorders*? Would

- 1 that be correct?
- 2 A North American psychiatrists use that to make
3 their diagnoses, yes.
- 4 Q And you'd be familiar with the diagnosis of
5 delirium as set out in the *DSM-IV*?
- 6 A Yes.
- 7 Q And as I understand it, they set out delirium in
8 four forms?
- 9 A I believe so, yes.
- 10 Q One is delirium related to a medical condition?
- 11 A Yes.
- 12 Q Another is delirium related to substance
13 withdrawal?
- 14 A Yes.
- 15 Q Or, sorry, substance addiction or withdrawal?
- 16 A Yes.
- 17 Q Another is multiple etiology?
- 18 A Yes.
- 19 Q And the last one is referred to as not otherwise
20 specified?
- 21 A Right.
- 22 Q All right. Now, in terms of the medical
23 conditions that can cause delirium according to
24 the *DSM-IV*, that would include electrolyte
25 imbalances in the body?
- 26 A Yes.
- 27 Q And electrolyte imbalances could be caused by
28 things like dehydration?
- 29 A Extreme dehydration, yes.
- 30 Q And the medical conditions that can cause delirium
31 also include cardiopulmonary disorders?
- 32 A Yes.
- 33 Q And that could include dilated cardiomyopathy?
- 34 A If there is compromised cardiac output, yes.
- 35 Q And then when we deal with the delirium that can
36 be caused by substance withdrawal, those
37 substances include alcohol?
- 38 A Oh, yes.
- 39 Q All right.
- 40 A Probably the most common.
- 41 Q I'm sorry?
- 42 A Probably the most common.
- 43 Q And do those substances also include nicotine?
- 44 A I'm not sure that I've ever seen delirium
45 associated with nicotine. It's possible as it's
46 an addictive substance.
- 47 Q And then as I understand it, the category of

1 multiple etiology is if there's a number of
2 factors that can contribute to causing delirium in
3 a person?

4 A Yes.

5 Q And the category of not otherwise specified. As I
6 read -- I'll just read you something from the
7 *DSM-IV*, under section 780.09, if anybody's
8 following along. It says:

9

10 This category should be used to diagnose a
11 delirium that does not meet criteria for any
12 of the specific types of delirium described
13 in this section.

14

15 A Yes.

16 Q So it's the left-over category, if you will?

17 A It's the left-over ones where you don't know the
18 multiple etiologies or you're not sure of them.

19 Q All right.

20 A But you know the person is delirious.

21 Q All right. And number 1 under that heading says:

22

23 A clinical presentation of delirium that is
24 suspected to be due to a general medical
25 condition or substance use but for which
26 there is insufficient evidence to establish a
27 specific etiology.

28

29 A Yes.

30 Q Do you agree with that?

31 A Yes, that's the definition.

32 Q And number 2 is:

33

34 Delirium due to causes not listed in this
35 section.

36

37 The example they give is sensory deprivation.

38 A Yes.

39 Q So the *DSM* itself seems to envisage that you can
40 diagnose delirium even though you have
41 insufficient evidence to establish a specific
42 etiology?

43 A Yes, that's correct.

44 Q So the fact that we can't say with any certainty
45 what the cause of delirium might be in Mr.
46 Dziekanski, that doesn't prevent -- if the
47 clinical picture fits delirium, that doesn't

- 1 prevent a psychiatrist from diagnosing delirium?
- 2 A No, it doesn't.
- 3 Q Have you been provided with Dr. Lu's third report
- 4 of May 12th, 2009?
- 5 A I've only been provided with what's listed.
- 6 Q Dr. Lu has prepared a third report responding in
- 7 part to your report.
- 8 A I haven't seen it.
- 9 MS. ROBERTS: Thank you, Mr. Butcher. I was just going
- 10 to say we should put it before you, then.
- 11 A Thank you.
- 12 Q And he addresses your report on page 3 of this new
- 13 report.
- 14 A I see that, yes.
- 15 Q And he says that he's reviewed your May 6th --
- 16 THE COMMISSIONER: Excuse me. I think maybe we should
- 17 pause a minute, Doctor, and maybe you should read
- 18 that.
- 19 A If I could.
- 20 MS. ROBERTS: Oh, please. It's only a few paragraphs.
- 21 I don't believe Dr. Lu's third report has been
- 22 marked as an exhibit, if that's what you're
- 23 asking, Mr. Giles.
- 24 A Fine, thank you.
- 25 Q If you need some time to review it again, let me
- 26 know. In the first paragraph he points out that
- 27 you differ from him in the possibility of a
- 28 delirium diagnosis.
- 29 A Yes.
- 30 Q You agree with that?
- 31 A Yes.
- 32 Q And then he says you dismiss the important finding
- 33 that Mr. Dziekanski was hyperventilating. He goes
- 34 on to say:
- 35
- 36 Hyperventilation of more than 25 --
- 37
- 38 I believe that should say "breaths."
- 39
- 40 -- per minute is extremely difficult to self-
- 41 sustain and is almost always a sign of some
- 42 kind of physiological distress.
- 43
- 44 A I don't disagree with that.
- 45 Q Is that a finding that's relevant to a diagnosis
- 46 of delirium?
- 47 A Not in my mind, no.

1 Q And in the second paragraph, he talks about
2 dehydration.

3 A Yes.

4 Q And he says:

5
6 Individuals with potential alcohol
7 withdrawal, dehydration and delirium can have
8 significant fluid imbalance that oral fluid
9 and a few glasses of water simply will not
10 replace.
11

12 I think he's differing from you as to whether
13 Mr. Dziekanski might have been suffering from
14 dehydration. Is that how you take that comment?

15 A Well, he's said three different things. I would
16 agree with him -- saying someone's in potential
17 alcohol withdrawal gives us no information at all.
18 If we say a person in alcohol withdrawal will have
19 a fluid imbalance, he's entirely correct. You do
20 need to rehydrate those individuals and you need
21 to do it in a careful, controlled fashion.

22 With dehydration -- well, I may be dehydrated
23 if I'm on the stand for three hours and don't have
24 a glass of water. I think what we're referring to
25 is significant or serious dehydration. And then I
26 would agree with him that a few glasses of water
27 would not be sufficient to deal with someone who's
28 severely dehydrated.

29 And finally, delirium is, as I think we've
30 already established, a multi-factorial state with
31 multiple different causes, all of which would
32 likely require the use of intravenous fluid to
33 properly rehydrate the person. But this is
34 circular logic in the sense that if he assumes
35 there's dehydration -- delirium, then yes, these
36 comments follow. If we don't assume he's got
37 delirium and we need to address his state, then I
38 stand by my opinion.

39 Q Doctor, you unfortunately have not had the benefit
40 of seeing the medical records from Poland or the
41 evidence from the Polish witnesses. So I'll just
42 give you --

43 A No, I have.

44 Q -- a bit of background that we've heard.

45 A I've seen some medical records from Poland.

46 Q Oh, I'm sorry.

47 A I think I've listed them. I won't have seen

- 1 the --
- 2 Q You've seen the Immigration Canada form.
- 3 A And the medical records, English --
- 4 Q Oh, I'm sorry. You were referring to the Polish
- 5 records in number 5, then?
- 6 A Yes. Yes.
- 7 Q All right. We've had evidence that Mr. Dziekanski
- 8 hadn't slept for a couple of nights prior to his
- 9 departure.
- 10 A Yes.
- 11 Q That he had been smoking up till two days before
- 12 his departure and then stopped.
- 13 A Yes.
- 14 Q That he had a fear of flying to the extent where
- 15 he was clinging to a radiator and didn't want to
- 16 go to the airport and also vomited several times
- 17 in his home.
- 18 A Yes.
- 19 Q You've seen Dr. Lee's report so you know that he
- 20 is of the view that Mr. Dziekanski suffered from
- 21 chronic alcoholism?
- 22 A Yes.
- 23 Q We've also had evidence, and it's in Dr. Lee's
- 24 report, that there were no stomach contents, and
- 25 according to Dr. Lee, that suggests he hadn't
- 26 taken any food for a significant period, and I
- 27 can't remember if it's 28 to 48 hours or something
- 28 along those lines.
- 29 A Okay. I can't recall either but I do recall that.
- 30 Q We have some evidence that you may not have been
- 31 provided in terms of his lack of sleep, his
- 32 possible withdrawal from alcohol and nicotine,
- 33 hadn't eaten well for a couple of days. In fact,
- 34 he was found with the airline breakfast still in
- 35 his possession. We're not sure what he took on
- 36 the flight. So we have a number of -- a bit more
- 37 evidence than perhaps you had to work with.
- 38 A I'm not sure that I was unaware of much -- I
- 39 believe I was aware of much of that information.
- 40 But that's fine. There were factors -- he was
- 41 severely stressed. There's no question.
- 42 Q What I was going to say was, could all those
- 43 factors be interpreted in the way that Dr. Lu has
- 44 interpreted them, to say that he was possibly
- 45 withdrawing from alcohol and was dehydrated?
- 46 A Yes, they could be interpreted that way. Dr. Lu
- 47 interpreted them that way.

- 1 Q I take it it's not uncommon for psychiatrists to
2 reach different conclusions about patients?
3 A Particularly in medical-legal settings. That's
4 true.
5 Q On page 6 of your report, sir, at the top.
6 A Page 6, yes.
7 Q In the first full sentence, "It would be..." Are
8 you with me there?
9 A Yes.
10 Q
11 It would be my considered psychiatric opinion
12 that Mr. Pritchard's video of Mr. Dziekanski
13 does not demonstrate significant signs or
14 symptoms of delirium.
15
16 A Yes.
17 Q You use the words "significant signs or symptoms
18 of delirium." Did he show any signs or symptoms
19 of delirium, in your view?
20 A Yes. Given that delirium is a state of agitation,
21 usually with a state of -- it can vary from either
22 being somnolent or highly agitated, he certainly
23 showed signs or symptoms that could have been
24 related to delirium.
25 Q Whether or not he met the official diagnosis of
26 delirium, I take it your evidence is he was highly
27 agitated?
28 A Yes. That's -- yes.
29 Q And you're aware that he was engaging in
30 destructive behaviour as well?
31 A Yes.
32 Q And would you agree that's abnormal behaviour?
33 A Yes.
34 Q And we know that he had a long flight --
35 A Yes.
36 Q -- and that he was nervous and upset. But the
37 airport people have testified that they've not
38 seen behaviour like that before. So this is even
39 abnormal for a tired, stressed passenger, if you
40 will. Would you agree with that?
41 A I -- if they haven't observed it, then I can't
42 disagree with that.
43 Q And in that situation it was appropriate for
44 people to call the police to deal with Mr.
45 Dziekanski?
46 A The problem with that question is that we're
47 talking about a long period of time in which

Paul Janke

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

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

1 Mr. Dziekanski is in the airport. Are you asking
2 me was it appropriate to call at the time of the
3 Pritchard video, or was it appropriate to -- would
4 it have been appropriate to call two hours, four
5 hours, six hours, eight hours, ten hours, twelve
6 hours earlier?

7 Q Fair enough. Sorry. I'm referring to his
8 behaviour in the later stages before the police
9 arrive, in other words when he's banging on the
10 glass, when he's yelling, swearing, destroying
11 property, things like that.

12 A Yes, I think that was appropriate to get people
13 who would be trained in dealing with that
14 situation in an appropriate fashion.

15 Q And once the police were called, it would be their
16 duty to deal with him in some manner?

17 A I would expect it to be their duty, and it's been
18 my experience that they make it their duty to deal
19 with the situation.

20 MS. ROBERTS: Thank you. Those are all my questions.

21 MR. HIRA: Doctor, my name is Ravi Hira and I represent
22 Officer Kwesi Millington.

23

24 CROSS-EXAMINATION BY MR. HIRA ON BEHALF OF CONSTABLE
25 KWESI MILLINGTON:

26

27 Q The first issue that I'd like to deal with is,
28 when were you instructed on this matter?

29 A I'll have to look at the date because I -- I think
30 contact was May 6th, maybe May 4th.

31 Q All right. May 6, May 4, I'm not going to quibble
32 over --

33 A I'm sorry, May 5th, May 4th, yes.

34 Q May 4, May 5, I'm not going to quibble over that.
35 Do you have your letter of instruction?

36 A I believe so.

37 MR. HIRA: Mr. Commissioner, I wonder whether I could
38 take five minutes just to look at the file. It'll
39 make this much quicker. I'm not going to be very
40 long in my examination.

41 THE COMMISSIONER: Yes. Doctor, he wants to look at
42 the file.

43 A Oh, the whole file?

44 THE COMMISSIONER: Just make sure there's nothing
45 personal in there.

46 A I don't believe there is.

47

Paul Janke

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

1 THE REGISTRAR: The hearing will now recess for five
2 minutes.

3
4 (WITNESS STOOD DOWN)

5
6 (PROCEEDINGS ADJOURNED)
7 (PROCEEDINGS RECONVENED)

8
9 PAUL JANKE, a witness,
10 recalled.

11
12 CROSS-EXAMINATION BY MR. HIRA ON BEHALF OF CONSTABLE
13 KWESI MILLINGTON, continuing:

14
15 Q Thank you for letting me look at your file,
16 Doctor. So on May the 5th, you received a letter
17 from the Commission enclosing the materials that
18 are set out at page 1 of your report? Is that a
19 fair statement by me?

20 A Yes.

21 Q You reviewed the materials and provided, frankly,
22 an incredible turnaround, the eight-page report of
23 May 6?

24 A Yes.

25 Q Now, was there any specific question posed to you
26 in the letter of May the 5th?

27 A No. No, as I -- no. I've looked at it myself.
28 There's no question. It was outlining the
29 materials.

30 Q And so the purpose of your report -- I've gone
31 through your report and I don't note in there any
32 purpose or question, unless I'm missing something.
33 Is that a fair statement by me?

34 A I haven't read it recently, but I'm going to
35 accept your opinion, yes.

36 Q Fair enough. So in terms of what you were
37 supposed to do, was there someone or something,
38 some question that was posed to you, such as,
39 would you review Dr. Lu's initial report and
40 comment on it?

41 A Yes. I was contacted by phone in my private
42 office by Mr. Vertlieb, and that's the question
43 that was posed: Could I review the material,
44 could I provide an opinion reviewing Dr. Lu's
45 report.

46 Q And that occurred on May the 5th?

47 A May the 5th or May the 4th.

1 Q Fair enough. So a question not unlike the one
2 you've given earlier and not unlike the one I've
3 tried to paraphrase was posed on that date?

4 A Yes.

5 Q Thank you. Now, moving to some evidence that you
6 gave in examination by Mr. Vertlieb, you noted
7 that the process that you're undertaking to some
8 degree had -- well, has a considerable degree of
9 speculation involved in it?

10 A That's correct.

11 Q And when you say that he responded or appeared to
12 respond to police direction, that is speculation
13 on your part?

14 A I'm not sure I'd call it speculation. I guess
15 what I'm referring to is that police give
16 directions; he appears to move in the direction
17 that they are pointing. He seems to be responding
18 to what they're saying.

19 Q Okay. Now, I noted that you analyzed -- that you
20 made some notes regarding the video.

21 A Yes.

22 Q And with respect to those notes, the last page of
23 your notes - if I may approach you - you have a
24 time period, 3:35 to 3:42. That is the -- I'm
25 sorry. You have a time period starting at 3:05.
26 You've got something "police."

27 A "Recognizes police.

28 Q Right. And then you have 3:35 to 3:42. Could you
29 read the three lines that appear after that.

30 A "Interaction with police and appears to respond to
31 direction. Then" -- oh, I'm sorry. "Then
32 tasered."

33 Q All right. Now, in terms of responding to the
34 police, you would agree with me that picking up a
35 stapler, opening it and holding it in a clenched
36 fist, chest high, with the other fist clenched,
37 that doesn't appear to be a proper response to the
38 police?

39 A I wouldn't call it a proper response to police,
40 no.

41 Q Thank you. Now, you noted at page 3 of your
42 report, the third full paragraph, that:

43

44 ...he was making comments that were
45 consistent with the circumstances he found
46 himself in. There is no indication that his
47 speech was confused.

Paul Janke

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

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

1 A I'm sorry. Which page?

2 Q Page 3, third full paragraph.

3 THE COMMISSIONER: It begins "While standing..." The
4 next one, is it, "The translation...?"

5 MR. HIRA: Yes.

6 A Okay.

7 Q Sorry, Doctor --

8 A I think it may have been reformatted so I wasn't
9 able to follow --

10 MR. HIRA: Can I show him my paragraph (indiscernible -
11 not at microphone).

12 A Okay, the third full paragraph, "The translation
13 of the sound track..." Yes.

14 Q That is correct. You noted that his comments:

15
16 ...were consistent with the circumstances he
17 found himself in. There is no indication
18 that his speech was confused.

19

20 A Yes.

21 Q And you're basing that on Exhibit 33, the
22 translation prepared by Mr. Barski?

23 A As I speak no Polish, I would have to, yes.

24 Q Thank you, Doctor. And the comments such as "I
25 will trash this office," "I will smash the glass,
26 and I will smash the glass here. And you will
27 see" -- you view those as consistent with the
28 circumstances?

29 A Yes. We have an individual who's frustrated,
30 anxious, clearly is unsure as to what is going on
31 or why he's where he is, and he's responding with
32 anger and agitation.

33 MR. HIRA: Okay. Those are my questions. Thank you,
34 Doctor.

35 MR. BUTCHER: Just two areas, Doctor. I'm David
36 Butcher and I act for Constable Bill Bentley.

37

38 CROSS-EXAMINATION BY MR. BUTCHER ON BEHALF OF CONSTABLE
39 BILL BENTLEY:

40

41 Q The first area deals with the question of how long
42 have you had this divided practice between your
43 private forensic practice and your Youth Services
44 practice.

45 A Since 1987.

46 Q So obviously for 22 years?

47 A Yes.

- 1 Q During that time, how often have you seen people
2 in a state of delirium?
- 3 A It would not -- it would not be all that
4 frequently. We've had several youths who have
5 been in delirious states, usually secondary to
6 medication and severe psychiatric illness. But I
7 would not have seen many patients directly. I
8 will have reviewed hundreds of files of people who
9 had suffered major injuries and been hospitalized
10 and then assessed and treated for delirium in that
11 time, though.
- 12 Q But you're looking at that after the fact --
- 13 A That's correct.
- 14 Q -- in a forensic setting?
- 15 A Yes, after the fact.
- 16 Q For legal proceedings?
- 17 A Yes.
- 18 Q In a clinical setting, are we talking about once a
19 year?
- 20 A Maybe once in a year, yes.
- 21 Q And I think you've conceded that Dr. Lu's practice
22 would involve dealing with people in active states
23 of delirium on a daily basis?
- 24 A If he's working in consultation-liaison
25 psychiatry, yes.
- 26 Q And that means working in a hospital with medical
27 and surgical patients?
- 28 A Well, there's different aspects of psychiatric
29 practice, but consultation-liaison, that's a large
30 part of that practice.
- 31 Q The second area has to do with a comment you made
32 about withdrawal from alcohol. My note says that
33 you said this: "You need to rehydrate in a
34 careful an controlled fashion." Do you have much
35 experience in addiction medicine?
- 36 A Yes.
- 37 Q I presume it's a fairly common feature of
38 people --
- 39 A Yes.
- 40 Q -- who come to see you?
- 41 A Yes, it's a common feature of the people that see
42 me. In the youth population I'm dealing with,
43 probably 25 percent present with what we would
44 likely call dependence on various drugs and 75 to
45 90 percent are active heavy users of drugs. So
46 it's part and parcel of that aspect of my
47 practice. And in the context of the medical-legal

1 practice, addiction, either before the event
2 leading to the civil litigation or addiction
3 subsequent related to medical treatment, is
4 unfortunately quite common.

5 Q And I take it from the comment that you made that
6 I referred to that a person in withdrawal from
7 alcohol has to be treated quite carefully and --

8 A Yes.

9 Q -- under medical supervision?

10 A Yes, because they have a tendency to go into
11 delirium, which can be a fatal condition.

12 Q And in a medical setting, what is done to assist
13 patients undergoing a withdrawal?

14 A Alcohol withdrawal?

15 Q Yes.

16 A You would treat them with intravenous fluids. You
17 would treat them with vitamins because of
18 particular problems that arise with rehydrating
19 people who haven't been eating properly. You
20 typically treat their agitation and delirium with
21 medications such as benzodiazepines in low doses
22 or neuroleptics. Nowadays Seroquel, Risperidone
23 would be used to manage the person's agitation.

24 Q Withdrawal without that medical treatment can be
25 quite dangerous, both from a medical and
26 psychiatric perspective?

27 A Yes. Yes.

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

29 THE COMMISSIONER: Mr. Hira, what was the exhibit
30 number of the translation of the voice recording?

31 MR. HIRA: Thirty-three, Mr. Commissioner. And I was
32 quoting from or citing page 1.

33 THE COMMISSIONER: Doctor, you were asked some
34 questions about things that were said, and we have
35 the translation here. And I notice that according
36 to the translation, at time mark 3:00, that's when
37 he says, "Police, police."

38 A Yes.

39 THE COMMISSIONER: And then at 3:43 he says words to
40 the effect, "Leave me alone. Leave me alone! Did
41 you become stupid. Why?" Did that mean anything
42 to you?

43 A As I recall from viewing the video, this is when
44 he's having some interaction with the police, and
45 I believe it's when they are around him. And to
46 me it's, I think -- the impression I get is that
47 Mr. Dziekanski was happy to see the police

1 initially. That's the tone of voice he has and
2 that seems to be his response, and then he becomes
3 what appears to be puzzled or upset by their
4 actions, and that's when he made that particular
5 comment to them.

6 THE COMMISSIONER: Are there any other questions?

7 MR. KOSTECKYJ: That translation, my recollection is
8 that when I asked the translator whether it could
9 also be interpreted as "Have you lost your minds?"
10 he agreed with me that that was another version of
11 that translation, "Have you become stupid?" "Have
12 you lost your minds?"

13 THE COMMISSIONER: That's right. I used the word
14 "nuts" the other day but I was wrong.

15 MR. VERTLIEB: It seems that everyone's finished, and
16 perhaps Dr. Janke could then be excused.

17 THE COMMISSIONER: Doctor, thank you so much. That was
18 certainly a quick turnaround. You've obviously
19 put a lot of effort into this. Thank you so much.

20 A Thank you.

21
22 (WITNESS EXCUSED)

23
24 MR. VERTLIEB: Now, just as the doctor is leaving the
25 witness stand, Ms. Roberts has asked that the
26 report of Dr. Lu, May 12th, 2009, be marked as an
27 exhibit, and that's totally reasonable.

28 THE COMMISSIONER: Yes, that will be marked as the next
29 exhibit.

30 MR. VERTLIEB: Thank you.

31 THE REGISTRAR: That will be marked as Exhibit 155.

32
33 EXHIBIT 155: Copy - Report of Dr. Lu Shaohua
34 dated May 12, 2009
35

36 MR. VERTLIEB: And just so you know, Mr. Commissioner,
37 this of course is in response to the order that
38 you made that the different medical practitioners
39 be sent material, and the plan would be that if
40 any of these experts write back, that that
41 material would be provided to the Commission as
42 well.

43 THE COMMISSIONER: Oh, yes, quite so.

44 MR. VERTLIEB: I see Mr. Hira at the podium.

45 MR. HIRA: I believe Mr. Neave has some questions and
46 issues regarding this report and the materials
47 sent. I stand up to alert the Commission of that

1 rather than to try to elucidate his concerns. One
2 of the things that may be an issue is whether or
3 not the transcripts of the doctors - Chambers,
4 Kerr, Janke and Tseng; that is the cross-
5 examination transcripts - were sent as well.

6 THE COMMISSIONER: All right.

7 MR. VERTLIEB: We understand, Mr. Hira - and this may
8 assist your last comment - that these have been
9 sent to these different people. As they've come
10 in, they've been sent out, and as far as we know
11 that's all been done.

12 THE COMMISSIONER: All right. Now, is that everything
13 for today?

14 MR. HIRA: Just on that last point, I think the concern
15 was - and again, I'm not speaking for Mr. Neave -
16 whether or not Dr. Lu had them prior to his report
17 of May 12th. That's all.

18 THE COMMISSIONER: Well, you don't know.

19 MR. HIRA: Well, the face of the report would suggest
20 not, and certainly the production of the
21 transcripts as of May 12 would suggest not. But
22 again -- now I'm going where I really don't want
23 to go, which is leave that to Mr. Neave.

24 THE COMMISSIONER: All right.

25 MR. VERTLIEB: So that concludes the session for today,
26 Mr. Commissioner. And may we reconvene tomorrow
27 afternoon at 1:00 p.m.?

28 THE COMMISSIONER: All right. One o'clock tomorrow.

29 THE REGISTRAR: The hearing is now adjourned until 1:00
30 p.m. tomorrow afternoon.

31

32 (PROCEEDINGS ADJOURNED TO MAY 22, 2009, AT
33 1:00 P.M.)

34

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