1 **Vancouver, B.C.**
2 **October 19, 2011**
3 **(PROCEEDINGS RECONVENED AT 10:00 A.M.)**
4 THE REGISTRAR: Order. The hearing is now resumed.
5 MR. VERTLIEB: Apparently Mr. Ward has something he needed to
6 discuss.
7 THE COMMISSIONER: Yes.
8 MR. WARD: Thank you, Mr. Commissioner. I'd just like to take
9 a brief moment, if I may, to recognize two of my
10 clients who are here today.
11 THE COMMISSIONER: Yes.
12 MR. WARD: Lillian and Rene Beaudoin, who have attended from
13 Welland, Ontario.
14 THE COMMISSIONER: Yes. Thank you. Thank you for being here.
15 MR. WARD: The reason I've asked for this moment is because
16 today is the tenth anniversary of Lillian's
17 stepsister Dianne Rock's disappearance from the
18 Downtown Eastside. She went missing on October
19 the 19th, 2001, and so this is a significant day
20 for Lillian and Rene Beaudoin. Lillian will be
21 testifying next week. But thank you and thank
22 commission counsel for allowing me the opportunity
23 to note the significance.
24 THE COMMISSIONER: All right. Thank you. Thank you for
25 appearing.

1 MS. BROOKS: Good morning, Mr. Commissioner.
2 THE COMMISSIONER: Yes.
3 MS. BROOKS: This morning our witness is Ms. Catherine Astin.
4 Mr. Giles, if you'd affirm the witness, please.
5 THE REGISTRAR: Good morning.
6 **CATHERINE ASTIN: Affirmed**
7 THE REGISTRAR: I need you just to turn on your -- that's
8 right.
9 A I do.
10 THE REGISTRAR: Would you state your name, please?
11 A My name's Catherine Astin.
12 MR. GILES: Thank you. Counsel.
13 THE COMMISSIONER: Could you spell your last name for me?
14 A A-s-t-i-n.
15 **EXAMINATION IN CHIEF BY MS. BROOKS:**
16 Q Good morning, Ms. Astin.
17 A Good morning.
18 Q If I could start by asking you a few questions
19 about your background. So could you just tell us
20 what you do?
21 A I'm a registered nurse, and currently I work at
22 Sheway, which is a program in the Downtown
23 Eastside for woman who live in Vancouver who have
24 drug use issues and who are pregnant or parenting
25 a child under the age of 18 months.

1 Q And you're a nurse there, are you?
2 A I'm a nurse. I work as a registered nurse, a
3 community health nurse.
4 Q So you've said a community health nurse.
5 A Yes.
6 Q So what's a community health nurse as opposed to a
7 nurse that works in a hospital?
8 A A community health nurse works in the community
9 with families and individuals trying to meet the
10 healthcare needs of certain individuals. At
11 Sheway we have an extended mandate in that we
12 provide services for women and children, primary
13 healthcare, pre- and postpartum, we do services
14 for under fives, immunizations, prevention
15 services.
16 Q And I understand that you worked as a street nurse
17 in the Downtown Eastside from 1999 to 2005?
18 A I did.
19 Q And what does a street nurse do?
20 A A street nurse is a kind of community health nurse
21 that works -- at that time -- I think the program
22 has changed slightly since I worked there, but at
23 the time I was working there we provided services
24 to marginalized populations in the Downtown
25 Eastside who were unable to access health services

1 through mainstream healthcare for many reasons,
2 and we had focused populations that we would work
3 with. Our mandate was HIV prevention, and that
4 encompassed a huge -- a huge area of expertise
5 because HIV prevention, it can cover the whole --
6 everything that you do in your life if you're
7 working on the Downtown Eastside, so --
8 Q Okay.
9 A So, yeah, one of the populations that we worked
10 with specifically were the women in the Downtown
11 Eastside.
12 Q Okay. And so I'm just trying to understand or
13 have us understand the differences between a
14 community nurse and a street nurse and a nurse
15 that works in a hospital. So would a street nurse
16 be actually out on the street?
17 A A street nurse is working on the street. At that
18 time you also had community clinics, because there
19 weren't many clinics in the Downtown Eastside, so
20 we were trying to bridge, I guess, a gap in
21 healthcare for marginalized populations in the
22 Downtown Eastside whereby we were an entry point
23 into the system. So we tried to meet the people
24 down there on their turf, so we would go out and
25 we would meet them wherever they were as opposed

1 for them having to come to a hospital or a clinic
2 where they may be uncomfortable accessing
3 services.
4 Q So, Ms. Astin, you said that you were a registered
5 nurse?
6 A Yes.
7 Q Can you take us through your educational
8 background and your nursing qualifications?
9 A Yes. I graduated as a nurse in England in 1981,
10 and I became a midwife in 1983 also in England,
11 and then in 1988 I graduated from a community
12 health nurse program called Health Visiting in
13 London, England, and then I came to Canada in
14 1989.
15 Q And is a health visitor, is that our equivalent to
16 a community nurse?
17 A As we would know it in Vancouver, community health
18 nurses generally provide prevention services to
19 the under fives and pregnant, postpartum women.
20 Q So when did you come to Canada?
21 A I came to Canada in 1989.
22 Q And then how did your career evolve?
23 A I -- with regards to my qualifications, I obtained
24 my degree, undergraduate degree from University of
25 Victoria in 1994, and then in 19 -- 2002 I got my

1 master's degree from UBC, and I have a couple of
2 other extra qualifications recently through the
3 CRNBC, that's the governing body for nurses in
4 British Columbia, regarding sexually transmitted
5 infections and birth control.
6 Q And you said you had your master's degree?
7 A I do, yes.
8 Q And that's in nursing?
9 A Yes.
10 Q What was the focus of your research in your
11 master's program?
12 A My focus was HIV education to persons using street
13 drugs, and so I was looking at is harm reduction
14 effective when you educate the population --
15 Q You've used --
16 A -- the most at risk.
17 Q The population most at risk?
18 A Yes.
19 Q You've used the term harm reduction.
20 A Yes.
21 Q Tell us what harm reduction refers to.
22 A Harm reduction refers to -- it's a term that's
23 used to denote a number of things that you can do
24 to reduce harm. It specifically applies to
25 persons who use drugs, and it's not about changing

1 behaviour, it's about making behaviour safer.
2 It's nonjudgmental. It's not -- it's not trying
3 to stigmatize people who use drugs, because people
4 use drugs for many reasons. It's more about how
5 to make that behaviour safer.
6 Q So what kind of -- and I think it's referred to as
7 interventions -- what kind of interventions are
8 used in a harm reduction model for drug users?
9 A So a harm deduction model, it ranges from
10 injecting drugs into veins as causing the most
11 harm, to abstinence, which would cause the least
12 harm. So if, let's say, I came across somebody
13 who was injecting drugs, harm reduction strategies
14 might involve the correct way to insert a needle
15 into a vein. It's called bevel up. There's an
16 insertion on the needle, and it's the bevel, and
17 the bevel has to be facing a certain way to cause
18 the least trauma to the veins. About not sharing
19 needles, so always using clean needles and not
20 sharing needles. How to clean the skin prior to
21 injecting, using a tourniquet, how to find a vein,
22 which veins are healthy, rotating veins so you
23 don't use the same vein every time. So trying to
24 preserve the integrity of the vein. Like, which
25 veins to use. Like, not shooting up in the neck,

1 because that can cause the most health problems to
2 an injection drug user, all the way to, you know,
3 maybe somebody wants to go into detox or somebody
4 wants to go into rehab. So there's many different
5 aspects with, you know, injection drug use, and
6 then it could be changing from injection drug use
7 to maybe smoking because there's less harm
8 associated with that. Never using alone. So, you
9 know, don't be alone when you use because you
10 could overdose and there's nobody there that's
11 going to know that. So there's many different
12 things that you can do. And it's all done in a
13 nonjudgmental way, and it's to help the person.
14 Q You talked about rotating veins. What are the
15 sites then on the body where drug users would
16 inject if they were injecting heroin?
17 A Well, most start with the most -- you know, with
18 the veins that are the easiest to find, which is
19 usually in this part of the arm, the antecubital
20 fossa it's called. The hands, the arms, the feet,
21 the legs. Most people use the neck veins last
22 because they do know it's dangerous. And some
23 women will even inject in the breasts if there's
24 veins there. So anywhere really where they can
25 find a good vein. Some women can't inject

1 themselves. They have people that will do it for
2 them, and they're commonly referred to as doctors.
3 They'll be people that will inject for them.
4 They're people on the street, not professionals.
5 Q And is that a generally safe way of injecting, to
6 have a street doctor --
7 A It depends. If they use clean needles and if they
8 do it correctly, then it could be safer than the
9 person doing it themselves. It depends.
10 Q Now, you stated that you're currently working as a
11 community nurse at Sheway?
12 A Yes.
13 Q And you've told us that Sheway is an outreach
14 program for pregnant women and women with infants
15 under 18 who use drug and alcohol?
16 A Under 18 months.
17 Q Under 18 months. Thanks.
18 A Yeah. Sorry.
19 Q Who use drug and alcohol?
20 A Yes.
21 Q So I just want to ask you a few more questions
22 about Sheway. Is it located in the Downtown
23 Eastside?
24 A Yes.
25 Q And what's the address?

1 A 533 East Hastings.
2 Q Is that on the corner of Hastings and Princess?
3 A It's in between Jackson and Princess itself,
4 halfway between.
5 Q And you've given us a general overview of the
6 services that Sheway provides. Before you you
7 should see an information sheet, and attached to
8 that is a Sheway intake form.
9 A Yes.
10 MS. BROOKS: Mr. Commissioner, do you also have a copy of that?
11 THE COMMISSIONER: Yes.
12 MS. BROOKS:
13 Q Does this information sheet set out the kind of
14 services that Sheway provides?
15 A Yes. This is the handout that we give to all the
16 women when they first come to Sheway and also to
17 -- you know, if somebody wants some information
18 about Sheway this is kind of just a quick -- it's
19 just a quick sheet to just give -- just give an
20 overview, a quick overview of what -- what we
21 provide.
22 Q So Sheway is a multi-disciplinary program then, is
23 it?
24 A Yes, it is.
25 Q Can you take us through some of the highlights on

1 this sheet, some of the services that you think
2 are particularly important that Sheway provides?
3 A Well, first of all I'd like to say that the
4 cornerstone of our program is food, so we provide
5 food on a daily basis to the women through a hot
6 lunch program and --
7 Q If I can just ask -- yeah.
8 A Sorry.
9 Q I was going to say why is food such an
10 important --
11 A Food is important because most of our women don't
12 have food security. A lot of our women don't have
13 access to nutritious food. Often they don't have
14 the money to buy the food. After their welfare
15 cheque has paid for their rent they probably have,
16 like, a hundred dollars left to cover all their
17 other expenses, so they don't have a lot of money,
18 and food is very expensive, as we know. So we do
19 provide food. Plus, some of the other food
20 outlets in the Downtown Eastside, they're not
21 really safe places for women to frequent. If they
22 go, they have to stand in line. It's mostly men.
23 Some of them feel very insecure around men, and
24 some of them may be afraid of bumping into people
25 they'd rather not see at that time. It could be

1 people they may owe money to, it could be drug
2 dealers. Somebody might be after them for
3 something. So some of the places where they go
4 get food aren't always safe. And plus they may
5 just be generally harassed for no particular
6 reason, just the fact that they're women and --
7 yeah.
8 Q What other kind of services does Sheway provide
9 that are particularly important?
10 A Well, apart from the hot lunch program we provide
11 the food bank, so we provide a bag of food every
12 day to all the pregnant women. We provide milk
13 and eggs to every woman that comes to the program,
14 and we also provide vegetable and fruit bags once
15 a week, and bread is donated from a local bakery
16 once a week. So that's the food. And then we
17 provide emergency food bags. Food is really
18 important to -- to our program.
19 Other services that we provide is on the
20 list. Alcohol and drug counsellor is accessible.
21 We have the community health nurses, myself and
22 two or three other nurses that work out of the
23 clinic and out of Sheway in general. We have
24 social workers, nutritionists, infant development
25 consultants, outreach workers, peer support

1 workers. We have a cook, of course. And we have
2 volunteers that come and help with the food bank
3 and in the kitchen. And then we have a
4 coordinator, and we have a couple of -- an office
5 assistant and a medical office assistant.
6 Q Ms. Astin, you talked about how the clients are --
7 all use drugs. That's a requirement to be part of
8 the program, is it?
9 A Yes.
10 Q And can you tell us a bit about the importance of
11 food over abstinence from using drugs?
12 A Well, we don't -- we don't -- when a woman comes
13 to Sheway, we don't advocate abstinence. We --
14 we're women-centred, so we try to -- we try to
15 assist the women. We let them guide us as to how
16 we can help them. We provide services, and
17 they're free to access the services in the
18 safest -- the way that's safest for them. Food's
19 a basic necessity of life, abstinence isn't. Food
20 provides comfort, security. Food makes a place
21 welcoming. And food is -- they need food. If
22 they're pregnant, they need food. They need good,
23 nutritious food, they need vitamins so that they
24 can grow a healthy baby. It's really important.
25 And so we -- we would advocate that they eat one

1 good meal a day and take food from the food bank
2 and take their daily multivitamin than become
3 abstinent from drugs because that would be a
4 healthier option for them, is the way we see it.
5 Q What kind of responsibilities do you have at
6 Sheway?
7 A At Sheway? I work as a nurse, and so I provide
8 services to women and children under the age of
9 five, which can include prenatal care, postpartum
10 care, care for mothers and children up to the time
11 the child is about 18 months, although if a mother
12 has older children and she brings them to the
13 clinic we would never turn them away if they
14 needed some assistance. We refer them to the
15 other people within Sheway or to other agencies
16 for various health concerns. We try to make it
17 one-stop shopping at Sheway, so we try to do as
18 much as we can while they're there. So we'll do
19 immunizations. We'll take blood. We do -- we
20 take them to their ultrasounds, if they need them,
21 or any other appointments with specialists or
22 other agencies. We provide support in court, the
23 family court, for custody issues. Yeah. We have
24 a food bank. We do everything there.
25 Q How many clients does Sheway have?

1 A I think our mandate is up to 120. We have
2 anywhere between 120 to 150, and then when a
3 client's closed we do leave the door open for them
4 if they get into difficulties, if they need
5 assistance at any time, so in a recent survey that
6 we did we saw, I think, 75 clients, closed clients
7 on top of our 140 clients, I think we had, and
8 they -- the 75 closed clients had about over 200
9 visits within that month.
10 Q How many of those would be women involved in the
11 sex trade?
12 A Currently or in the past?
13 Q If there's been a range or it's fluctuated, maybe
14 you can comment on that as well.
15 A I don't have specific numbers or figures, but a
16 good number of our women have at some time been
17 involved in the sex -- in the sex trade.
18 Q When was Sheway established?
19 A Sheway was established -- established in the early
20 '90s, yeah, as a -- it was a response to the fact
21 that these women weren't getting their health
22 needs met, and their children were being removed
23 directly at birth, and so something needed to be
24 done to help these women and children, to provide
25 them with better service.

1 Q Are there any other kinds of service providers
2 like Sheway for this particular population in
3 Vancouver?
4 A I don't think there is anywhere in Canada,
5 actually, anywhere like Sheway.
6 Q How does Sheway attract its clients?
7 A Well, we don't advertise. People know we exist.
8 Women have to self-refer. We don't take referrals
9 from other health professionals. We don't coerce
10 women to come in, and we don't condone other
11 health professionals coercing women. We find if
12 we get forced referrals, say from social services
13 or from another physician's office, the women
14 don't want to come. So the women have to walk
15 freely through the door.
16 Q Tell us --
17 A And usually they've found out through their
18 friends, or another health professional may tell
19 them about Sheway. They may find out in the
20 hospital as well.
21 Q Tell us about the first encounter a woman will
22 have when they walk through the door at Sheway?
23 A It's really difficult for most of our clients to
24 actually walk through the door at Sheway because
25 they really don't know what's going to be beyond

1 the door. You know, a lot of them have a history
2 of -- you know, they've been abused by so many
3 systems, whether it's the foster care system,
4 they've gone to hospitals and not been treated
5 well, they're very afraid of anything that may
6 resemble anything institutional because they're
7 often judged and mistreated, so for them to
8 actually walk through the door is huge, and that's
9 a big -- a big first step for them in accessing
10 services. We have a receptionist. As you walk
11 through the door there's two receptions, and one
12 of them belongs to Sheway. We share the building
13 with another -- with another agency. And -- and
14 so the receptionist would greet the woman. She
15 would recognize the woman as being new to Sheway.
16 We know all of our women, so -- and she would
17 introduce herself and explain, you know, that this
18 is Sheway and how can I help you. And so
19 depending on the woman's circumstances, she may
20 directly ask her what she needs, "I'm here, I'm
21 pregnant, and I need to -- to talk to somebody,"
22 or she may say, "I just want to find out what
23 you're all about," and so then the receptionist
24 would either explain to her what Sheway is about
25 or she would introduce her to another staff member

1 in the drop-in to -- to explain if she's busy. We
2 really try to make the woman feel comfortable, so
3 first part we would see -- if the woman looks
4 cold, we would maybe ask her if she wants
5 something warmer to wear. Is she thirsty? Does
6 she need a drink? Does she want some tea? Does
7 she want a glass of water, juice? Is she hungry?
8 We'd offer some food to her. And that might be
9 all we do. The first encounter that might be it.
10 She might go home with her food. If we offer a
11 food bag, we would ask her does she have cooking
12 facilities, because often she might not even have
13 a home to live in or she may not have a cooking
14 facility in her room, so then we would just give
15 her food that she could eat without having to cook
16 or that she could make, you know, with hot water
17 from a kettle or something.
18 Q And eventually you might ask the woman to fill out
19 an intake form?
20 A We do. Well, we don't ask her to fill it out per
21 se. We would ask if we could -- we could complete
22 the intake with her, and we generally do the
23 writing. Some of the women can't read or write
24 well because a lot of them have their education
25 interrupted at an early age through no fault of

1 their own, so we don't -- we don't presume that
2 everyone that walks through the door could
3 actually read the form. And also it's very
4 stressful, and some of the questions we ask will
5 be very personal and painful to answer, and so we
6 ask the questions and then we write down their
7 answers.
8 Q Is a copy of the form before you after the Sheway
9 information sheet in that package --
10 A Yes.
11 Q -- of materials?
12 Mr. Commissioner, could I have this Sheway
13 information sheet and intake form marked as an
14 exhibit?
15 THE COMMISSIONER: All right. Any objections? All right.
16 That will be the next exhibit.
17 THE REGISTRAR: Exhibit number 8.
18 MR. COMMISSIONER: Yes.
19 **(EXHIBIT 8: Sheway Intake Form)**
20 MS. BROOKS:
21 Q Ms. Astin --
22 THE COMMISSIONER: Mr. Ward has --
23 MR. WARD: Just if I could get a description of it and where I
24 find it in the document disclosure, please, the
25 document number.

1 MS. BROOKS: The document was provided to all participants by
2 e-mail along with a summary of Ms. Astin's
3 evidence, and I can give you an extra copy.
4 MR. WARD: Thank you. Does it have a document reference
5 number?
6 MS. BROOKS: It doesn't have a document reference number. It
7 will now be referred to as Exhibit 8.
8 MR. WARD: Thank you.
9 MS. BROOKS: Thanks, Mr. Ward.
10 Q Ms. Astin, I'd like to just -- if you could just
11 walk us through the intake form and tell us what
12 kind of information you seek and why that
13 information is important, and I may ask you some
14 questions from time to time as we go through it.
15 A Before I even start to fill out the form I ask the
16 woman for permission to fill out the form. I'll
17 show her the sheet and say, "As part of our intake
18 process we like to fill out this form with you,
19 and there's some questions here that might be
20 painful to answer, and you don't have to answer
21 all of the questions. If it's too difficult to do
22 all the application, the intake today, we can
23 finish it another day." There's no rush. It's
24 certainly at the woman's discretion whether she
25 wants to complete the form. She might want to

1 leave and come back and do the form another day or
2 she might want to just do the form, and it might
3 take several visits to do the intake. So -- so
4 that's how we usually start doing the intake. We
5 usually take her to a private place where she can
6 feel comfortable, so we actually have a -- one of
7 the staff at Sheway actually set up her office as
8 a safe space, and she has some -- she's a First
9 Nations worker from the Haida Nation, and so she
10 has some things that are relevant to her culture,
11 and often if the woman is aboriginal, and even if
12 she's not, it does provide a really comfortable
13 place to fill out the form, if the woman so
14 wishes. So we try to sort of make her
15 surroundings as comfortable as possible because we
16 want it to be a positive experience for her.
17 Q So the first thing then you do is ask for her name
18 and some other information --
19 A Yeah.
20 Q -- about her housing arrangements?
21 A Yes.
22 Q Do women give their name readily?
23 A Some women do. Some women have a street name.
24 They prefer to go by their street name. There can
25 be a lot of implication for them to give their

1 full name, and so they may not give their full
2 name until they feel comfortable with us. And we
3 do reassure the women the information is purely
4 for Sheway and we don't share this information
5 with anybody else out of Sheway. It's
6 confidential. And, actually, we would be
7 breaking, you know, rules of confidentiality if we
8 did that, so we do assure the women that. And
9 then we ask them for their address. So they may
10 have an address, they may not. They often use the
11 term "couch surfing", which basically means
12 they're sleeping wherever they can lay their
13 heads. Some of them stay at the First United
14 Church or some other -- some other shelter. And
15 some women will choose to say no fixed address, so
16 -- and then we ask them if they have a phone. And
17 so this is -- the "Housing Type" would refer to
18 the kind of housing that they have. And then we
19 ask them are they open to us doing outreach, which
20 means do you mind if we come and look for you; if
21 we don't see you, can we come and look for you.
22 Q And what do the women normally --
23 A Most of them say yes. Some of them will say no,
24 they don't want us going looking for them because
25 they might not -- the people that they're staying

1 with might not know they're pregnant, for one
2 thing, and they might not want -- it might not be
3 a safe place. They might not feel safe if we go
4 looking for them. It's another -- they might have
5 to answer questions about that to whoever they're
6 staying with, so often -- sometimes they'll say
7 yes, and sometimes they'll say no. Most people
8 say yes. Most people feel okay with that. We
9 explain that we're not going to be -- we'd only
10 come looking if we had information to give them or
11 if we hadn't seen them for a while. So if we
12 don't see a women for two weeks, then we would
13 probably go out and start -- and start looking for
14 her.
15 Q And you also ask if they are -- if they identify
16 as being aboriginal?
17 A Pardon?
18 Q You also ask if they identify as being aboriginal?
19 A We do.
20 Q And what responses do you -- what's the response
21 rate there?
22 A I'd say up to 80 per cent of our women identify as
23 being aboriginal. Even if they're not -- they
24 don't have status, then they still identify being
25 aboriginal.

1 Q And the next box you ask them about their drug
2 use?
3 A We do.
4 Q And their alcohol use?
5 A Yes.
6 Q What does -- so you have -- they identify the drug
7 and then the route. What does that mean? How
8 it's taken?
9 A Yeah. So we'd ask them what drug, what's the most
10 common drug, so -- and then how do they -- you
11 know, how do they take the drug, do they use
12 needles, do they smoke it, do they snort it, do
13 they use pills, do they inject into their muscles,
14 do they swallow it. So there's different ways for
15 them to ingest drugs, and so we just find out
16 which drugs, how much, when they last used, and
17 the different variety of drugs that they may be
18 on. We include alcohol and marijuana in that
19 question too.
20 Q You also ask them about their pregnancy history?
21 A Yes.
22 Q How many women would this be their first
23 pregnancy?
24 A Our women range in age from 16 to 40, their mid-
25 40s, and so some women it's their first baby.

1 Most of our women have probably had babies before,
2 but we have -- we have a sizeable portion that
3 have never had children before.
4 Q You also ask what their wishes for the pregnancy
5 outcome are, if they want to be a parent or they
6 want to relinquish care. Do you have a sense of
7 what the responses to those questions are
8 generally?
9 A Most of the woman want to parent their child.
10 Q And the next page you talk about their intake
11 needs, intake issues?
12 A Intake issues. So we ask all these questions
13 because we're trying to find out what the needs of
14 the women are. So we want to find out how come --
15 we have a wide variety of services that we offer,
16 so we want to find out -- and some of the basic
17 things aren't being met for these women, so we
18 want to find out how can we help them. And so a
19 lot of our women don't have ID. You know, where
20 they live, they don't live in safe places. If
21 they leave their places for more than a night,
22 often there's no lock on the door, so somebody
23 will go in and clean their room out, and that
24 often includes their ID. So do they need help,
25 coverage. If they haven't been on welfare for

1 whatever reason and they have no income, they
2 probably don't have health coverage, so we need to
3 find that out and need to get them health
4 coverage. Any mental health issues. A lot of our
5 women do identify with having anxiety, depression
6 or other -- or other mental health issues.
7 Q There's also a box there for "Did Not Ask", so is
8 that sort of at the discretion of --
9 A Yeah, it depends. Yeah, it's a discretion. And
10 as I said, a lot of these questions are really
11 personal and can bring up some painful memories,
12 and if we get a sense the woman isn't open to that
13 kind of question, then we wouldn't. And the woman
14 might say she doesn't want to answer that question
15 right now, and I would -- before I start asking
16 these questions about mental health and violence I
17 would say, "I'm going" -- "Do you want" -- "We've
18 got some questions on the form regarding to
19 violence and mental health. Do you want me to ask
20 you these today or do you want me to leave it,"
21 and they'll let me know. And then we ask about
22 income assistance and housing, do they have
23 housing, do they have food, do they have food
24 support, do they have somewhere to cook their
25 food, do they have a stove, a hotplate, a fridge.

1 Q Would some women be ticking off all of these
2 boxes?
3 A Absolutely, yeah.
4 Q You've also asked for what supports they have in
5 their life and whether the partner is supportive
6 or not, so would there be some circumstances where
7 the women will come in and they wouldn't have a
8 support or the person wouldn't be supportive of
9 them?
10 A Yeah, that's quite common for our women, to come
11 in -- and even if they identify their partner,
12 they're not always supportive, and they might --
13 sometimes they may say they're supportive, but
14 often it comes out -- turns out they're not, and
15 -- but we do have some women that do have
16 supportive partners, and most of them do have an
17 identified partner when they come.
18 Q Those are all my questions for the intake form,
19 Ms. Astin. Do you take attendance when the women
20 come to the centre?
21 A Can I just say one thing about the intake form?
22 Q Absolutely.
23 A Before we share this information with another
24 member of the team we actually ask the women to
25 sign the intake form, and that's given -- it's

1 called a Sheway Information Sharing Agreement, and
2 so she has to sign the form before we can share
3 this information with other members of the team.
4 Q Thanks for clarifying that. And do you take the
5 women's attendance?
6 A We do.
7 Q And what happens if a woman misses an appointment
8 or she doesn't show up for a couple weeks?
9 A Yeah, we don't have appointments. We're drop in,
10 because we find that best suits the population
11 that we serve. If we don't see a woman for a
12 couple of weeks, we have a weekly meeting every
13 Wednesday where we get together, the whole team,
14 and we discuss each family, each woman and her
15 family to whatever depth we need to that
16 particular day, and if it turns out nobody has
17 seen somebody for a couple of weeks, then we'll go
18 and look for her, and we go back to the intake
19 form and we see where she's living and are we able
20 to do outreach, and if we can't do outreach to her
21 address, if she's specified a location where we
22 may find her, and so then we would go and look for
23 her and just either to give her an appointment or
24 just to see how she's doing. We'll take a food
25 bag with us usually when we go.

1 Q How do you do the outreach? How do you go looking
2 for someone when they don't show up?
3 A We go to their address where they're living. So
4 if it's in one of the SROs downtown, then we
5 would -- we would go usually with another staff
6 person and we would go knock on her door, and if
7 she's not there, we would leave a note on the
8 door. If it was a building that had somebody at
9 the front desk and there were -- you know, they
10 seemed like they were fairly organized, then we
11 may leave a note for her on their board on the
12 front desk and then the front-desk person would
13 give the note.
14 Q If you knew she was involved in the sex trade
15 would you walk along the stroll to look for her?
16 A If we knew where she frequented, yeah, we often go
17 out looking for women on the strolls to see -- to
18 see where they are.
19 Q How often do you find the women when you go out
20 looking for them?
21 A If we don't find them and we leave a note, I would
22 say most of the time if we don't find the women on
23 the visit they will come to Sheway within a couple
24 of days of us leaving a note or a message for
25 them. So our success rate is very high of finding

1 the women when we go look for them.
2 Q I understand when Sheway was initially
3 established, and it may still be the case now,
4 that they were -- it was established in a
5 partnership with the Vancouver Native Health
6 Society, the Richmond/Vancouver Health Board, the
7 provincial Ministry of Children and Families, and
8 the YMCA through Crabtree Corner. Is that --
9 A Yes.
10 Q -- accurate?
11 A Yes.
12 Q Is that still the case?
13 A It is, yeah. We're actually not for profit, and
14 we receive funding from those four agencies, plus
15 donations.
16 Q So I'd like now to talk about your experiences as
17 a street nurse in the Downtown Eastside from 1999
18 to 2005. You said that you were doing this street
19 nurse work as part of an outreach program?
20 A Yes.
21 Q And that outreach program was through the BC
22 Centre for Disease?
23 A Yes.
24 Q What was the purpose of the program?
25 A The official title for the street nurses was HIV

1 prevention, so our official mandate was to -- at
2 that time there was a very high incidence of HIV
3 in the Downtown Eastside. It was probably the
4 highest not just in Canada but in the western
5 world, really. It was -- it was -- it was quite
6 phenomenal the -- the rates of HIV amongst the
7 population in Vancouver, particularly the Downtown
8 Eastside, so the mandate was to reach out to this
9 population and try to provide interventions that
10 would lower the incidence of HIV transmission.
11 Q In terms of the vulnerable population groups that
12 you were targeting, was sex workers part of that?
13 A Yeah, they were a big part of the work that we
14 did, yes.
15 Q What form did the outreach take?
16 A The outreach took several forms. We would -- we
17 drove a van at that time. We had a street nurse
18 van, so Monday to Friday we would take the van out
19 around 6:00 in the evening till 10:00 at night,
20 and we would take the van to the various locales
21 where the women were. So we would go to the SROs
22 and to the strolls where the women were working.
23 Q How many clients would you see in an evening when
24 you were in the outreach van?
25 A In the hundreds, probably. Not all women, because

1 we saw men too, but we saw probably over a hundred
2 clients.
3 Q How did the van approach the client? Would you
4 pull up right beside them and ask if they needed
5 any services? What was involved?
6 A Sorry, can I just go back to that first question?
7 We also saw the women in -- in detox, and we would
8 visit the Vancouver jail, the old Vancouver jail
9 that was in the Downtown Eastside, until that
10 closed. We visited the women there every morning
11 at 7:00. And also a nurse would go out to the
12 Burnaby women's prison. That's since closed, but
13 that's what we did. So we located the women in
14 several areas. And so in the van we would -- from
15 6:00 till 10:00 Monday to Friday we went out in
16 the van, and we went to the SROs. We used to do
17 meal exchange, give out condoms, give out
18 over-the-counter medications for headaches. And
19 sometimes the people we'd seen were detoxing at
20 home, so we would provide them with support for
21 that too, home detox from heroin. And we would go
22 to the strolls where the women worked, like the
23 streets where the women worked.
24 Q When you went down to the strolls would the van
25 station itself somewhere and then would you get

1 out and walk the streets or just take us --
2 A No, we -- we would take the van to where they were
3 working, and if we saw -- like, we recognized a
4 lot of the women, and the women recognized us, so
5 there was a kind of a little bit of a relationship
6 there in the fact that there was recognition, and
7 we had "Street Nurses" written on the van too, so
8 they kind of knew it was us. But, no, if we saw a
9 woman working or a group of women, we would -- we
10 would drive slowly towards them, and then -- there
11 was always two of us in the van, and then we had
12 the window down, and we would just say, "How are
13 you tonight? Is there anything we can do for
14 you?" And if they turned away and ignored us,
15 then we would just leave them. If they approached
16 us, then we would park the van and then we would
17 provide them with whatever service they required
18 of us if we could.
19 Q Why were you sensitive about that?
20 A Many reasons, really. If a woman was working, she
21 might not want to be disturbed. If there was
22 somebody coming -- there might be somebody coming,
23 you know -- you know, because she was working, and
24 we didn't want to disturb her, and also because
25 they may not know us, and we didn't want to scare

1 her. We didn't want to frighten her. We wanted
2 to build a trusting relationship, and so very
3 cautiously that we would approach the women. And
4 we didn't take it for granted that they would want
5 to speak to us, and definitely if they didn't want
6 to, we -- they would make that clear, we didn't
7 pursue them. We would leave them. We often would
8 give them our card. A lot of time we'd give out
9 clean needles and condoms.
10 Q Would you tend to see clients on a regular basis?
11 A Yeah. Yeah.
12 Q So you'd come to know them by name, would you?
13 A Yeah. We'd know them by their street name or by
14 their real name. You know, most of the women
15 would work from a particular area. They didn't go
16 to different areas. Usually they -- they usually
17 had their places where they would go, so it wasn't
18 hard to find somebody if you knew them fairly
19 well.
20 Q And as a healthcare professional would it be
21 important to know something about the client's
22 life so that you could treat them properly?
23 A Absolutely, yes. I think anybody's who's going
24 down there should know.
25 Q Can you give an example of what their life

1 circumstances looked like, how that would matter
2 in terms of the care that you were recommending?
3 A I will. I'm really cautious with this answer
4 about some of their early childhood experiences
5 because I don't want to apportion blame to anybody
6 because a lot of their early childhood experiences
7 relate to the fact of their -- the abuses that a
8 lot of aboriginal faced because of colonization
9 and the residential schools, so a lot of the
10 traumas that these women suffered were actually a
11 direct result of the intergenerational abuse
12 that's happened, and I really wanted to make that
13 clear because I don't want anybody to feel that
14 I'm blaming them or I'm apportioning blame to
15 somebody for some of their experiences because I
16 don't want to do that because I feel that the
17 victims extends to the families too of these
18 women.
19 Q Okay. Thank you.
20 A So I can only tell you in the way that I know it,
21 so that's really through talking to some of the
22 women during that time and after, so if we start
23 with their early childhood, often the children --
24 these women when they were children, their first
25 experiences was of abuse, their first memories was

1 of abuse. I've talked to women who've told me
2 that their first memory is a man lying on top of
3 them at the age of three or four, so that's their
4 first memory, and that's their kind of -- that's
5 where they're coming from. Often the women have
6 been separated from their families for whatever
7 reason and placed into foster care. And I
8 recently read somewhere that children between the
9 ages of 14 and 18 who had experienced foster care
10 have a higher incidence of post-traumatic stress
11 disorder than men who have been in combat. So
12 these women have faced many traumas throughout
13 their lives suffering from early -- I'm not saying
14 all of them, but a lot of them have suffered early
15 sexual abuse or physical, emotional abuse from
16 many different systems. They have been diagnosed
17 with various disorders: ADHD, schizophrenia,
18 bipolar. They've been labelled from a very early
19 age as having serious mental health issues. None
20 of them have -- many of them haven't -- don't
21 realize that they've suffered trauma. They've
22 suffered repeated trauma. And it might not always
23 be from a very early age, but I haven't -- I
24 haven't spoken to a woman who's told me her story
25 that hasn't been raped, so rape is a huge factor

1 in these women's lives. Violence occurs on a
2 daily basis for these women, and it's not a choice
3 that they make consciously, because for them it's
4 survival. A lot of them use the drugs because
5 they're self-medicating because nothing else makes
6 them feel better. So when they've gone to health-
7 care institutions they've been judged and they've
8 been made to feel different from everybody else.
9 I mean, I had a woman tell me when she was seven
10 years old she was -- she was gang raped by four
11 men, and she said when she went to school she felt
12 different from all the other children because she
13 knew things they didn't know and she was
14 different, and she knew she was different, but she
15 didn't know why she was different. It was only as
16 an adult that she was able to work through that,
17 that feeling of why she was different. So the
18 women have led fractured lives. They've been
19 abused. They've been mistreated by people who
20 were supposed to take care of them. Institutions
21 haven't really met their needs. Their education
22 is -- they don't -- a lot of them don't have a
23 Grade 12 education. Some of our women can't read
24 because they weren't able to focus on education at
25 that time in their life and they weren't able to

1 finish their schooling because, you know, if you
2 move to a different foster home on a, you know, on
3 a regular basis, it's really hard to make friends
4 and stay in school. So some of our women ended up
5 on the streets when they were like 12 or 13. So
6 that's -- that's -- yeah, so -- and so now the
7 women that are out there that were out there
8 working, the abuses are still going on on a daily
9 basis for them.
10 Q One of the things you said, I think you said, that
11 I'm interested in is some of the women don't
12 realize that they've suffered trauma. Did you say
13 that?
14 A Yes.
15 Q What do you mean by that?
16 A Well, a colleague of mine told me this story of a
17 woman had -- was running into a building -- no.
18 Sorry. A woman came in to do an intake or -- and
19 somebody asked her if she was fleeing violence,
20 and the woman said no, but the reason why she had
21 gone into the building was because somebody was
22 chasing her with a bat and trying to hit her with
23 a bat. So the women see some of the violence in
24 their life as kind of a normal pattern of their
25 lives, and often they don't want to disclose the

1 violence because there's a lot of shame and stigma
2 attached to it. Some of the women are really --
3 they feel shameful for what's happened to them.
4 Q What have the women told you about their
5 relationship with people in authority?
6 A They're afraid of people in authority. They
7 haven't been treated well by people in authority,
8 whether it's a teacher, whether it's going into a
9 hospital emergency. Even when they come into
10 Sheway or even with the street nurses, we could be
11 seen as people of authority because we could have
12 some power over them. So anybody who they
13 perceive as having -- if it's a power
14 relationship, that person would have authority.
15 They're afraid of people in authority.
16 Q I'd like to ask you some questions about the
17 material aspects of these women's lives in the
18 Downtown Eastside. What did you understand their
19 sources of income to be?
20 A Some of the women have a welfare cheque every
21 week. A lot of the women are in what is known as
22 the survival sex trade as a source of income. And
23 some of the women, they deal drugs. Like, they
24 sell drugs to earn income. Some of the women work
25 and they have -- they may have a job working in a

1 store or some -- I'm just trying to think of
2 somewhere that -- sometimes at Sheway even we
3 might offer part-time work for a short term to
4 give women job experience. But the women that I
5 knew as a street nurse that were on the street,
6 their main source of income was on the street, so
7 it was either through survival sex or through the
8 drug trade.
9 Q You talked about women being involved in the
10 survival sex trade. How was it that you
11 understood the women became involved?
12 A Well, the women didn't really have -- they didn't
13 have an education that would allow them to access
14 work. They had a history of post-traumatic stress
15 disorder from the multiple traumas they'd suffered
16 throughout their lives, and they often had
17 diagnoses, and the first time they used the drugs
18 that they're addicted to it made them feel better.
19 I've heard women say to me they had the high --
20 the only time they got high was the first time
21 they used, and that -- when they use drugs,
22 they're kind of chasing that high, but they never
23 get it, and really they're using the drugs so that
24 they can feel normal and they feel like they can
25 function and they can feel like they're the same

1 as everybody else because it takes the pain away
2 of their trauma --
3 Q You talked about --
4 A -- their multiple traumas and the traumas that
5 they're still experiencing. Like, the trauma
6 isn't over for them. It's still going on. So
7 they use -- they use -- they use the drugs as
8 self-medication.
9 Q You talked about visiting the strolls in the
10 health van in the Downtown Eastside?
11 A Yeah.
12 Q What were the strolls -- can you describe for us
13 what they looked like?
14 A Okay. Well, if I had one word in my mind it would
15 be Dickensian. It was like going back to some
16 movie from Charles Dickens. The strolls were in
17 the most isolated parts of the Downtown Eastside.
18 It was often dark, wet, raining, and very -- you
19 know, the street lighting would be poor. They
20 weren't busy thoroughfares where there's people
21 coming and going. There were no coffee shops.
22 The only cars going down really were either the
23 street van or the van from the DEYAS or johns
24 looking for dates, the occasional police car, but
25 really they were isolated, dark, gloomy areas. It

1 took a lot of courage, I think, for those women to
2 stand there because they didn't feel the safest.
3 They were isolated. The women were kind of pushed
4 out of the communities, because of complaints from
5 the communities, to these isolated areas, but then
6 there was no protection afforded them for having
7 to work in those areas. So it -- they were --
8 they were kind of dark, gloomy, isolated, nobody
9 around.
10 Q Did women tell you about the risks that they faced
11 when they were involved in the sex trade?
12 A Sometimes the women would make complaints about
13 events that happened to them. There was --
14 there's a sheet, a red alert sheet that goes out,
15 I think it's weekly or monthly, where women can
16 report, and that was -- that used to go out --
17 they used to call it the date rape sheet then, I
18 think, and sometimes they would tell us about an
19 event that happened to them, and we would
20 encourage them to at least report it to the date
21 rape, or we would do it on their behalf, to warn
22 other women that this perpetrator is out there
23 that might do this to them. Sometimes it would be
24 a van of youths come in to look for somebody that
25 they could beat up or sexually assault. Sometimes

1 it was an individual.
2 Q So you talked about the date -- bad date sheets.
3 Did women tell you about other kinds of safety
4 measures they took to look after themselves?
5 A Yeah, the women, they would work in pairs
6 sometimes. They would work from the same spot.
7 They would -- sometimes they would have what they
8 call spotters, so somebody would be close by to
9 where they were working and they would -- they
10 would spot for them. So they would see them
11 getting in a car, maybe take the number plate
12 or -- and then they would wait for them to come
13 back.
14 Q You talked also, Ms. Astin, about visiting the
15 SROs. What were they like?
16 A In those days?
17 Q Yes.
18 A Well, they're not much better now, but horrible,
19 horrible places. They would -- single-room
20 occupancy, we used to call them hotels, but they
21 really didn't resemble a hotel. They were dark.
22 They were dirty, full of roaches, bedbugs. They
23 were -- the rooms would be unlocked. There would
24 be -- often they didn't have locks on the doors.
25 The bathrooms -- they had communal bathrooms and

1 toilets, which I couldn't imagine anybody really
2 wanting to use. The doors would be broken often
3 on them. There was no safe place that these women
4 could actually go and shower, bathe, use the
5 bathroom. They would probably more rely on
6 community services for those things than actually
7 using the facilities in their building. There was
8 no cooking facilities. Some of the women had a --
9 would have, like, a hotplate or a microwave or
10 maybe a small fridge, but not all of them.
11 Nowhere to store things. Yeah, quite -- very
12 basic. I mean, some women would choose not to
13 stay in them because of the safety issues.
14 Q Where would those women stay?
15 A They may stay at a shelter. Some of the women
16 would go to WISH till midnight. WISH used to be
17 open until, I think, midnight at that time or
18 thereabouts. Or sometimes they'd just stay on the
19 street. Sometimes the street was safer for them.
20 Q Were there many temporary shelters available for
21 women only?
22 A I don't know of any that was women only at that
23 time. I can't recall any. There were some
24 safe -- there was Powell Place, which was a safe
25 place for women, and they could access that any

1 time of the day or night if there were places
2 available. There had to be a bed available. And
3 they had to also be on welfare to access that, so
4 if they weren't on welfare when went there, they
5 had to go on welfare.
6 Q You've talked a bit about the drug use, and I'd
7 like to just ask you some more specific questions
8 about it. What kind of drugs were women taking
9 during your time as a street nurse?
10 A Heroin, cocaine, crack cocaine, and benzos. They
11 would drink sometimes. Not many of the women
12 drank, but some of the women. And rice wine was
13 actually fairly big at that time. But a lot --
14 most of the women wouldn't drink that, but some
15 may have. And they would use Ritalin, Talwin.
16 Q Did you have the opportunity to observe any of the
17 women when they were under the influence of these
18 drugs?
19 A Did I observe them?
20 Q Yes.
21 A Yes, I did.
22 Q And tell us what their behaviours looked like when
23 they were under the influence of heroin?
24 A On heroin? Heroin is a sedative, it has a
25 sedative effect, so heroin would make -- somebody

1 using heroin would become sleepy and they would
2 nod. So they'll just literally nod their heads.
3 So that -- they become more mellow. Often that's
4 why we tell -- we advise people not to use heroin
5 alone because of the risk of overdose, because it
6 can actually depress respiration to the point of
7 not breathing, and that's how people die of the
8 overdose.
9 Q What about crack cocaine? Did you see --
10 A Crack cocaine is when -- is usually smoked. So
11 crack cocaine is smoking, and -- or they could
12 inject cocaine too or crystal meth. And so they
13 were what they call the uppers as opposed to the
14 heroin, which was a downer. So uppers would --
15 would make somebody very alert, very hyperactive.
16 Somebody that's on a cocaine run probably wouldn't
17 sleep for three or four days. They don't really
18 eat. They have very spasmodic, jerky movements.
19 It's very obvious when you see somebody that's
20 been using cocaine that they've used it or if
21 they've been on a run because of the way it
22 affects their physical movements.
23 Q And how frequent would the women have to take
24 these drugs before they started experiencing
25 symptoms of withdrawal or showing symptoms?

1 A If somebody's using heroin, they would probably
2 have to use every few hours before they would get
3 symptoms of withdrawal. Heroin is a very painful
4 withdrawal. It causes abdominal pain. It
5 causes -- the first sign is usually sneezing. It
6 causes deep body aches, vomiting. It's a very
7 painful, uncomfortable process to withdraw from
8 heroin, and it can last, I think, three or four
9 days.
10 Q What about with crack cocaine?
11 A Cocaine withdrawal is a different process. It
12 doesn't really have the physical symptoms that
13 heroin does. Somebody that's withdrawing from
14 cocaine would be very sleepy and would probably
15 sleep, would go into a deep sleep, and often it
16 can be -- they can be confused with somebody
17 that's maybe overdosing from heroin, but,
18 actually, they're very tired. They've been up for
19 three or four days, so they would sleep. There's
20 a psychological withdrawal from cocaine where
21 people might imagine bugs crawling on their skin
22 or they can get what they call psychosis, and so
23 they imagine their skin crawling and might see
24 things.
25 Q Did you ever observe or did women ever tell you

1 about how their safety is affected by these
2 symptoms of withdrawal?
3 A Yeah, because they'll do anything sometimes to
4 come out of their withdrawal. So if a women is
5 in -- withdrawal can be really, really painful.
6 Even if you don't have physical effects, you've
7 got the psychological effects, and you can have
8 terrible nightmares coming off cocaine, you can
9 have terrible nightmares coming off any drug
10 because if you don't have the drug then all the
11 trauma comes back to you, which is the reason why
12 you were taking the drug in the first place. So
13 any woman that's coming off of drugs, if she
14 didn't have correct supports in place then she'll
15 do -- she'll do anything to get the drug if she's
16 in that much pain.
17 MS. BROOKS: Mr. Commissioner, is now an appropriate time for a
18 break?
19 THE COMMISSIONER: How much longer are you going to be?
20 MS. BROOKS: About 10 minutes.
21 THE COMMISSIONER: What more am I going to hear from her?
22 MS. BROOKS: You're going to hear about the relationship with
23 the police.
24 THE COMMISSIONER: Oh, all right.
25 THE REGISTRAR: We'll now recess for 15 minutes.

1 **(PROCEEDINGS ADJOURNED AT 11:05 A.M.)**
2 **(PROCEEDINGS RECONVENED AT 11:20 A.M.)**
3 THE REGISTRAR: Order. The hearing is now resumed.
4 THE COMMISSIONER: Yes.
5 MS. BROOKS:
6 Q Ms. Astin, the final area I wanted to cover with
7 you is about the police relationship that these
8 women had. Did they tell you about their
9 relationship with the police?
10 A It wasn't something that was talked about a lot.
11 If an incident happened to them where they would
12 need to go to the police, they often didn't go, so
13 I think for a lot of the women the relationship
14 was more one of aversion. They avoided going to
15 the police if they could. They didn't feel they
16 were safe always going to the police. Their
17 stories would either be the traumas that happened
18 to them because often they weren't listened to or
19 maybe they felt they weren't going to be treated
20 in a respectful manner and it was just too hard
21 for them to do that or they felt it was a waste of
22 time.
23 Q And when you were working as a street nurse did
24 you hear about the missing women?
25 A Yes.

1 Q How did you become aware of that issue?
2 A Well, it was -- before I started working as a
3 street nurse it was already being talked about,
4 and there was, you know, talk about the women that
5 were going missing and nothing was really being
6 done about it, and, of course, with the street
7 nurse program, because we worked with these women
8 specifically, we heard about them because we
9 didn't see them or from my colleagues who had been
10 working longer, and so there was talk, talk on the
11 street.
12 Q What was that talk? What were people saying on
13 the street about what had happened to the women?
14 A That something had happened, something bad had
15 happened, but nobody knew really what. A lot of
16 people -- I didn't really talk to any of the women
17 themselves, and the thought around that was there
18 was a lot of fear among the women about what was
19 going on, but women didn't just disappear, and
20 women were disappearing. A colleague of mine was
21 telling me about one of the women, Angela, who she
22 always used to see standing on a specific corner,
23 every morning she saw her, and then one day she
24 wasn't there, and so the presence of the women,
25 even if they didn't connect very well, was missed

1 by -- by people working down there who worked with
2 them to any extent.
3 Q Did you know any of the women who disappeared?
4 A Yes, I did.
5 Q Who did you know?
6 A I knew Sereena Abotsway, and Mona Wilson, I didn't
7 know her well, but I did talk to her -- somebody
8 who described himself as her partner after she
9 disappeared.
10 Q Can you tell the commissioner about Sereena?
11 A Sereena. I knew Sereena from working with the
12 street nurse program. Sereena was -- she had been
13 on the streets a long time. I think she had grown
14 up in foster care or with adoptive parents. She
15 was very playful. She was -- she was just lovely.
16 She was a very kindhearted, playful kind of
17 person. She used to go to WISH. I used to go to
18 WISH at least once a week and provide services
19 there. Just one story about Sereena is that I was
20 quite heavily pregnant at the time I was going to
21 WISH, and Sereena -- and I didn't have a proper
22 table to examine the women, and so I had a massage
23 table that was very cumbersome and difficult to
24 erect, so Sereena, when she saw this, she would
25 just wait, and she was a woman of few words, so I

1 didn't really have too many conversations with
2 Sereena, but she would wait, and she would give me
3 a smile when she came in, and then she would
4 follow me into the room and she'd go to the corner
5 where the table was, and with the flick of her
6 wrist she would just erect this table, give me a
7 smile and leave. And that was, you know -- and to
8 me that was such a kind act that she did because
9 she saw me struggling with it week after week and
10 then she came in and solved my problem and wasn't
11 expecting anything back from that, and to me that
12 spoke volumes about her -- her as a person, you
13 know, the kindness that she gave to me, who was
14 providing services to her. So I think, you know
15 -- and she always had this playful smile, so --
16 yeah. And Sereena was connected. I mean, she
17 used to go to WISH a lot. I saw her every time I
18 went there. She would come to the clinic. She
19 was on the street. She would -- she loved getting
20 shots from the nurses that were going around
21 giving the hepatitis shots. I mean, she was
22 visible, and then when she wasn't visible it was
23 noticed because she wasn't there anymore and we
24 missed her, and we -- she wasn't there. And so
25 when she disappeared, you know, we -- the street

1 nurses, we would ask after her. We would ask,
2 "Has anybody seen Sereena?" We'd go, "Did you see
3 Sereena," you know, ask about her on the street,
4 if anybody had seen her. She just disappeared.
5 She didn't fade away. She disappeared. She was
6 there one minute, and then she was gone. It was
7 quite dramatic when she disappeared. And it was
8 the same for Angela Jardine. My colleague was
9 telling me one minute she was there and the next
10 minute she was gone. It was noted that she wasn't
11 there anymore, that she was missed.
12 MS. BROOKS: Thanks, Ms. Astin. Those are my questions, Mr.
13 Commissioner.
14 THE COMMISSIONER: All right. Thank you. Cross-examination.
15 **CROSS-EXAMINATION BY MR. WARD:**
16 Q Just on that last point --
17 THE REGISTRAR: Speaker.
18 MR. WARD: Sorry, Cameron Ward, counsel for 18 families of the
19 missing and murdered women.
20 Q Ms. Astin, just on that last point, when you and
21 your street nurse colleagues noticed that one of
22 these workers had suddenly disappeared, you
23 indicated that you followed up by asking after
24 them, correct?
25 A Yes.

1 Q And when your inquiries did not produce any
2 results, did you go further and take your concerns
3 to any authorities, like, for example, the police?
4 A I think -- I know some of my colleagues actually
5 went to the coroner's office and talked to the
6 coroner at that time, Larry Campbell, and asked
7 him -- just told him of their concerns.
8 Q But the coroner deals with --
9 A He does.
10 Q -- the deceased?
11 A I think he had connections, though, with the
12 police department. I don't really know, but they
13 were so -- they talked to anybody, anybody who
14 would listen.
15 Q Would the police lis -- sorry.
16 A No, I don't -- no. I think -- I didn't personally
17 talk to any police, but I think the people that
18 did, they didn't feel heard.
19 Q They didn't feel heard?
20 A No, they didn't feel like anything was done about
21 it.
22 Q Would it be fair to say that to your knowledge you
23 and your colleagues went to the coroner --
24 A I didn't personally, but my colleagues did.
25 Q Right. Your colleagues went to the coroner

1 because going to the police was known to be
2 futile?
3 A I think that was the feeling.
4 MR. HERN: Mr. Commissioner, this has now moved from context
5 and impressionistic evidence to direct evidence
6 about -- which links directly to the missing women
7 investigation.
8 THE COMMISSIONER: Yes.
9 MR. HERN: And I think hearsay at this stage is not
10 appropriate.
11 THE COMMISSIONER: Well, I agree with you that it is hearsay,
12 and we've had a lot of hearsay here, and this is
13 an inquiry, and I think that -- I think the wise
14 thing to do in these matters is to hear it and
15 then attach the appropriate weight to it. I fully
16 agree with you that she has no personal knowledge
17 of any of this, and it is somewhat general, and so
18 you, you know, you might well want to argue that
19 it should -- about the weight that ought to be
20 attached to it.
21 MR. HERN: If I can just add --
22 THE COMMISSIONER: Yes.
23 MR. HERN: -- a few comments to that. I think that, yes, I
24 understand entirely that a public inquiry,
25 yourself, can accept evidence that is hearsay and

1 can accept evidence of all forms, but in a case
2 like this where we have -- we have very specific
3 findings of fact that you are being asked to
4 make --
5 THE COMMISSIONER: Yes.
6 MR. HERN: -- at the end of the day about specific issues and
7 then you are also being asked by other members in
8 the room to make much more broad and general
9 analysis of the situation in the Downtown Eastside
10 of the prostitution context, of the drug addiction
11 context, there is going to be a mixture of
12 evidence of different sorts, but I respectfully
13 submit that when we get down to the specific
14 findings of fact, which will largely be against
15 the police agencies or potentially prejudice the
16 police agencies, in terms of them wanting to
17 verify those facts and look into them to make sure
18 they're accurate -- I mean, these are
19 recollections from 12 years ago -- letting
20 everything in and going to weight in my submission
21 would not be appropriate, and particularly when we
22 get to the police witnesses and so on I'm sure
23 that my friends will not appreciate that.
24 THE COMMISSIONER: I think -- I think, Mr. Hern, your point is
25 well taken, and what's happened here is when this

1 witness testified in chief she was allowed to give
2 evidence in chief of a very general nature of what
3 would this have happened, what would that have
4 happened, and I have to be quite frank with you, I
5 don't know what to make, really, of the -- from
6 some of this evidence that the commission counsel
7 led, because it really lacked any kind of specific
8 circumstances, so I -- maybe in answer to your
9 concern I think that the most I can take from what
10 the witness has said is that she worked there, she
11 dealt with people, and she told of the difficult
12 circumstances in which they lived, and she can
13 give a general impression that they didn't trust
14 the police without any kind of specific personal
15 knowledge. I think that's -- and you're free to
16 argue at the end of the day that I ought to pay
17 little or no attention to that type of evidence.
18 MR. HERN: Right.
19 THE COMMISSIONER: And I fully appreciate that when your
20 clients are called, when the police are called
21 it's impossible for them to refute anything. I
22 mean, what are they supposed to say when you have
23 general statements and general allegations that
24 are made? So I don't know if that answers your
25 concern.

1 MR. HERN: Well, perhaps I can answer it this way. I think
2 that -- and in fairness to commission counsel, I
3 know that -- my understanding of what they're
4 trying to do here with these witnesses is create
5 context so that we're not hearing evidence from
6 the police witnesses only and hearing it in a
7 vacuum, and I appreciate that that's --
8 THE COMMISSIONER: This is background evidence.
9 MR. HERN: Exactly, and that's an entirely reasonable purpose
10 to put this evidence forward. But, for example,
11 this will come up, I believe from what I've seen
12 in the "will says", with another witness, who will
13 testify to context but then also apparently wishes
14 to speak directly to her own experiences with the
15 police in the early 1990s, you know, so -- so we
16 move then in that evidence from an impressionistic
17 view, which in a civil court or a criminal court
18 might be hearsay but here, in my submission, it's
19 acceptable, but when we move to very specific
20 issues of fact that will be for you to make a
21 finding, that's when I grow concerned about the
22 fairness to the police agencies in order to verify
23 those facts.
24 THE COMMISSIONER: I'm well aware of the time parameters set
25 out in the Order in Council, so it may well be

1 that those -- that type of impressionistic
2 evidence, as you call it, may be of limited or no
3 value. And I know this is a difficult area, and I
4 want to ensure that everybody has an opportunity
5 to be heard, and I recognize that there are
6 families here and there are people here who are
7 not familiar with our stricter rules of evidence,
8 and I'm aware of the somewhat flexible approach
9 that inquiries take on these matters, and maybe
10 counsel can keep that -- those concerns in mind.
11 Mr. Vertlieb.
12 MR. VERTLIEB: Yes, I understand, Mr. Commissioner, I totally
13 understand Mr. Hern's comment.
14 THE COMMISSIONER: Yes.
15 MR. VERTLIEB: And I think everyone has known that it was --
16 and I think my colleague Ms. Brooks took the
17 witness exactly as I had wanted her to take her,
18 that is, just to set the general environment in
19 the contextual setting, but what I do want to do,
20 just so you know this, I will sit with Mr. Hern,
21 and I want to sit with him and hear about the
22 witnesses concerning him because I am alive to his
23 worries.
24 THE COMMISSIONER: I think that's a wise thing to do.
25 MR. VERTLIEB: Yes.

1 THE COMMISSIONER: And I didn't interrupt commission counsel.
2 I don't like interrupting counsel, so I didn't do
3 that, but, you know, I was a little bit concerned
4 about some of the vague statements that were made,
5 and, you know, I appreciate what this witness is
6 doing, and I know what she does on the Downtown
7 Eastside, and that's very valuable for her to come
8 here and tell us all of that, so -- but thank you
9 for raising those concerns.
10 MR. HERN: So just returning to the specific objection, all of
11 this witness's important work in terms of the
12 Downtown Eastside I have no objection to at all
13 and her impressions of working with the sex trade
14 workers and so on. The question that's been asked
15 is what did her colleagues, who she hasn't named
16 and that she wasn't in the presence of, told her
17 about a conversation that they had with the
18 coroner about the missing women. That's --
19 THE COMMISSIONER: Well, I think I've made it clear that I
20 don't think I can draw any firm conclusions of
21 fact with what someone else may have told her,
22 particularly a colleague had with the coroner and
23 their impression of not going to the police for
24 reasons that it would be futile. I mean, those
25 are her impressions, and if that's an impression

1 on the street, then it's worth listening to, but I
2 recognize -- look, this is going to be a fair
3 hearing, so everybody is going to have an
4 opportunity to be heard. So I'm well aware of
5 some of the difficulties that are incurred by
6 witnesses who are called and are in a position
7 where they have to refute general allegations with
8 specific knowledge, and I'm aware of that.
9 MR. HERN: Thank you.
10 THE COMMISSIONER: Thank you. Okay. Yes, Mr. Ward.
11 MR. WARD: I would only say in response to the speeches I've
12 heard that I wish to be present when Mr. Vertlieb
13 sits down with Mr. Hern to discuss Mr. Hern's
14 concerns. I expect that that wish will be
15 respected.
16 Q Carrying on with my cross-examination, Ms. Astin,
17 I see from your resume that you were a community
18 health nurse in the City of Vancouver --
19 A Yes.
20 Q -- starting in 1997 and continuing until 2005?
21 A No. I was a community health nurse from 1997.
22 THE REGISTRAR: Turn on your microphone, please.
23 A Oh, sorry. Until -- 1997 until 1999 with City of
24 Vancouver and then -- or Vancouver/Richmond Health
25 Board, and then I joined the street nurse program

1 in 1999, which was a different employer.
2 MR. WARD:
3 Q Yes, I understand that, but you were --
4 A I was working in the community.
5 Q -- employed as -- sorry?
6 A I was working in the community.
7 Q Yes. And would you consider the women that you
8 have been testifying about, namely, marginalized,
9 disadvantaged, often aboriginal, drug-addicted and
10 poor sex trade workers on the street, to have been
11 your patients while you were a street community
12 health nurse?
13 A Yes.
14 Q And you got to know many of your patients, as
15 you've indicated?
16 A Yes.
17 Q And you also testified that during the period of
18 time that you worked on the street as a community
19 health nurse some of your patients suddenly
20 disappeared?
21 A Yes.
22 Q You also said that you did not report the
23 disappearances to the police?
24 A No.
25 Q Why didn't you?

1 A Well, part of the reason was I was on maternity
2 leave when -- for part of that time, and I don't
3 really know why I didn't report them to the
4 police. I guess -- I don't know why I didn't
5 report them to the police. I didn't -- I
6 didn't -- I don't know why I didn't report them.
7 I didn't -- I didn't feel it was my responsibility
8 to report them to the police even though I guess I
9 noticed they were missing, but I -- I guess as a
10 group, you know, as a group, the street nurses, we
11 remarked that the -- the women were missing, but
12 personally I didn't go to the police with my
13 concerns. I knew -- I knew of some of the women
14 that did go missing and then I knew Sereena, so
15 Sereena was -- and then I met Mona's partner after
16 the fact, and he'd already been -- he told me he
17 had already been to the police, so --
18 Q If, God forbid, you had a family member go missing
19 suddenly, who would you report the disappearance
20 to?
21 A To the police.
22 Q And you live in an area of Vancouver just off
23 Cambie Street where houses probably cost 2 or 3
24 million dollars, right?
25 A Yeah. We're very fortunate we inherited some

1 money and we were able to. And I wouldn't say 2
2 to 3 million dollars, actually. I think that's an
3 exaggeration.
4 Q Seems to change from one day to the next, perhaps.
5 Can you please, by looking at the photographs
6 behind you if necessary, indicate whether you knew
7 by name or by sight the following women, and I'm
8 listing these because they appear to have
9 disappeared while you were working on the streets
10 as a community health nurse. Brenda Wolfe, was
11 she known to you?
12 A No.
13 Q How about Dawn Crey?
14 A Dawn who? Sorry.
15 Q Dawn Crey.
16 A Crey. She looks somewhat familiar, but I didn't
17 know her well if I knew her at all.
18 Q All right. Georgina Papin?
19 A No.
20 Q Angela [sic] Joesbury?
21 A She looks familiar, but I -- I can't say that I
22 knew her. I might have met her if she was -- if I
23 was in a street nurse van or she may have come to
24 the clinic. I don't remember her specifically.
25 Q All right. Heather Bottomley?

1 A No.
2 Q Mona Wilson? I think you mentioned you did know
3 her.
4 A I knew her. I didn't know her well. I had met
5 her. But I spoke to her partner after she
6 disappeared.
7 Q And who --
8 A Sereena. Sereena Abotsway.
9 Q Sorry, her partner was Sereena Abotsway?
10 A No, no, no. I don't know what his name is. I
11 don't remember.
12 Q All right. And what was the nature of that
13 conversation?
14 A With Mona. He just came to the Main Street clinic
15 where I used to work, and he was very concerned
16 because he'd seen Mona -- I guess he was -- as I
17 talked earlier, like, one of the safety things was
18 spotting, so I guess he was spotting for Mona, and
19 he'd seen her get into a car, and she hadn't
20 returned, so he was very concerned about her, he
21 was very worried. And he said he had gone to the
22 police because that was -- would have been our
23 advice, was to go to the police, and he said he
24 did. So that was my conversation. And I think he
25 had that conversation with more than one person.

1 Q And did you provide any further assistance to him
2 or refer him to anyone else who might assist him
3 with his concern that his partner had gone
4 missing?
5 A I can't remember the details, but I know for sure
6 we did talk about going to the police and maybe
7 contacting some of the agencies, like WISH, where
8 Mona may have frequented and see if they had seen
9 her.
10 Q I just want to put this into a temporal context.
11 Under Mona Wilson's name does it indicate when she
12 was last seen or when she went missing?
13 A I think it was November.
14 Q November of 2001; is that right?
15 A November 25th.
16 Q November 25th, 2001?
17 A Yes.
18 Q All right. And you will recall that throughout
19 the period that you were working as a street nurse
20 right up until the day before the news broke that
21 the Pickton pig farm in Port Coquitlam was being
22 searched the *Vancouver Sun* was running regular
23 stories about the issue of the missing women,
24 right?
25 A Yes.

1 Q The women you dealt with on the street as your
2 patients were fearful and concerned?
3 A Yes.
4 Q There was a lot of discussion from 1999 right up
5 until 2002 about the issue of women going missing
6 while plying the sex trade on the streets of the
7 Downtown Eastside?
8 A That's correct.
9 Q I suggest that from as early as 1999 it was the
10 subject of considerable discussion among the women
11 that you treated as patients and yourself that
12 women had been going to a Port Coquitlam pig farm
13 and disappearing there, right?
14 A I never heard that personally. Myself, I never
15 heard that from anybody.
16 Q All right.
17 A Nobody told me about a pig farm in Port Coquitlam,
18 like who had been there. I had never --
19 Q I'm not talking about people who had been there.
20 A No, but I'm talking at that particular time I had
21 never heard, nobody had told me anything about a
22 pig farm before -- before, you know, the arrest
23 was made.
24 Q Had Robert William Pickton's name shown up on the
25 red alert weekly bad date sheets?

1 A I don't know. I can't answer that question.
2 Q Who produced those?
3 A WISH and PACE, I think, used to produce them.
4 Q And do you know whether they kept those?
5 A I don't know. You'd have to ask them. I don't
6 know.
7 Q I will. Just carrying on with the list of women,
8 how about Dianne Rock?
9 A No, I didn't know her.
10 Q Andrea [sic] Jardine you said you did?
11 A I didn't know her. It might be classed as
12 hearsay, but one of my colleagues knew Andrea --
13 Angela. Is it Angela? Angela.
14 Q What was her name or his name, your colleague?
15 A My colleague. Am I allowed to give that? I don't
16 know if I'm able to give her name. I haven't
17 asked her permission to use her name, so --
18 THE COMMISSIONER: Yes.
19 A Yeah.
20 THE COMMISSIONER: If you know it, yes.
21 A Liz James.
22 MR. WARD:
23 Q And do you know what she does now, where she
24 works?
25 A She's retired.

1 Q Living in Vancouver?
2 A Yeah.
3 Q Can you describe from your perspective as a
4 community health nurse how these disadvantaged
5 women obtained their social assistance or welfare
6 payments?
7 A The same as anybody else. I think they would have
8 to have an address to be -- to be eligible to
9 claim them, so they have to have a fixed address.
10 And they have to apply for welfare, so they'd have
11 to go to an office and -- where they would be
12 assigned a worker, and then they would fill out
13 the appropriate forms, and somebody may have to
14 help them depending on their ability to fill out
15 the forms, and then they would be given a cheque
16 either on a monthly basis -- some people would get
17 their cheques weekly, depending on how they were
18 able to manage their money, at their request, and
19 then the cheque would be -- they usually picked
20 their cheque up from the office.
21 Q Okay. I want to focus on that. What office or
22 offices?
23 A Well, the office that they were assigned to to
24 pick up their cheque. There's several within --
25 within Vancouver, so I think it's dependent upon

1 your address as to which office you would go and
2 pick up your cheque from.
3 Q All right. In the Downtown Eastside of Vancouver,
4 the area where you provided nursing services, can
5 you please tell me the identities of the offices
6 where these women would collect their cheques?
7 A I don't know the exact addresses. There was
8 dockside --
9 Q Okay.
10 A -- or waterside. And then there's one -- is it
11 down on Powell Street? There's one down there
12 somewhere.
13 Q Did you have any discussions with the workers
14 there about the fact that during the period of
15 time that the media was reporting sex trade
16 workers from the Downtown Eastside going missing
17 in large numbers their cheques, their welfare
18 cheques were sitting uncollected at the offices?
19 A No. No, I didn't. When I worked as a street
20 nurse we weren't as involved in the women's lives
21 as perhaps now my work is at Sheway, where we're
22 definitely more involved with the women's lives,
23 and so the only contact we might have with a women
24 is on a Tuesday night working the street van, and
25 so we didn't really know which office or even if

1 they were on welfare always. Didn't have those --
2 didn't always have those particular details.
3 Q All right. You referenced your experience with
4 Sheway in your testimony, and you said, if I noted
5 it correctly, that now at Sheway if you don't see
6 a women for two weeks "we'd go out looking for
7 her"?
8 A Mm-hmm.
9 Q Do you recall that evidence?
10 A Yeah, and I'd repeat that, yes.
11 Q And in the event you don't find her after you've
12 gone out looking for her what steps do you take?
13 A I can't recall that we haven't not found a woman,
14 so I can't answer that question because we've
15 usually found her. Like, we can see if she's
16 picked up her cheque, just as you suggested,
17 because we are more involved, so we know which
18 women -- most of our women are on welfare. They
19 have to be to provide any stability in their life.
20 So we would -- there's not many women that we
21 don't find. I don't recall that we haven't -- and
22 if we can't find them, then something -- we might
23 get a report from the prison with her name on it
24 and so we know she's in the prison. So I don't
25 recall that we haven't found a woman in the time

1 that I've worked at Sheway.
2 Q All right. The previous number of years when you
3 worked as a community health nurse in the Downtown
4 Eastside --
5 A Mm-hmm.
6 Q -- did you have any inquiries from any Vancouver
7 Police Department member, whether in Missing
8 Persons or elsewhere, about specific women who
9 were said to, either in the media or elsewhere,
10 said to be missing?
11 A You mean when they were going missing you mean?
12 Q Yes.
13 A Yes. No.
14 Q Nobody -- no police officer came to you to make an
15 inquiry?
16 A To me personally, no.
17 Q And I just want to be clear. When in 1999 did you
18 commence the job you described in your resume at
19 the foot of page 2?
20 A Street nurse you mean?
21 Q Yes.
22 A It would have been around April.
23 Q April?
24 A Yeah, April.
25 Q Of 1999?

1 A Yes.
2 Q And my records indicate that that's precisely the
3 time that the *Vancouver Sun* was running major
4 stories regularly on the missing women --
5 A Mm-hmm.
6 Q -- on the possibility of a reward being offered
7 for information leading to the conviction of the
8 person responsible. Do you recall that around the
9 time you started your work?
10 A I don't recall the reward. I recall there was a
11 lot of media interest in the women disappearing,
12 but I don't recall a reward.
13 Q And just to be clear, your resume says that your
14 work between 1999 and 2005 as a street nurse
15 consisted of providing prevention and clinical
16 services to marginalized populations in the
17 Downtown Eastside of Vancouver, including persons
18 with addiction issues, gay, lesbian, bisexual,
19 transgendered --
20 A Yes.
21 Q -- homeless, and women in the sex trade?
22 A Mm-hmm.
23 Q
24 I worked in a variety of settings, including
25 clinics, street nurse vans, single-room

1 occupancy dwellings or SROs, detox units,
2 Vancouver jail, parks, street corners, and
3 alleys.
4 A Yes.
5 Q That's accurate?
6 A Yes.
7 Q Is there anything you wish to add to or expand on
8 that?
9 A No.
10 Q All right. And you spoke about the conditions in
11 that environment.
12 A Mm-hmm.
13 Q You said that the strolls, the places where the
14 sex trade workers operated, were Dickensian in
15 nature?
16 A Mm-hmm.
17 Q And you described them as dark and gloomy?
18 A Mm-hmm.
19 Q Is that correct?
20 A Correct.
21 Q You spoke about the SROs and described those
22 conditions as horrible?
23 A Mm-hmm.
24 Q In your view, based on your own observations and
25 given your evidence that some women elected to

1 actually sleep on the street rather than the SROs,
2 were the SROs fit for civilized human occupancy
3 based on what you saw?
4 A I -- I would say no. I don't think you could
5 expect anybody to live in those conditions.
6 Q Were you aware of any efforts being taken then by
7 those who may be responsible for ensuring that
8 residential properties meet health and safety and
9 other regulations to enforce those regulations?
10 A I don't understand your question.
11 Q I'm sorry. It was a bit awkward. Were you aware
12 whether City of Vancouver inspectors were dealing
13 with the horrible conditions that you observed in
14 the SROs?
15 A I wasn't aware. I wasn't aware.
16 Q Did you see any improvement in the horrible
17 conditions in the SROs during the course of your
18 tenure?
19 A You mean since 1999 to 2000 -- well, there's been
20 efforts made in the last few years to improve, you
21 know, conditions in the hotels, so -- but, you
22 know, there's still a lot of people living there
23 in the same conditions that they were in 1999.
24 Q In the period between April of 1999 and 2005, when
25 you transitioned out of the street nurse

1 occupation, it looks like about six years, what
2 did you observe to be the nature of the
3 interaction or relationship between sex trade
4 workers that you were providing services to,
5 treatment services, and members of the Vancouver
6 Police Department? I'd like you to think about
7 that and perhaps offer --
8 A I never actually saw a police officer with a woman
9 on the street, so I only know what the women have
10 told me.
11 Q What was that?
12 A The women have told me that they're -- they're
13 afraid to report things to the police. I mean,
14 sometimes we see women who have been sexually
15 assaulted, and so one of the questions that we ask
16 them is, "Do you want to report this to the
17 police," and more often than not they will say no
18 because they're -- they're -- because it means
19 they have to tell their story again. They're not
20 sure if they're going to be listened to, and they
21 have very little trust, as I said earlier, in
22 institutions, so they don't feel secure to go
23 forward. And that still happens today. That's
24 just an example, that they're afraid. They live
25 in fear a lot of the time.

1 THE COMMISSIONER: Safe to say there's a general distrust of
2 the whole system?
3 A Yes.
4 THE COMMISSIONER: All right.
5 MR. WARD:
6 Q And a specific distrust of the police?
7 A Yes.
8 Q You also mentioned both in the resume and in your
9 testimony seeing this cohort of Downtown Eastside
10 sex trade workers in detox in the jail?
11 A Mm-hmm.
12 Q Sorry, you have to answer with a yes or no.
13 A In detox in the jail. I didn't say that. Sorry,
14 I don't know what you mean.
15 Q You would see them in detox --
16 A Or --
17 Q -- every morning at 7:00 a.m.?
18 A No, I would see them in the Vancouver jail. One
19 of the street nurses would visit --
20 Q Yes.
21 A -- every morning at seven o'clock because I think
22 the court -- they used to be taken out around
23 eight o'clock to go meet the court workers, so
24 they would be in jail for whatever they were
25 picked up from the night before, and so we would

1 go and visit the women to provide -- it was an
2 access point for them because they're in this
3 place and they were open to -- some of them, if
4 they were open to seeing the street nurse, we'd go
5 in and offer them, you know, some health
6 interventions if they wanted it.
7 Q And from your own observation what were the
8 conditions like in that place?
9 A In the Vancouver jail? Well, they were like
10 cages. The jails were like cages, and so there
11 was no privacy. And I think -- I can't remember
12 now if there was a toilet in the cages. I can't
13 quite remember. So I was quite shocked when I
14 first saw the jails, but there was an element of
15 camaraderie that actually went on. The girls
16 could see each other, the women could see each
17 other, and they could talk to each other, so they
18 weren't alone per se. But they were -- yeah, it
19 was old. The jail was old. Yeah. And they were
20 there just usually for overnight. I don't think
21 they were there for -- I don't know. I can't
22 remember how long they were kept there for.
23 Q Were these women, to your knowledge, were these
24 women there because they had been charged or
25 because they were being held there for other

1 reasons overnight?
2 A I can't answer that question. I don't know.
3 Q Just one last question then just in summary on
4 some of these points. Given the gloomy and dark
5 Dickensian environment of the streets, the
6 horrible conditions of the SRO, the shocking
7 condition of the jail, would you agree that the
8 women from the Downtown Eastside involved in the
9 sex trade with whom you dealt were living in the
10 most inhumane and squalid conditions?
11 A For the most part I would say yes.
12 MR. WARD: Thank you. Those are my questions.
13 MR. GRATL: Ms. Astin, I introduced myself before.
14 THE COMMISSIONER: Microphone, please.
15 **CROSS-EXAMINATION BY MR. GRATL:**
16 Q Ms. Astin, I introduced myself before, but my name
17 is Jason Gratl, and I'm counsel for affected
18 individuals and groups in the Downtown Eastside.
19 A Yes.
20 Q Primarily sex workers and drug users. I just have
21 a few questions.
22 A Yes.
23 Q The first is in relation to access to the services
24 at Sheway.
25 A Yes.

1 Q And you spoke about the rather -- the delicacy and
2 sensitivity with which you approach the intake
3 interview?
4 A Yes.
5 Q In comparison with that, do you believe that any
6 of the women who access the services at Sheway
7 would do so if they were required to submit to a
8 probing examination of their criminal history or
9 sexual history as a pre-condition of access to the
10 services?
11 A I think it would be a huge barrier for many women.
12 Q They would be intimidated by that?
13 A I think they would be very afraid by that, yeah.
14 They would be intimidated, and they would be --
15 yeah, I think they would be -- I think they would
16 just leave, they would turn around and leave, most
17 of them.
18 Q They might find it humiliating and degrading?
19 A And shameful, yeah.
20 Q And then on another topic, in terms of the
21 connection between the women who access the
22 services at Sheway and their connection
23 specifically to the Downtown Eastside community, I
24 take it that they have relatively strong
25 connections to the Downtown Eastside?

1 A Yes.
2 Q That is -- and some of those are for positive
3 reasons, and some of them are for negative
4 reasons. What I mean by that is a lot of them
5 have a friend network?
6 A A friend network?
7 Q Yes. They have networks of friends?
8 A They have connections, I guess, yeah. I don't
9 know friends, but -- I don't know.
10 Q Okay. Some of them have families?
11 A Yes.
12 Q Children?
13 A Mm-hmm.
14 Q Or, otherwise, parents?
15 A Yes.
16 Q Or siblings or other relations in the Downtown
17 Eastside?
18 A Yes, are connected. Yeah, definitely.
19 Q And certainly many of them depend, for a variety
20 of reasons that you've already referred to, on the
21 services that are available in the Downtown
22 Eastside?
23 A Yes.
24 Q A lot of those services are specialized services
25 that target delivery of services to the most

1 vulnerable?
2 A Yes.
3 Q And those types of services, such as Sheway, for
4 example, are not available anywhere else in the
5 Lower Mainland or British Columbia really?
6 A Correct. Well, Sheway for sure. I can't speak
7 for the other services, but --
8 Q Well, let's go through a few of those. There are
9 a number of food programs in the Downtown
10 Eastside?
11 A Yes.
12 Q First United Church, for example --
13 A Yes.
14 Q -- offers a dinner program, a lunch program; is
15 that right?
16 A Yes. Yes.
17 Q And those types of food programs, they're just not
18 available with that level of consistency and
19 reliability outside the Downtown Eastside?
20 A I would say so. I don't think there's a demand
21 probably outside --
22 Q All right.
23 A -- the Downtown Eastside.
24 Q Okay. And in addition to Sheway there are other
25 forms of health services or drop-in clinics --

1 A Yes.
2 Q -- that are only available in the Downtown
3 Eastside, a native health clinic, for example?
4 A Yes.
5 Q They have a very open door policy?
6 A Yes.
7 Q You're familiar with their work?
8 A Yes.
9 Q And that type of open-door clinic, nonjudgmental
10 environment is only available in the Downtown
11 Eastside?
12 A I don't know. I don't work in any other areas. I
13 can't speak for other places, but I do know the
14 women report that they feel uncomfortable
15 accessing healthcare in a lot of places, so from
16 their perception they feel that they're judged
17 very much by accessing healthcare in places, in
18 other places, such as hospitals, other clinics,
19 walk-in clinics.
20 Q All right. Aside from health services, there are
21 also public health programs, like needle
22 exchanges, that are available in the Downtown
23 Eastside?
24 A Yes.
25 Q So DEYAS for a while? You're familiar with them?

1 A Yes. They don't operate from that building
2 anymore.
3 Q All right. But I'm thinking in about the late
4 '90s they operated a --
5 A Yes. Oh, yeah, they had a big -- they had a
6 needle exchange. In fact, the street nurses had a
7 clinic above the needle exchange on Main Street
8 there just below Cordova.
9 Q Were you associated with that clinic above
10 the needle exchange?
11 A Yeah, we used to operate the clinic. All the
12 street nurses worked in that clinic.
13 Q Okay. So that was the home base really for the
14 work that you did?
15 A In the Downtown Eastside, yes, it was -- it was
16 pretty much, yeah.
17 Q Okay. So the fixed location needle exchange was
18 right below there basically --
19 A Yes.
20 Q -- across from the police station at 312 Main?
21 A Yes.
22 Q And so that needle exchange, to your knowledge,
23 was the only needle exchange operating in British
24 Columbia at the time?
25 A Well, the only fixed site needle exchange. We

1 used to do needle exchange too with the street
2 nurse program, and we used to do a mobile needle
3 exchange as well.
4 Q Okay. And the mobile needle exchange was a needle
5 exchange worker who usually drove the van along
6 with a registered nurse who would travel around
7 with the van?
8 A The street nurses.
9 Q The street nurses.
10 A And it would be two nurses or a nurse and a
11 healthcare worker.
12 Q Okay.
13 A Didn't matter who drove as long as you were --
14 Q And you would travel around to the SROs?
15 A Yes.
16 Q And to some of the strolls?
17 A Yes.
18 Q And to some of the other locations where services
19 were offered and people in need were --
20 A Yes.
21 Q -- known to congregate?
22 A Yes.
23 Q So that program, the mobile health van --
24 A You're talking about the street nurse van or the
25 DEYAS van?

1 Q Okay. Well, let's talk just about the street
2 nurse van.
3 A Okay.
4 Q That was only available in the Downtown Eastside?
5 A The street nurse van would actually go all the way
6 out to New Westminster.
7 Q Okay.
8 A On a couple of nights a week it would go out
9 and -- because the women that were working along
10 the Kingsway routes often weren't able to access
11 services. There wasn't much beyond the Vancouver
12 boundaries --
13 Q I gotcha.
14 A -- and so we drove to New West and did needle
15 exchanges out there.
16 Q Okay. But that was the limit of it for the Lower
17 Mainland?
18 A Yes.
19 Q Okay. It went down the Kingsway stroll, and while
20 they were on Kingsway they just made it all the
21 way down to New West?
22 A Yes.
23 Q And the DEYAS van, can you speak to them?
24 A No, I can't. I never worked on the DEYAS van, so
25 I can't speak to them. I don't know.

1 Q Okay. So in addition to health services, clinics,
2 and public health services like the street nurse
3 van --
4 A Mm-hmm.
5 Q -- of course the Downtown Eastside offered ready
6 access to the illicit substances to which women
7 were addicted?
8 A Yes.
9 Q And so there would be -- women would, of course --
10 they'd have regular dealers? They wouldn't just
11 flit from dealer to dealer?
12 A We'd encourage them to stay with the same dealer
13 if we thought that was a safer bet. When we talk
14 about harm reduction, that's a way to keep harm --
15 reduce harm, is to stay with the same dealer. But
16 some women would -- would change dealers. It
17 depended on the circumstances.
18 Q Well, sure, but generally speaking women were
19 loyal to a single merchant?
20 A I can't speak for every woman. I don't know the
21 answer for that. We would encourage them to,
22 definitely.
23 Q But -- fair enough, but the overall picture that
24 I'm left with is that there are many, many points
25 of connection for --

1 A Absolutely.
2 Q -- women to the Downtown Eastside; is that right?
3 A Yes.
4 Q And leaving the Downtown Eastside would represent
5 a significant reduction in the services and
6 opportunities to fulfil their desires and needs?
7 A Yes, I would say so.
8 Q There was, in effect, a great deal keeping them in
9 the Downtown Eastside?
10 A Mm-hmm. Yes.
11 Q And it was for that reason that the women tended
12 not to be transient?
13 A I would say so, yes.
14 MR. GRATL: Thank you.
15 MS. GERVAIS: Robyn Gervais, independent counsel for aboriginal
16 interests.
17 THE COMMISSIONER: Yes.
18 A Hi.
19 **CROSS-EXAMINATION BY MS. GERVAIS:**
20 Q Hi. I introduced myself outside.
21 A Yes.
22 Q But just to make my role more clear, my role is
23 with respect to the aboriginal interests, and
24 today I'll be asking you questions about -- just
25 expanding on Karey's direct examination of you and

1 also asking you some specific questions about
2 aboriginal clients that you worked with.
3 A Mm-hmm.
4 Q In your experience working as a health nurse in
5 the Downtown Eastside, what were common sources of
6 violence that the women were exposed to?
7 A Common source. It could be domestic violence,
8 partner violence. It could be stranger violence.
9 It could be violence associated with working,
10 being involved in the sex trade. So somebody
11 that's, you know, obtaining sex from one of the
12 women may turn violent, and that could be somebody
13 they knew or didn't know. It could be just a hit
14 and run in the street. You know, walking across
15 the street they could be hit by a car. And some
16 of the women did complain that they weren't always
17 well treated by the police.
18 Q Okay. And what types of injuries did the women in
19 the Downtown Eastside sustain from these violent
20 interactions? I'm sure they're varied, but --
21 A Yeah. Well, bruising, sometimes broken bones,
22 jaws often broken, facial injuries, head injuries.
23 Head injuries are quite common, actually, for the
24 women in the Downtown Eastside, probably more
25 common than the general population. Sexual

1 injuries. So you're just talking about physical
2 injuries?
3 Q Yes.
4 A So bruising, broken bones, head injuries, sexual
5 injuries. And if you want to call -- you know,
6 they might get a sexually transmitted disease from
7 somebody if they've been sexually assaulted.
8 Q And you mentioned that head injuries are more
9 common --
10 A Yes.
11 Q -- amongst this population. Why is that?
12 A Well, they are more prone to, you know, being
13 struck by a vehicle. Sometimes they might be
14 thrown from a vehicle. Just being beaten around
15 the head.
16 Q And how did these health issues or the injuries
17 they sustained affect their work as sex trade
18 workers?
19 A Well, if they -- for fairly obvious injuries they
20 may be hospitalized, so they're not able to work.
21 Makes them more fearful that it could happen
22 again. It's another trauma, so often trauma can
23 lead to an escalation of drug use because the drug
24 is the thing that makes them feel better because
25 it takes away some of the pain, it numbs them a

1 little bit, so it may actually cause an increase
2 in their drug use, and it makes them more
3 vulnerable because then they have to go out and
4 work more to get the money or deal more in drugs
5 to get the money to pay for the drugs because none
6 of the drugs are prescribed. They have to buy the
7 drugs.
8 Q And you testified earlier that you worked with
9 some of the same women over your work -- in your
10 work as a health nurse --
11 A I don't understand.
12 Q -- is that correct?
13 You would see some of the same women from
14 time to time in your work in the Downtown
15 Eastside?
16 A Oh, yeah. Yeah. Yes.
17 Q And did you develop a relationship with these
18 women?
19 A Some of them, yeah. Do you mean when I worked as
20 a street nurse or when I worked at Sheway?
21 Q When you were working as a street nurse.
22 A As a street nurse, yes, you would all the time.
23 Q Okay.
24 A All the time. Some of them you don't. I guess if
25 you have recognition over a period of time you

1 could say there's a relationship. If you're
2 providing services, there's an element of a
3 relationship there.
4 Q Okay.
5 A Yes.
6 Q And do you feel that these women trusted you?
7 A Yes.
8 Q And how were you able to gain their trust?
9 A I think we gained their trust by being
10 nonjudgmental in our approach and providing them
11 with information or services that they needed. It
12 was a relationship that was solely dependent on
13 their wish to be in that relationship. Like, they
14 weren't coerced or forced. It was their -- it was
15 their wish to be involved, so definitely it was a
16 consensual sort of relationship. Like, they --
17 they agreed to it. And I think we had a softer --
18 a softer approach. We would approach women
19 cautiously and always introduce ourselves and give
20 them information where they could contact us if
21 now's not a good time.
22 Q Okay. And did you have, in your capacity as a
23 street nurse did you have conversations with the
24 sex trade workers about the violence that they
25 experienced?

1 A Sometimes. Sometimes we would. Sometimes they
2 would report incidents that happened to them.
3 Sometimes they'd come to the clinic, they'd want
4 to be checked because they had a sexual assault or
5 they'd been beaten by somebody, so yeah.
6 Q And did they ever discuss with you how this
7 affected their lives?
8 A I wouldn't say deeply, no. I would say they were
9 more afraid. It made them more afraid.
10 Q Did the women you worked with ever talk about
11 leaving the Downtown Eastside?
12 A If they talked about it, it was more in context of
13 going back to their communities where they came
14 from, trying to reconnect with family. I didn't
15 really hear anybody talking about making a fresh
16 start in a new city because I think for most of
17 them that wouldn't be possible because they would
18 have no connections there. So I didn't know of
19 anybody that made a fresh start and left and went
20 to a new place and met new friends and started all
21 over. It was mostly in the context of reuniting
22 with family and that kind of thing.
23 Q And were there many women that reunited -- left
24 the Downtown Eastside and reunited with their
25 family?

1 A I don't know many. When I was working as a street
2 nurse I don't know of many that did that. A lot
3 of the women were in contact with their family.
4 Like, some of them would call regularly. I
5 think -- yeah.
6 Q So did they discuss with you their family
7 situations?
8 A Sometimes.
9 Q And you said that they would maintain contact by
10 telephone with their families?
11 A Yeah, they would call them, yeah.
12 Q Any other ways of maintaining contact?
13 A I don't know of any. Sometimes the families would
14 call if they knew that they were involved with the
15 street nurses. They would sometimes call and
16 leave messages for the women and then we would
17 pass the message onto the women with a phone
18 number to call and we would provide them with a
19 phone call -- with a phone if they wanted to make
20 a phone call to their family members. Sometimes
21 their family members just wanted to make sure that
22 they were okay.
23 Q Okay. And did the women that you worked with as a
24 street nurse, did they talk to you about their
25 children?

1 A Yes.
2 Q What kinds of things would they tell you?
3 A Often they would have a photograph on the wall at
4 the SRO where they were living. They might have a
5 wall with some pictures that they'd been given.
6 They were very proud of their children, and even
7 though they may not talk to them, they have
8 stories about their children. Sometimes they may
9 have a letter from their child if their child's
10 old enough to write, but I would say most of them
11 had at least a photograph of their children.
12 Q And was this the photographs that they carried
13 with them or --
14 A They'd carry it with them or they'd have it on the
15 wall in their room where they lived.
16 Q Okay. I'd like to talk a little bit about the
17 child welfare system and the residential school
18 system and particularly with a focus on aboriginal
19 women.
20 A Mm-hmm.
21 Q So in your time as a public health nurse or at
22 Sheway, as a rough estimate what percentage of the
23 women that you worked with had children who were
24 involved in the child welfare system?
25 A When you say child welfare, do you mean like the

1 Ministry of --
2 Q Yes.
3 A -- Children and Families?
4 Q Yes.
5 A I'd say most of them. I can't give you a
6 percentage, but most. Most of them at some
7 degree. We actually encourage early referrals to
8 the ministry during pregnancy just so that we can
9 build a relationship with the social workers and
10 then -- you know, with a view -- at Sheway the
11 view is always if the mother wants to keep her
12 children when the baby's born, if they want to
13 stay together, then we encourage that relationship
14 early because it's beneficial.
15 Q Okay. And you said -- pardon me.
16 A For the women that were working -- that I met
17 working as a street nurse, they wouldn't have
18 custody of their children for the most part
19 because of their lifestyle, so I would say, yes,
20 there was ministry involvement with all of those
21 women.
22 Q And what percentage of those women would you say
23 are or were aboriginal?
24 A Which women, the women on the street or the women
25 at Sheway? Sorry.

1 Q Both.
2 A Both. Well, at Sheway we know 80 per cent of the
3 women identify as aboriginal.
4 Q Okay.
5 A And on the street, the majority, I would say.
6 Probably the same. Similar. I don't know the
7 exact number.
8 Q And let's talk about your experience with the
9 women working on the street as a street nurse.
10 A Mm-hmm.
11 Q How did they describe their interactions with the
12 Ministry of Children and Family Development?
13 A You know, I didn't have many conversations with
14 the women at that time about that, so I can't
15 really comment. It wasn't really -- working as a
16 street nurse there's a different focus to the
17 work. And they would talk about their children
18 lovingly, and they were grateful their children
19 were being well taken care of. They missed their
20 children. They grieved their children. I don't
21 recall having conversations about the ministry per
22 se because at that point they weren't in a
23 position to, you know, live with their children,
24 or some of them I'm sure had visits with their
25 children.

1 Q Okay.
2 A And a lot of their children were actually in the
3 care of family too. Like, not all the children
4 are in the care of the ministry.
5 Q Okay. Now turning to your work with Sheway, and
6 how do the clients that you service at Sheway view
7 the ministry?
8 A Because a lot of our clients were foster children
9 themselves, they have some trust issues with the
10 ministry because they don't feel that they were
11 treated well as children, and they -- some of
12 their biggest fears is for their child to go into
13 foster care or to have the same experiences as
14 they had, so there is a little bit of fear
15 attached because the ministry can take their
16 children away, so there's a reluctance on the part
17 of some women, especially if they've got a history
18 of losing several children and several children
19 being in the care of the ministry or other family
20 members. There is some fear around losing their
21 child, and so some women choose not to do what we
22 call the early referral earlier in pregnancy to
23 the ministry to try and build a relationship with
24 the social worker. Some women choose to wait
25 until the baby's born because they are -- they're

1 scared they're going to lose their children. And
2 one of the first questions that a woman may ask at
3 Sheway is, "Are they going to take my baby away?"
4 So it's a palpable fear, it's a real fear for
5 them.
6 Q And the women that you worked with at Sheway whose
7 children have been removed by the ministry, do you
8 know about the visits that occur between the
9 children and --
10 A Yes.
11 Q -- the parents?
12 A We do.
13 Q And does Sheway supervise those visits?
14 A We don't do supervised visits. We will provide a
15 safe place for the women to have their visits. We
16 don't have the capability to do supervised visits.
17 We don't have the staff. And it's not a position
18 that we really want to get ourselves into because
19 we want to be a support to the women, so we will
20 provide a safe place for them if they want -- as
21 long as the ministry is okay with that, and if it
22 needs to be supervised, then the ministry needs to
23 provide a supervisor to come with the woman for
24 the visit.
25 Q And I'm sure that this varies, but how often do

1 women get to see their children?
2 A Yeah, it does really vary. I think if the woman
3 meets with the ministry, regardless of her
4 circumstances, and she's able to be clean for the
5 visit, most women have access to their children at
6 least once -- once a week. It really depends on
7 the woman's circumstances and where she's at.
8 Q So they -- at the low end they might see their
9 child if they're clean?
10 A The low end is they wouldn't see their child,
11 going up to once a week, maybe two or three times
12 a week. If the woman becomes stable she may get
13 to have overnights. If she's got stable housing,
14 she's got lots of supports in place and she's kind
15 of working on a plan for her own sort of recovery,
16 then she may build up to overnight visits, and
17 usually when they build up to overnight visits
18 then the view is to return the child to the
19 mother, and then when the child returned it would
20 be under a supervision order. The majority of our
21 women actually take their children home from the
22 hospital. I'd say 70 per cent of our women from
23 Sheway take their children home. Some are with a
24 supervision order, most of them are with a
25 supervision order, but they do get to take their

1 children home. And then the other 30 per cent,
2 the majority of those have visits with their
3 children.
4 Q In the case where the children have become
5 permanent wards of the court are the parents
6 allowed to have any access to their children?
7 A You mean if they're adopted?
8 Q If they're adopted or they remain -- perhaps not
9 adopted but in a foster home.
10 A If -- yeah, if they're in a foster home they can
11 see their child. And, again, it really depends on
12 the woman's situation as to how many times she
13 sees her child. If the child is adopted, then
14 there's what we call an open adoption where
15 letters can be written and exchange of
16 photographs.
17 Q So letters being the only contact if there's
18 adoption?
19 A And photographs.
20 Q And photographs.
21 A Yeah, I think that's -- for an open adoption.
22 Q Okay. Have you had conversations with the
23 aboriginal women you work with about any abuse
24 that they suffered as a result of being in the
25 foster care system?

1 A Yeah.
2 Q And what were the general themes of those
3 conversations?
4 A General themes. Some women were physically
5 abused. Emotional abuse. Some women suffered
6 sexual abuse. Sometimes the separation from
7 family is a traumatic event in a women's life, in
8 a child's life. Well, it is most of the time, I
9 would say.
10 Q And of the women that you work with at Sheway,
11 could you give any kind of guess as to what
12 percentage of those women were raised in the
13 foster care system?
14 A I don't know percentages, but a lot. A lot of
15 them may not have been raised but may have
16 experienced foster care.
17 Q Have any of the aboriginal women that you've
18 worked with talked to you about experiences with
19 the residential school system?
20 A No, not the women I've worked with.
21 Q Have they talked about any experiences that their
22 parents had with the residential school system?
23 A Some of them have mentioned that their parents or
24 their grandparents were in residential school.
25 Most of the women we work with, they weren't part

1 of the residential school system. They were too
2 young. You know, it had already ended. But a lot
3 of their older relatives were.
4 Q And have they talked to you about the effects
5 that that has had on their life?
6 A I don't think they talk about in terms of the
7 effect themselves, but they talk about they don't
8 know their culture and they talk about they don't
9 know where they're from. They'll actually say
10 that, "I don't know where I'm from." So they
11 don't know what their heritage is or where they're
12 from or who they're connected to. They don't even
13 know where -- they don't know where their
14 ancestors or from. They don't -- and they don't
15 know the important parts of their culture. The
16 significant things about their culture they
17 don't -- they don't know. They don't feel
18 connected to their culture, so --
19 Q So it would be fair to say that they feel very
20 disconnected from their culture and from their
21 communities?
22 A And when they feel disconnectedness, no, they
23 don't have a connection.
24 Q Dr. Lowman was here testifying earlier this week.
25 He is a -- he provided expert evidence with

1 respect to prostitution law and prostitution law
2 enforcement in Vancouver, and he provided
3 testimony that 30 to 70 per cent of women working
4 in the sex trade in the Downtown Eastside are
5 aboriginal. Would you agree with that?
6 A Yes.
7 Q Okay. And in your work either at Sheway or as a
8 public health nurse did you notice any difference
9 in the frequency of violence towards aboriginal
10 and non-aboriginal women?
11 A Is there a difference between?
12 Q Yes.
13 A I didn't notice. I think -- because their life
14 circumstances are so similar, I think all the
15 women that work down there are subject to the same
16 risks.
17 Q Did you notice any differences in the sources of
18 violence between aboriginal and non-aboriginal
19 women? For example, were aboriginal women more
20 subject to domestic violence than stranger
21 violence or --
22 A No, I can't say I've noticed a trend.
23 Q Did you talk to women specifically about their
24 aboriginal culture?
25 A No. I don't really feel like I'm qualified to do

1 that. I'm not aboriginal, as you can see. I
2 would -- if they wanted to talk to me about their
3 past and where they're from, I would try -- if
4 somebody wanted to talk about their culture, I
5 would try and connect them with somebody that
6 would know about their culture rather than myself.
7 I wouldn't feel I would be credible to talk to
8 them about their culture. I'm not -- yeah, I'm
9 not an expert on their culture.
10 Q Okay. Do the aboriginal women you work with ever
11 talk to you about racism or how that has affected
12 their lives?
13 A I don't think they talk about racism as such.
14 They just talk about injustices that have happened
15 to them. And for a lot of them, because it's so a
16 part of their life, I don't think a lot of them
17 even recognize it for what it is. I don't think
18 they know that they're being treated differently
19 sometimes because of their race. They know
20 they're being treated differently. They might not
21 put it down to being aboriginal.
22 Q Now I just want to talk a little bit about Sheway
23 and about the aboriginal staff at Sheway. In the
24 material that you submitted, and Ms. Brooks
25 referred to it this morning, there is the Sheway

1 intake form?
2 A Mm-hmm.
3 Q And do you have it there with you?
4 A Yeah, I do.
5 Q Okay.
6 A The intake form, yeah.
7 Q Yes. Okay. In the "Client Information" box I
8 notice that there's a space for people to indicate
9 whether they're aboriginal or not?
10 A Mm-hmm.
11 Q And in your view why is it important for Sheway to
12 keep track of the number of aboriginal women
13 accessing their services?
14 A Because it's always good to know who your client
15 base is so that you can direct services, and also,
16 you know, I think it -- it's just important to
17 have that information just to -- so we know that
18 we have 80 per cent aboriginal, and if at any time
19 there needs to be a policy change, it's good
20 information as well, but I think it's good for us
21 to know that this is indeed who we're working with
22 and so we can try and be sensitive to that.
23 Q And I notice that there is actually quite a few
24 descriptors with respect to women being
25 aboriginal, their status, First Nations, Metis,

1 Inuit, status number, band, other. Why are all
2 those descriptors in there?
3 A Because there's a difference in the type of
4 services that they can access. So if somebody's
5 status as opposed to non-status, it would -- if
6 they needed to be attached to say the Ministry for
7 Children and Families or to the aboriginal VACFSS,
8 which is the aboriginal counterpart, if they're
9 status then they would be attached to VACFSS and
10 they would receive services through them as
11 opposed to MCFD. It's good for us to know that.
12 And some of the -- and it gives us a bit of a --
13 the band as well because if they need -- certain
14 medical requirements will be covered by certain
15 bands and not others, so there's certain things
16 that they can receive depending. And it gives us
17 a breakdown too of where -- of where the women
18 that we serve come from. So, yeah, it gives us
19 more of a background on the women as well so that
20 we know where we can refer them to and have an
21 idea of what services they're eligible for.
22 MS. GERVAIS: Okay. Mr. Commissioner, I'll probably only be
23 maybe less than five minutes, if you'd like to
24 keep going, or --
25 THE COMMISSIONER: How long do you think you'll be?

1 MR. HERN: Just two or three minutes.
2 THE COMMISSIONER: Yes.
3 MR. MAJAWA: Nothing from the Government of Canada.
4 THE COMMISSIONER: Pardon me?
5 MR. MAJAWA: Nothing from the Government of Canada.
6 THE COMMISSIONER: I see. All right. Why don't we finish this
7 off and then she won't have to come back.
8 MS. GERVAIS: Okay.
9 Q Do you have contact with the bands where the women
10 come from? Does Sheway as an organization have
11 contact with the bands?
12 A Not officially, no. We usually encourage the
13 women to contact the bands themselves, although we
14 can phone. We can phone if we need to get their
15 number so that they can access -- access things,
16 because it's helpful to get certain things
17 medically if they have their band number. But we
18 don't work directly with the bands. Sometimes
19 we'll talk to -- say, for example, if we have a
20 woman that's living -- that moves over to North
21 Vancouver and she's living on the Squamish reserve
22 there, the First Nations reserve there, then
23 there's a nurse that works out of there, so we
24 might talk to the nurse around certain health
25 issues, but we don't really work with the bands a

1 lot, no.
2 Q Okay. And the other piece of -- or the other part
3 of the exhibit, the Sheway brochure, if you could
4 just have a look at that. And I notice under the
5 heading that says "Sheway Staff" or "Staff at
6 Sheway" there is an aboriginal community support
7 worker?
8 A Mm-hmm.
9 Q Is this an aboriginal person?
10 A Yes.
11 Q Okay.
12 A Yeah.
13 Q And why, in your view, is it important for Sheway
14 to have an aboriginal support worker?
15 A Well, our population is predominantly aboriginal,
16 and it's really difficult to find people to work
17 that are aboriginal. We want to be culturally
18 sensitive, and we want -- part of the role of the
19 aboriginal support worker is to introduce women to
20 their culture and to -- even though each --
21 depending on where you're from you might have
22 different traditions, but she's able to maybe
23 introduce them to some things in their culture and
24 make them feel more connected. And the aboriginal
25 support worker, she's got some common ground with

1 the women too, so she's going to have an
2 understanding of some of their issues regarding
3 their culture. It's very important. We feel it's
4 very important and -- yeah.
5 Q Are there any other aboriginal people employed at
6 Sheway?
7 A The cook is aboriginal, and we have -- our family
8 support worker is aboriginal. We used to have a
9 community health nurse, but she no longer works
10 with us, who was aboriginal. We have an infant
11 development worker. And I think that's -- yeah,
12 that's -- yeah, that's the list.
13 Q And would you say that it's a bit easier for the
14 aboriginal women to form a rapport and trusting
15 relationships with the aboriginal employees?
16 A I wouldn't necessarily say that. I think the most
17 important thing for the women is that when they do
18 come to Sheway that they're greeted in a way
19 that's nonjudgmental and compassionate and maybe
20 provides them support for their basic needs and
21 allows them a place to be safe, and I think if we
22 can provide those things for them I don't think it
23 really matters where you're from. I think the
24 most important thing -- I think the fact that
25 we're all female helps too because, you know, I

1 think it's just less threatening just from a size
2 perspective, and also a lot of the women have been
3 victimized by males, so -- but we are woman-
4 centred, so I think as long as we provide those
5 things then we can -- you know, I think the women
6 will relate to any one of us, actually.
7 MS. GERVAIS: Thank you. Those are my questions.
8 **CROSS-EXAMINATION BY MR. HERN:**
9 Q Ms. Astin, Sean Hern for the Vancouver Police
10 Department and Vancouver Police Board. I just
11 have a very, very brief set of questions. You
12 observed that among your drug-addicted sex trade
13 worker patients that they had difficulty trusting
14 authorities of all kinds, right?
15 A Yes.
16 Q And that would include health authorities?
17 A Yes.
18 Q And mental health workers?
19 A Yes.
20 Q And Ministry of Children and Families?
21 A Mm-hmm. Yes.
22 Q Although I guess back then it was called something
23 different.
24 A I can't remember.
25 Q I think it was Social Services and Housing. And

1 the criminal justice system?
2 A Yes.
3 Q And even Sheway sometimes had difficulties
4 establishing a relationship of trust, a patient
5 relationship?
6 A I wouldn't say there was difficulty. I think it's
7 a process sometimes, and sometimes a process takes
8 time, and even though the initial visit is
9 probably the most important visit because that's
10 where you set your impression, so if you give an
11 impression that's not something that they're going
12 to relate to -- if you can set an impression of
13 kindness, compassion, openness, nonjudgmental,
14 then you're more likely to establish a
15 relationship, but if you can't establish a
16 relationship after one visit, it takes time and
17 it's a process. So at Sheway we do recognize that
18 to establish a relationship with these women can
19 takes months, if not years, and so we're accepting
20 of that, and that's how we work, on that premise.
21 Q Right. And do you have Exhibit 8 in front of you
22 there?
23 A Which one was that?
24 Q It's the Sheway --
25 A Intake.

1 Q -- form. Yeah, the intake form.
2 A Mm-hmm.
3 Q Just flip. I observed that on the third page
4 there is the box at the bottom that talks about
5 the information sharing agreement?
6 A Yes.
7 Q And it provides that confidentiality is assured
8 except in three prescribed circumstances --
9 A That's right, yeah.
10 Q -- at the bottom there, and one is that if there's
11 reason to believe a child is in danger of abuse or
12 neglect --
13 A Yes.
14 Q -- in need of protection Sheway is legally obliged
15 to make a report to the Ministry of Child and
16 Family Development?
17 A That's correct, yeah.
18 Q And then secondly, if compelled by a court order
19 or legislation --
20 A Yes.
21 Q -- information might be revealed?
22 And then third, if Sheway perceives the woman
23 is in danger to herself or others they may be
24 obliged to -- well, they are obliged to seek
25 help --

1 A Yes.
2 Q -- for the woman?
3 And so did that information sharing, those
4 exceptions to confidentiality sometimes interfere
5 with the ability of Sheway to develop a patient --
6 A No.
7 Q -- relationship?
8 A No, I've never -- in my experience it's never
9 affected, those three elements. It's -- for any
10 informed consent or any confidentiality agreement
11 it's standard. Like, you'll see those on any
12 confidentiality agreement that you sign with
13 anybody in healthcare. It's kind of a legal
14 obligation, and most of the women understand this.
15 It's not the first time they've heard this, and if
16 it is, then we explain it to them. I don't recall
17 anybody refusing to sign the agreement, and --
18 and, no, it doesn't seem to affect our
19 relationship with the women because we don't
20 actually report that often to the ministry, and we
21 don't -- because we do have relationships with the
22 social workers and we have relationships with the
23 women, and the women are very honest with us, and
24 so part of the women -- with regards to the
25 ministry, part of the women having their children

1 in their care is having a safety plan for their
2 children and for themselves. What do you do if
3 you use? What do you do -- how do you keep your
4 children safe? And so those things are all talked
5 about over the course of our relationship with the
6 women, especially if they're going to be taking
7 their children home. And so, no, it's -- it's
8 never -- I've never known it to be an issue. And
9 a woman can refuse to sign it, in which case we
10 don't share the information and we don't open her
11 officially, although that person that does the
12 intake may continue to work with her --
13 Q Right.
14 A -- to gain her trust.
15 Q Right.
16 A But I can recall maybe once or twice when somebody
17 hasn't signed. More often when it's not signed
18 it's that the workers forget to ask for the
19 signature even though they've gone through the
20 whole thing and something's happened and -- but
21 for the most part that's not a barrier.
22 Q I see.
23 A Yes.
24 Q And, of course, these requirements, as you say, as
25 a healthcare provider that Sheway is, there are

1 simply limits to the extent of the confidentiality
2 that can be offered?
3 A There's limits to any confidentiality, and these
4 are the limits, and we're very honest with the
5 women. We're not trying to hide anything from
6 them. We tell them this at the beginning, and we
7 don't -- usually if we report something to the
8 ministry the women would often know. Often we
9 will encourage the woman to call herself and we'll
10 be there as a support person. So we try -- it's
11 not a punitive thing. It's more it's part of the
12 care that we give and it's part of the services
13 that we provide, and it's to keep everybody safe,
14 and women recognize that because of all the women
15 I've worked with I've not met one that doesn't
16 want the best interests for her child. So that's
17 really important, yeah.
18 Q Or her own safety?
19 A Her own safety, yeah.
20 MR. HERN: All right. Well, thank you for the important work
21 that you do.
22 A Thank you.
23 MR. HERN: It's interesting to hear about it.
24 THE COMMISSIONER: Thank you. Thank you, Ms. Astin, for
25 coming.

1 A Okay.

2 **(WITNESS EXCUSED)**

3 THE COMMISSIONER: Thank you. All right. We'll adjourn until
4 2:15.

5 THE REGISTRAR: The hearing is now adjourned until 2:15.

6 **(PROCEEDINGS ADJOURNED AT 12:45 P.M.)**

7 **(PROCEEDINGS RECONVENED AT 2:20 P.M.)**

8 THE REGISTRAR: Order. The hearing is now resumed.

9 MR. VERTLIEB: Thank you, Mr. Commissioner. We have in the
10 witness box Dr. Thomas Kerr. Dr. Kerr, would you
11 stand, please, to affirm your evidence.

12 **THOMAS KERR: Affirmed**

13 THE REGISTRAR: Would you state your name, please.

14 A Thomas Kerr.

15 THE REGISTRAR: Thank you. Counsel.

16 MR. VERTLIEB: Thank you, Mr. Giles. Mr. Commissioner, Mr.
17 Giles has a copy of a brief containing the
18 instruction letter from the commission, which is
19 number 1, at tab 2 the full curriculum vitae, at
20 tab 3 the opinion of Dr. Kerr and supporting
21 appendices with articles he references, and that's
22 been distributed to everyone. I want to ask you,
23 please, to accept Dr. Kerr as an expert in
24 educational psychology focusing on health and
25 counselling psychology and with particular

1 knowledge in the study of drug use and illness
2 from drug use. I don't know if there's any
3 objection. I'll take him through --
4 THE COMMISSIONER: Does anybody have any objections to his
5 expertise so that he may be able to give opinion
6 evidence in what?
7 MR. VERTLIEB: Educational psychology with a focus on health
8 and counselling psychology and particular
9 experience in the field of the use of illicit
10 drugs.
11 THE COMMISSIONER: I assume that everybody has Dr. Kerr's
12 curriculum vitae. All right. Thank you.
13 MR. VERTLIEB: Thank you, Mr. Commissioner.
14 **EXAMINATION IN CHIEF BY MR. VERTLIEB:**
15 Q Dr. Kerr, very briefly then with what's just
16 transpired, you have a master's degree, a Master
17 of Arts in counselling psychology from the
18 University of Victoria granted September 1997; is
19 that correct?
20 A Yes.
21 Q Thank you. You were granted a doctorate Ph.D. in
22 health psychology from the University of Victoria
23 in April 2003?
24 A Yes.
25 Q And tell us, please, what you are presently doing.

1 What work are you doing?
2 A I'm employed as a research scientist at the
3 British Columbia Centre for Excellence in HIV/AIDS
4 where I oversee a program focused on the -- on
5 urban health with a particular focus on infectious
6 diseases and addiction. I'm an associate
7 professor within the Division of AIDS in the
8 Department of Medicine at the University of
9 British Columbia. My primary responsibilities
10 involve overseeing several large prospective
11 cohort studies involving people who use illicit
12 drugs.
13 Q Thank you. You mentioned the word "cohort". We
14 also heard that word from Dr. Shannon when she
15 gave evidence. What does cohort mean?
16 A A cohort study is a particular type of methodology
17 that's used within the field of medicine and
18 epidemiology. The method involves recruiting into
19 a study a very large group of people. In our case
20 our studies are generally around a thousand,
21 involve around a thousand individuals, and then we
22 follow these individuals over time to better
23 understand the dynamics of disease morbidity and
24 mortality in these populations and also to
25 evaluate the impact of health programs and related

1 policies.
2 MR. VERTLIEB: In your report, which was prepared at our
3 request in September and is marked at tab 3 -- and
4 I will ask that the report and all the materials
5 in the binder I've referenced earlier be marked as
6 the next exhibit, please, if that's agreeable, Mr.
7 Commissioner.
8 THE COMMISSIONER: I assume there are no objections.
9 MR. GRATL: I have no objection, Mr. Commissioner, but now that
10 I've heard Dr. Kerr give evidence as to his
11 background I thought to request that he be
12 qualified to give evidence in public health and,
13 in particular, drug policy as it pertains to
14 public health.
15 MR. VERTLIEB: Fair enough. I should mention, Mr.
16 Commissioner, that in his report at -- dated
17 September 12th, 2011, in his first paragraph under
18 "Background" he, in fact, says:
19 Areas of Expertise: HIV/AIDS, illicit drug
20 use, public health and related research
21 methods.
22 I think Mr. Gratl is quite correct.
23 THE REGISTRAR: That will be marked as Exhibit number 9.
24 **(EXHIBIT 9: Dr. Thomas Kerr - Expert Report and**
25 **Appendices)**

1 THE COMMISSIONER: Yes.
2 MR. VERTLIEB:
3 Q So cohort is a recognized term to people in
4 medical research such as yourself?
5 A That's correct.
6 Q Now, in your report you give your name and your
7 title, Co-Director, Urban Health Research
8 Institute, B.C. Centre for Excellence in HIV/AIDS,
9 Associate Professor, Division of AIDS, Department
10 of Medicine, Faculty of Medicine, University of
11 British Columbia, but then you provide your
12 address as St. Paul's Hospital. Where is it that
13 you basically are then headquartered?
14 A We operate out of the British Columbia Centre for
15 Excellence in HIV/AIDS, which is located at
16 St.Paul's Hospital and is affiliated with the
17 University of British Columbia.
18 Q Now, the work that you're involved in as part of
19 your research study and the work that's outlined
20 in your report, would you please tell us who is
21 funding that work?
22 A Our work is primarily funded by the US National
23 Institutes of Health through the National
24 Institute for Drug Abuse. We also receive funding
25 from the Canadian Institutes for Health Research.

1 Those are our primary funders.
2 Q And approximately what per cent is provided by the
3 US National Institute of Health?
4 A Approximately 70 per cent.
5 Q And approximately how much from the Canadian
6 federal government?
7 A Pretty much the balance.
8 Q So more or less 30 per cent?
9 A That's right.
10 Q Tell us why, to your understanding, that an
11 American institution would come to you and your
12 group here in Vancouver to do this research?
13 A I think the initial interest was based on the fact
14 that in 1997 Vancouver experienced a very
15 explosive epidemic of HIV infection in the
16 Downtown Eastside area, and there is a great deal
17 of interest in the factors that both facilitated
18 this epidemic and also down the road things that
19 would help prevent it from continuing to grow.
20 The -- subsequently to that I think based on the
21 high number of peer-reviewed publications coming
22 out of the study made it easy to renew funding for
23 the study, and it has become now one of the
24 longest standing cohorts of people who inject
25 drugs in the world, and I think there's a desire

1 to keep it going for that reason.
2 Q So would it be a fair way to say that to your
3 knowledge the work you're doing is at the leading
4 edge of any of this work anywhere in the world?
5 A I think that we are among a group of people who
6 are leading work in this area, yes.
7 Q Thank you. Now, I wanted to ask you just
8 generally just to help us understand this work why
9 is this research being funded? What's the purpose
10 behind the work you're doing?
11 A I think when our work began there was a very
12 limited understanding of the factors that
13 perpetuated the transmission of diseases like HIV
14 within this population. As well, there was
15 limited scientific evidence to base decisions
16 regarding what should be done to prevent these
17 epidemics from getting worse. The approach that
18 we are using helps provide some insights into
19 those policies and programs.
20 Q Is progress being made in the treatment of AIDS?
21 A Yes.
22 Q Can you give us some statistics to indicate to the
23 commissioner how progress is being made?
24 A In 1997 researchers working from our centre
25 documented an annual incidence of HIV infection of

1 19 per cent among people who inject drugs in the
2 Downtown Eastside neighbourhood, which means that
3 about 19 per cent of all drug users were infected
4 during that year. Recent estimates suggest that
5 that number has declined to about 1 per cent, so I
6 would say significant progress has been made with
7 respect to the prevention of HIV. Substantial
8 gains have also been made in the treatment of HIV
9 with people now being able to live almost a normal
10 life expectancy if properly treated with the
11 appropriate medications.
12 Q And this is in part due to the work being done by
13 you and others here in Vancouver?
14 A I would say the work that we have done has helped
15 inform the response to these health challenges and
16 in that way has contributed.
17 Q So your area of expertise as a doctor in the field
18 is focused on the use of injections and drug use
19 and focused on the Downtown Eastside?
20 A Yes.
21 Q Now, you've had a chance to in the last 24 hours
22 review your report that was prepared at our
23 request, now marked as a part of Exhibit 9. Your
24 report is thorough and comprehensive. I just
25 wanted to ask you if there's anything you feel the

1 need to add to that report?
2 A No.
3 MR. VERTLIEB: Mr. Commissioner, in order to allow Dr. Kerr to
4 have time with my learned friends and to
5 accommodate his schedule so that he can be
6 completed today, I have no further questions.
7 THE COMMISSIONER: All right. Thank you. Cross-examination.
8 MR. WARD: I have no questions.
9 THE COMMISSIONER: All right. Thank you. Mr. Roberts.
10 MR. ROBERT: Darrell Roberts on behalf of First Nations women.
11 Nature abhors a vacuum, Mr. Commissioner.
12 THE REGISTRAR: We need your microphone on, please.
13 MR. ROBERTS: I'll do this all again. Darrell Roberts on
14 behalf of First Nations women. I said that nature
15 abhors a vacuum, and so I have a few questions.
16 **CROSS-EXAMINATION BY MR. ROBERTS:**
17 Q Dr. Kerr, much of your work has been done in --
18 that term cohort which we heard from Mr. Vertlieb
19 is a term particularly identified with
20 epidemiology?
21 A Mm-hmm.
22 Q And the cohort in question is the same one that
23 you've worked with with Dr. Shannon?
24 A No. The cohort I was referring to is called the
25 *Vancouver Injection Drug User Study*.

1 Q I see. And on that particular cohort you've also
2 worked with Dr. Shannon?
3 A I have at times collaborated with Dr. Shannon, and
4 I have also collaborated at times with her on her
5 own cohort study primarily giving methodological
6 advice.
7 Q But you have -- just a moment, please. In your
8 expert -- in your expert report under
9 "Qualifications" you say that you're the --
10 currently the co-investigator of a large study of
11 sex workers in Vancouver, principal investigator
12 is Dr. Kate Shannon, "however, my sex work is not
13 my primary area of expertise". What is that
14 particular investigation?
15 A Of which I am a co-investigator?
16 Q Yes.
17 A That is the AESHA study, which is a cohort of
18 women involved in sex work that is overseen by Dr.
19 Shannon.
20 Q I see. Now, are you familiar with a particular
21 project led by Dr. Shannon, the Mada (sic)
22 Project?
23 A The Maka Project?
24 Q Maka Project.
25 A Yes, I'm familiar with it.

1 Q Did you give her advice on that one too?
2 A Very little.
3 Q I see. But you have done much work with her on
4 various projects?
5 A I think much work relative to my larger body of
6 work might be stretching it. I have done some
7 work with her.
8 Q You've co-authored with her?
9 A I have.
10 Q Yes. And your work -- and you've read some of her
11 work as well?
12 A Yes.
13 Q Yes. And her publications?
14 A Yes.
15 Q And with respect to -- are you familiar with the
16 conclusions which she has reached in her
17 publications about the violence that has been
18 brought to or for which women working in the sex
19 trade in the Downtown Eastside have been subjected
20 to?
21 A I am familiar with some of those conclusions but
22 certainly not all.
23 Q Your focus has been on the drug impacts and the
24 health factors with respect to those people?
25 A That's correct, and that has been my primary

1 contribution to Kate's work.
2 MR. ROBERTS: All right. All right. Thank you, sir.
3 A Thank you.
4 **CROSS-EXAMINATION BY MR. GRATL:**
5 Q I always wonder, do you prefer Professor or
6 Doctor?
7 A Either is fine.
8 Q All right. I'll go with Doctor then.
9 A Okay.
10 Q Before beginning my questions I just want to
11 emphasize that the focus of this inquiry is really
12 on policing, and part of what I understand your
13 role to be as counsel for affected individuals and
14 groups in the Downtown Eastside, including sex
15 workers and drug users, part of what I understand
16 your role to be is to provide a context for the
17 analysis of the appropriateness of police conduct
18 in the investigations. But I'd like to, if you'll
19 bear with me, just take you through a few aspects
20 of your report --
21 A Okay.
22 Q -- and unpack them. It's rather a brief report,
23 and I know that you refer to some of your
24 conclusions in a rather concise way --
25 A Okay.

1 Q -- and I'm hoping to unpack a few of the comments
2 that you make.
3 A Certainly.
4 Q The version of the report that I have has
5 "Background" and "Qualifications" on page 1 and
6 then "Opinion" starting on page 2.
7 A Okay.
8 Q And I'd like to begin at -- just at the bottom of
9 page 3 noting that you've generated a number of
10 studies that have found -- made findings specific
11 to sex work, and the first observation you make is
12 that "studies of street-involved drug using youth
13 showed that upon arriving in the local drug scene,
14 young people can quickly become entrenched there,
15 and can soon end up participating in various
16 income generating activities, such as sex work,
17 that can [sic] carry significant risk for
18 violence". What -- can you describe that study
19 and how it came to that conclusion?
20 A Yes, certainly. We have a cohort study called the
21 *At Risk Youth Study,* which is a study involving
22 street-involved drug using youth who primarily
23 reside in the downtown south area, although many
24 also go to the Downtown Eastside. As part of that
25 study we have a qualitative researcher and

1 ethnographer, Danya Fast, who has conducted
2 extensive interviews and undertaken ethnographic
3 activities related to this study. She published a
4 paper in the *Journal of Social Science & Medicine*
5 which really sought to evaluate how people become
6 immersed, young people specifically become
7 immersed in the local drug scene, and she found
8 that, as my opinion suggests, that this can be
9 very rapid and that because people are often in
10 need of a means to survive and generate money that
11 they -- because they are already entrenched in the
12 local drug scene they avail themselves of the
13 methods for generating income that are most
14 available within that drug scene, and for many
15 individuals this includes sex work or drug
16 dealing.
17 Q So it is as parents have always worried, that
18 entrenchment in the street scene can happen very
19 quickly?
20 A It can for some, yes.
21 Q Your next conclusion is that for many young women
22 their participation in sex work is a result of
23 male domination within the street drug scene.
24 Could you speak about gender relations within the
25 street drug scene and how that might operate to

1 push young women into sex work?
2 A We have in the paper that's referenced a number of
3 specific quotes from individuals who were
4 interviewed who described male domination, who
5 described their male associates controlling their
6 access to everything from drugs to prevention
7 tools, such as condoms. As well we have reports
8 from individuals who have talked about males
9 coercing their participation into sex work. We
10 also have other work showing that many women
11 experience harassment and violence at the hands of
12 men within the drug market often because they're
13 perceived to be engaged in sex work even when they
14 are not and that typically men, male drug users
15 assume that they are sex workers and because they
16 are sex workers they must have money and drugs on
17 them and that they are often accosted on this
18 basis.
19 Q Just for sheer robbery?
20 A Yes.
21 Q I take it as well that there's a certain amount of
22 violence that attends drug trafficking and the
23 physical threat advantage that men tend to have
24 selects men for that role?
25 A Yes, certainly.

1 Q And so, in effect, it makes it more difficult for
2 women to engage in drug trafficking to generate
3 the income necessary to sustain a habit, so they
4 have to turn to sex work?
5 A Women do occupy certain roles within the drug
6 dealing hierarchy; however, I think that it is
7 more likely a more male-dominated activity for
8 sure. And I also agree with your point insofar as
9 I believe that there are certain roles within the
10 drug dealing hierarchy that women typically do not
11 occupy for the reasons you've mentioned.
12 Q All right. Women, in a 2008 Fairburn and Small
13 study, articulated a mistrust of others and a fear
14 of violent confrontations that arise over money or
15 drugs. How common is that?
16 A I think it's pervasive.
17 Q All right. So everyone to some extent, to a
18 greater or lesser extent, is going to fear
19 violence?
20 A I would think so.
21 Q And I take it from your description of the
22 relationships that women might have, even with
23 their -- even with their male partners, spouses,
24 boyfriends the violence can come from any quarters
25 and may well be -- there may well be a risk that

1 it could come from all quarters?
2 A Absolutely. We've published work on physical
3 violence, and we found that 66 per cent of females
4 in our study had experienced violence and that it
5 came from a variety of sources with approximately
6 32 per cent reporting that violence came at the
7 hands of a stranger, 43 at the hands of an
8 acquaintance -- I could go on.
9 Q Please do.
10 A There's a wide -- 5 per cent partners, 4 per cent
11 friends, about 4 per cent drug dealers, 4 per cent
12 police, about 5 per cent a sex trade client or
13 worker, and 3 per cent made up the other category.
14 So, yes, I think a wide variety of actors, and I
15 think what's significant is that about 31 per cent
16 were strangers.
17 Q The only -- the only source that I don't see on
18 that list is non-profit organizations. I don't
19 see service providers for non-profit organizations
20 or health professionals on that list. Is that
21 fair to say?
22 A Yes.
23 Q That there are no or very few reports of violence
24 from non-profits and healthcare providers?
25 A I can't say that in my experience of investigating

1 violence among drug users that I've heard of any
2 such account.
3 Q In your paper you define drug dependence, and drug
4 dependence for the women who went missing is, of
5 course, a central issue. Could you please define
6 drug dependence?
7 A Most people define drug dependence by referring to
8 a number of criteria, including developing
9 increased tolerance to a drug, experiencing
10 withdrawal, the need to take larger amounts of
11 drugs over time, people having either a persistent
12 desire or repeated unsuccessful attempts to stop
13 or attenuate -- attenuate their substance use.
14 They tend to spend a large time -- amount of time
15 spent securing and using the substance or
16 recovering from the effects of the substance. And
17 I think perhaps the two most important criteria in
18 many people's minds is, is that there is usually
19 significant impairment in both work and social and
20 family activities because of substance use, and,
21 secondly, that the substance use continues despite
22 the fact that the individual is well aware of the
23 negative physical, psychological, and social
24 effects of their ongoing use.
25 Q So one of the potential features of drug

1 dependence is the prioritization of drug
2 acquisition and use over other things in their
3 lives?
4 A Yes.
5 Q And I guess drug dependence is marked by an
6 inordinate or highly unusual, irregular
7 prioritization of those things so that drug
8 dependence can take priority over nutrition,
9 proper nutrition?
10 A Yes.
11 Q It can take priority over proper family relations
12 and friends?
13 A Yes.
14 Q It can take priority over a career and other forms
15 of social well-being, status seeking?
16 A Yes.
17 Q And it can even take precedence over taking care
18 of one's own self psychologically and physically?
19 A In the most extreme case, yes.
20 Q To the point where drug dependence can ultimately
21 lead to a person preferring to engage in drug
22 acquisition behaviour over self-preservation in a
23 context of extreme personal danger?
24 A Absolutely. That is happening right now in the
25 Downtown Eastside. People are waking up each day

1 and literally risking their lives to -- as part of
2 their ongoing substance use.
3 Q And I'm thinking in particular of a context where
4 a person who is dependent on drugs might get to
5 the point where they would get into a car with
6 somebody they know is likely to cause them serious
7 personal injury in order to acquire drugs?
8 A I think that in order to acquire the money needed
9 to acquire drugs and stave off withdrawal that
10 people will use less discretion and accept
11 remarkably high levels of risk, yes.
12 Q All right. You've listed a number of different
13 factors that might go into drug dependence, and
14 just to put a finer point on it, is that a
15 checklist all of which have to be present, all of
16 which factors have to be present in order to find
17 somebody to be drug dependent, or need there be
18 only a preponderance of those factors or some of
19 those factors in sufficient weight in order for a
20 person to be considered to be drug dependent?
21 A People define drug dependence very differently.
22 The WHO definition is as simple as a state in
23 which the individual has a need for repeated doses
24 of the drug to feel good or to avoid feeling bad.
25 The criteria I listed are from the Diagnostic

1 Statistical Manual of the American Psychiatric
2 Association, which is I know now is actually being
3 revised and the next edition will have a slightly
4 different criteria. However, in my experience, in
5 my clinical experience and in my interactions with
6 addiction specialists, again, I feel that the two
7 most important criteria are the significant
8 disruption in work and social and family
9 experiences and continued substance abuse despite
10 severe physical, social, and psychological
11 consequences. Literally, you know, a loss of
12 control to an extent.
13 Q So when it comes to your experience of some of the
14 drug-seeking behaviour engaged in by sex workers
15 in the Downtown Eastside, I take it those drug-
16 seeking behaviours fall squarely, without a doubt,
17 into the definition of what you mean by drug
18 dependence?
19 A Yes, absolutely.
20 Q In your paper you set out that many people who are
21 dependent on illicit substances engage in various
22 high-risk income-generating activities, such as
23 sex work and drug dealing. Do you have numbers or
24 a breakdown of what proportion of --
25 A I do.

1 Q -- men and women engage in those -- who are drug
2 dependent engage in high-risk income-generating
3 activities?
4 A Yes. In a study we published in 2007, which
5 involved 275 eligible individuals, 27 per cent
6 were engaged in drug dealing, 18 per cent were
7 engaged in sex work, 9 per cent involved in
8 panhandling, 7 per cent involved in binning or
9 recycling, recovering recyclables, and another 4
10 in other criminal activities.
11 Q There's a gender distribution for each of those
12 categories of income-generating activities. I
13 take it that more men than women are involved in
14 drug dealing or trafficking?
15 A Yeah. I don't have the gender distribution in
16 front of me, but I would suspect so, yes.
17 Q And more to the point for this -- for the purpose
18 of this inquiry, more women than men, by far, are
19 engaged in --
20 A By far.
21 Q -- sex work?
22 A By far.
23 Q And even of the men engaged in sex work, they tend
24 to be -- it tends to be males having sex with
25 males or transgendered individuals?

1 A That's correct.
2 Q At the third full paragraph on the same page you
3 set out that your research has shown that
4 participation in sex work is for many individuals
5 closely linked to their need to generate money for
6 drugs. How closely linked is sex work to
7 generating -- to the need to generate money for
8 drugs?
9 A 63 per cent of participants in our sample who were
10 engaged in sex work said that they would give up
11 sex work if they did not need money for drugs, and
12 in every analysis that we conduct the intensity of
13 drug use is what predicts engagement in these
14 activities, meaning that the more drugs you use
15 the more likely you are to engage in these
16 activities. We also hear it anecdotally in more
17 in-depth, qualitative interviews, that people tell
18 us this is why they're engaging in this activity.
19 Q Does it work the other way around, that the more
20 money individuals have the more intense the drug
21 use, or does it just work -- is it a correlation?
22 A I suspect it's bidirectional.
23 Q All right. So 63 per cent of sex workers say they
24 wouldn't do it except for they need the money to
25 purchase illicit drugs?

1 A They said that they would forego the activity if
2 they didn't need money for drugs, yes.
3 Q And the remainder, I suppose, would continue to
4 need to engage in sex work in order to pay for
5 food or housing?
6 A Yes, I would suspect so.
7 Q Or clothing or other necessities; is that correct?
8 A I would suspect so.
9 Q All right. So it's not -- they're not -- but for
10 63 per cent money for drugs is the only reason
11 they engage in sex work according to their own
12 reports?
13 A It could be interpreted that way, yes.
14 Q Okay. I take it that the price of drugs then is
15 an important variable in terms of the willingness
16 or the need for women to engage in sex work?
17 A Hugely important.
18 Q So if the drugs were free, for example, 63 per
19 cent of the women who were engaging in the high-
20 risk, high-violence sex work activity wouldn't
21 need to do so?
22 A That's -- the effect you're describing has been
23 confirmed in very well-conducted randomized
24 controlled trials of prescription heroin in
25 several countries where individuals who are

1 provided with pharmaceutical grade heroin
2 significantly reduce their engagement in these
3 types of activities.
4 Q Okay. So that's been tested then rigorously?
5 A In the most rigorous way possible.
6 Q All right. And how many of those studies or tests
7 have been performed?
8 A I believe there have perhaps been, it's either
9 four or five randomized controlled trials,
10 including a very successful trial that was
11 undertaken in Vancouver's Downtown Eastside and
12 published in the *New England Journal of Medicine*.
13 Q All right. And I'm not sure whether there's any
14 specific data in the materials that you provided
15 as part of your report, but I wonder if you know
16 what the mark-up is of street drugs like heroin
17 from the price of manufacture to the price on the
18 street for small quantities, a single dose?
19 A You know, I'm reluctant to provide a precise
20 estimate because I can't recall it, but I can say
21 that I have heard it in the past and I've read it
22 in academic articles, and my understanding is it's
23 hundreds of times, that the mark-up is remarkably
24 high.
25 Q So even if the -- even if the illicit substances

1 weren't provided for free and they were provided
2 at -- even at cost or near cost, there would be a
3 dramatic decrease in sex work?
4 A Absolutely.
5 Q Street-level sex work in particular?
6 A Yes.
7 Q And as a consequence of that there would be a
8 dramatic decrease in violence against vulnerable
9 women?
10 A I believe so, yes.
11 Q And is it fair to describe drug dependence as an
12 illness?
13 A Without question.
14 Q Why would you say that? Why would you put it in
15 the illness category rather than some other
16 category like a moral choice?
17 A There is an overwhelming scientific and medical
18 consensus on the point that addiction is first and
19 foremost a health issue. That's been affirmed by
20 virtually every major medical and public health
21 body in the world, including the WHO. I don't
22 think there's any serious scientific or medical
23 debate about that issue.
24 Q Withdrawal of opiates is a subject discussed in
25 your report. Could you describe the physical and

1 psychological aspects of withdrawal from opiates?
2 A Yeah. It's by all accounts remarkably painful
3 physically and psychologically. It is associated
4 with sweats, nausea, diarrhoea, shakiness, mood
5 disruptions, such as anxiety, depression, and
6 very, very extreme physical pain, abdominal
7 cramping. It's an experience that most people
8 describe as very unbearable.
9 Q There's also vomiting, I take it?
10 A Yes. Sorry, I should have mentioned that.
11 Q So basically digestive, massive digestive
12 malfunction?
13 A Yes.
14 Q Massive muscular system malfunction? You're
15 nodding.
16 A Yes.
17 Q And massive respiratory problems as well?
18 A I'm not sure about respiratory problems in all
19 cases, but I think it is a very pervasive physical
20 experience that's quite debilitating.
21 Q Now, I take it the actual symptoms of withdrawal
22 as well as the anticipation of those symptoms
23 interferes with cognitive -- the cognitive
24 capacity of the individual?
25 A Oh, absolutely. I think it's a key driver of

1 compulsive activity that carries significant risk
2 for the population.
3 Q All right. So, in effect, when somebody's in
4 withdrawal there's no way they can think straight?
5 A It's hard to think straight, I would say.
6 Q All right. I'll try not to be so absolute in my
7 questions.
8 A Sure.
9 Q It tends to be extremely difficult for them to
10 make rational decisions and prioritize what are
11 ordinarily considered to be a hierarchy of human
12 needs?
13 A Oh, yeah, absolutely. I could perhaps share an
14 anecdote to illustrate this a little bit further.
15 The director of our centre, Dr. Julio Montaner,
16 was hit by a car at the bottom of the Burrard
17 Street Bridge a few months ago. He had numerous
18 broken ribs, some of which were 50 per cent
19 displaced, broken in two places. He developed a
20 pneumothorax, which means he had extensive blood
21 build-up on his lung. He also experienced a
22 concussion. And in a *Globe and Mail* article
23 interview he disclosed that the most painful
24 experience, the most painful aspect of the whole
25 experience was withdrawing from the opiate-based

1 pain medications, that the broken ribs and the
2 concussion, the pneumothorax paled in comparison
3 to the pain that was experienced upon withdrawal.
4 Q Now, outside of opiates and opiate withdrawal
5 there are also different forms of withdrawal
6 associated with different drugs?
7 A Mm-hmm.
8 Q So one common illicit substance used by sex
9 workers or highly correlated with sex work is
10 crack cocaine?
11 A Mm-hmm.
12 Q Can you describe the withdrawal symptoms from
13 crack cocaine?
14 A Yeah. I think it's much more idiosyncratic and
15 not as well described as the withdrawal from
16 opiates, and I don't consider myself a real expert
17 in the area of stimulant withdrawal; however, I
18 think a common experience that people have locally
19 that we've heard about is, unlike in the case of
20 opiate use, people who use crack and cocaine are
21 often able to stay up for days on end without
22 sleeping, and so often the crash is followed by
23 days of sleep, but I believe the withdrawal can
24 also be marked by, you know, agitation, anxiety,
25 similar types of experiences, paranoia,

1 depression. I think the effects are probably more
2 pronounced in the psychological realm and less in
3 the physical realm.
4 Q And in terms of gauging the intensity of those
5 withdrawal effects for crack cocaine, withdrawal
6 from high intensity use of crack cocaine was
7 associated with accepting -- higher levels of
8 accepting financial incentives for sex without a
9 condom?
10 A Yes.
11 Q That would be one indication of drug dependence,
12 would be to accept a more dangerous type of
13 activity?
14 A I think what's important to understand in the case
15 of the relationship between opiates and compulsive
16 activity might be more driven by -- is driven by
17 both a desire for continued use but also a desire
18 to avoid withdrawal, whereas in the case of
19 cocaine or crack the half-life of the drug is so
20 short that the compulsive need to acquire funds to
21 get your next dose is -- occurs more frequently.
22 It's greater. It doesn't last as long. People
23 who inject cocaine can inject up to 20 or 30 times
24 a day, whereas a typical heroin user might only
25 inject twice a day because of the dramatically

1 different half-life of the drug. So the situation
2 with crack users who are involved in sex work is,
3 is that they simply need to use more often and
4 more frequently, which means they need to generate
5 more income to support their habit.
6 Q All right. In addition to being correlated to
7 accepting financial incentives for sex without a
8 condom, staving off -- when attempting to stave
9 off withdrawal sex workers may be less
10 discriminating when accepting clients and may be
11 more willing to enter cars and other potentially
12 unsafe places with clients?
13 A That's correct.
14 Q I take it the more intense the drug use by an
15 individual the higher the risk for violence?
16 A Yes, certainly, and we've shown in several studies
17 that intensity of drug use is associated with
18 virtually every form of risk experienced by the
19 population.
20 Q There are difficulties as well with access to
21 treatment for drug dependency?
22 A Mm-hmm.
23 Q Could you speak to some of that?
24 A Yes, certainly. We have -- I think there's two
25 issues, and I'll try and speak to them both. We

1 know that as recently as 2009 approximately 14 per
2 cent of the individuals who use drugs and
3 participate in our studies report having
4 experienced difficulty accessing addiction
5 treatment within the last six months alone. So,
6 you know, this remains a persistent problem.
7 Another problem is the sheer quality of the
8 treatment that's provided and the limited options,
9 particularly for those individuals who use
10 stimulants such as crack. We have in British
11 Columbia a large methadone program. Methadone is
12 a substitute for heroin and is very effective in
13 reducing the health, social, and criminal
14 consequences of heroin addiction. We have no
15 similar -- we have no parallel for stimulant use,
16 and I don't think we're actually even close, so
17 really this is an area where there needs to be a
18 huge amount of work done. We currently do not
19 have many effective interventions for high
20 intensity stimulant users, which includes crack
21 cocaine users.
22 Q That's not to say that they don't exist or they
23 can't be conceived, it's just to say that they're
24 not being funded?
25 A They're not being -- what's available is probably

1 not being funded and made available to an adequate
2 level, and despite the fact that Vancouver has
3 been a leader internationally in addiction
4 research, there hasn't really been anything
5 happening locally in terms of developing
6 interventions for stimulant users.
7 Q And I take it, and this is a little bit of a
8 backhanded compliment, that's in part because of
9 the -- the work of the Centre for Excellence in
10 HIV/AIDS has placed so much local emphasis on
11 injection drug use rather than the use of crack
12 cocaine because crack cocaine is not really a
13 vector of transmission?
14 A Actually, it is a vector of transmission, but we
15 don't really understand the pathway. We recently
16 published a study showing that crack cocaine use
17 was independently associated with HIV infection,
18 but the method didn't allow us to identify the
19 precise mechanism, and we suspect it may well be
20 related to unprotected sex. But, yes, there needs
21 to be more attention paid to this issue and more
22 work done to provide appropriate treatments.
23 Q All right. The paper of which you are the
24 co-author and Professor Shannon is also a
25 co-author entitled *Income-Generating Activities of*

1 *People Who Inject Drugs*, I wonder if you could
2 turn to that at page 54. At page 54 in the
3 right-hand column you discuss the influence that
4 the lack of available alternative income might
5 have on other income-generating activity. I
6 wonder if you could set out a bit of your analysis
7 for the commission.
8 A If I could, pardon?
9 Q If you could set out a little bit of your analysis
10 for the commission.
11 A Yeah, certainly. What we found in this study, and
12 I think it's important to relate it to a future
13 study which is also included, we became very aware
14 that a huge proportion of people in our studies
15 engaged in some kind of high-risk income-
16 generating activity, such as drug dealing or sex
17 work. We were very concerned about the risks
18 associated with those activities, and we were also
19 interested in trying to use that evidence to
20 inform potential policy and programatic responses.
21 In this analysis we found that people, a large
22 number of people said they would give up this
23 activity if they didn't need money for drugs. And
24 we also said that the lack of access to other
25 forms of employment may also be a barrier, as is

1 the low level of social assistance people
2 received. We followed this up with another study,
3 which is very similar, except this time we asked
4 people would they be willing to forego their
5 activities if they had another opportunity to
6 engage in what we call low-threshold employment.
7 Q What's low-threshold employment?
8 A It means employment opportunities that don't have
9 a high threshold for participation. You don't
10 necessarily need to work full time. You don't
11 need to go to university for 12 years to be able
12 to do the job. You don't necessarily require any
13 special training or skills. And this type of
14 approach is used in many European settings.
15 People are often given an opportunity to simply
16 clean up around a program, and if they demonstrate
17 commitment to that activity, then they're given an
18 opportunity to do a more structured activity, and
19 eventually they can receive training in an
20 apprentice program. One facility I visited in
21 Frankfurt, Germany graduated people through the
22 steps I described, and they had the opportunity to
23 either get training as a cook or on a landscape
24 architecture team and were eventually given
25 placements. So we found in our analysis that 60

1 per cent -- 63 per cent -- 63 per cent of sex
2 workers said they would no longer be interested in
3 participating in sex work if they had access to
4 low-threshold employment. As a result of this
5 work and because we think it's a neglected area of
6 intervention, we are now working to develop an
7 intervention study to test this hypothesis that
8 many people will actually engage in and benefit
9 from this type of employment program.
10 Q I take it that the low-threshold employment
11 programs might also be less concerned about
12 punctuality of the employee?
13 A Yes.
14 Q And might make allowances for things like
15 relapses, which are almost inevitable for
16 drug-dependent individuals --
17 A Yes.
18 Q -- as they try to wean themselves off the drugs?
19 A Yes.
20 Q And so there would be -- the usual types of
21 employment expectations, always be on time, wear
22 your uniform, those types of --
23 A Relaxed.
24 Q -- rules would be significantly relaxed?
25 A Yes.

1 Q I wonder if you could discuss the risks associated
2 with intensifying police activity.
3 A For?
4 Q For -- in particular, on injection drug users.
5 A Well, we've conducted a number of studies looking
6 at the impacts of policing. We have found that
7 these -- that intensified policing activities tend
8 to first displace drug users. They move away from
9 the area where the policing is taking place. And
10 that's a well-described phenomenon in the
11 criminology literature and something that local
12 police themselves, I believe, are fully aware of
13 and admit. One consequence of that is that it can
14 disrupt important relationships with health
15 programs, health service providers, people get
16 disconnected from these programs, but also it can
17 disrupt established relationships within the drug
18 market, and those are often developed over time,
19 and when people are forced to forge new
20 relationships, that carries risk, including risk
21 of violence. So there are those dangers as well.
22 We also know that when people are fearful of
23 police presence that they will often skip a number
24 of important steps in the injecting process that
25 protect their health. For example, they will be

1 less likely to swab their skin with alcohol swab
2 prior to injecting, which reduces the likelihood
3 that skin-borne bacteria will be injected into the
4 bloodstream. They are less likely to cook and
5 filter their drugs, which again reduces the risk
6 of a variety of health consequences. They are
7 less likely to use a sterile syringe, and they are
8 more likely to inject their drugs in a hurried
9 fashion, which, particularly in the case of
10 opiates, carries elevated risk for overdose. We
11 have also documented cases where people when they
12 encounter police stash their syringes, which then
13 can be mixed up and result in accidental syringe
14 sharing.
15 Q So, in effect, all of those activities together
16 look like they're the product of impaired
17 judgment, that more intense police activity in an
18 area will actually impair an injection drug user's
19 judgment to the point where they'll endanger
20 themselves?
21 A I don't know if it's a case of impaired judgment.
22 I think it's about avoiding risks that are
23 important to the drug user at that time, and I
24 think there's interesting literature around that.
25 What public health professionals deem to be

1 important risks are not always the same risk
2 priorities that drug users themselves have, and
3 that's again where withdrawal is an important risk
4 that drug users seek to avoid at all costs.
5 Q Would it be fair then to characterize the
6 intensification of police activity as being
7 correlated with irrational reappraisal of the
8 value of personal safety on the part of injection
9 drug users, that they're, in effect --
10 A Depends what you mean by personal safety, I guess,
11 because being in withdrawal is a very unsafe thing
12 for many drug users, but, yes, I think I
13 understand the gist of what you're saying, and I
14 agree. I think it's fair to say that these types
15 of initiatives, while they often have temporary
16 benefits in terms of public order, they have well-
17 documented negative public health consequences.
18 MR. GRATL: All right. Thank you very much, Professor, Doctor.
19 A Thank you.
20 THE COMMISSIONER: Mr. Hern. How long will you be?
21 MR. DICKSON: Mr. Commissioner, I'm not sure, actually, and
22 perhaps we could take the break.
23 THE COMMISSIONER: All right.
24 THE REGISTRAR: The hearing will now recess for 15 minutes.
25 **(PROCEEDINGS ADJOURNED AT 3:15 P.M.)**

1 **(PROCEEDINGS RECONVENED AT 3:35 P.M.)**
2 THE REGISTRAR: Order. The hearing is now resumed.
3 **CROSS-EXAMINATION BY MR. DICKSON:**
4 Q Mr. Commissioner, it's Tim Dickson for the
5 Vancouver Police Department and the Vancouver
6 Police Board. Dr. Kerr, thanks for coming today
7 and giving your testimony. I only have a few
8 questions for you.
9 A Okay.
10 Q You said in your testimony that 63 per cent of sex
11 trade workers in one of your cohort studies said
12 they wouldn't engage in sex work if they didn't
13 need to in order to buy drugs; that's correct?
14 A 62 per cent.
15 Q Ah. And did you -- did you determine -- well, in
16 that study was the participant pool of sex trade
17 workers, were they predominantly street-based or
18 were they working indoors? Did you --
19 A Predominantly street-based.
20 Q And did you do an analysis of that result that we
21 just spoke of according to street-based or indoor?
22 A No.
23 Q Yesterday Dr. Shannon was here and gave evidence,
24 and she testified at one point that in her Maka
25 Project a hundred per cent of the participants in

1 that project reported using drugs. Are you
2 familiar with that, with that particular
3 statistic?
4 A No, I'm not. I was involved in the Maka study,
5 but I'm not intimately familiar with every detail
6 about it.
7 Q And have you participated in studies that look at
8 the degree, the percentage of sex trade workers
9 using drugs such as heroin and crack cocaine?
10 A My work is primarily focused on drug use, so when
11 we have a sample, a study sample, they're all drug
12 users to begin with.
13 Q You purposely sample for drug use --
14 A That's right.
15 Q -- among the sex trade --
16 A That's right.
17 Q -- worker population?
18 One of the trends that you were testifying to
19 is that you see an association between the amount
20 of drug use, the intensity of drug use and the
21 intensity of sex work? Have I summarized that --
22 A I would say the intensity of drug use and
23 involvement in sex work.
24 Q I see. And what I took from your testimony was
25 that the greater the intensity of drug use the

1 more involvement, the greater involvement there
2 would be in sex work?
3 A I would say the more likely one is to be involved.
4 Q I see. I see. And you said you suspect that that
5 relationship is bidirectional?
6 A Insofar as I think that as people acquire more
7 money from sex work they're probably more likely
8 to use more drugs; however, that's not something I
9 personally have evaluated.
10 Q I see. Now, just turning to withdrawal from
11 drugs, am I right in thinking that among sex trade
12 workers there are two common categories of drugs:
13 opiates and stimulants? Am I right to focus on
14 those two as the most common?
15 A Yes.
16 Q And you spoke a little bit to the effects of
17 withdrawal of those two, and I'm interested in how
18 quickly it occurs. You spoke to how the high for
19 crack cocaine is much shorter than for opiates.
20 Can you speak a little bit more to the timing of
21 withdrawal?
22 A I can't say this is really my area of expertise.
23 What I can say is, is that, again, people can
24 often inject heroin and not really need a second
25 dose for another 12 to 18 hours; however, in the

1 case of crack cocaine the half-life is much
2 shorter. The effect of the drug can wear off
3 within a very short period of time, a matter of
4 minutes, not hours, and that is usually followed
5 by some type of withdrawal syndrome, which is
6 predominantly psychological in nature.
7 Q And with crack cocaine the pattern of use is often
8 repeated use --
9 A That's right.
10 Q -- throughout the day, withdrawal begins to set
11 in, and then -- and then a user will go and use
12 again?
13 A I think that it -- the serial use isn't
14 necessarily driven by withdrawal. It's driven by
15 the desire to reacquire the high that has now
16 dissipated.
17 Q Right. Withdrawal is a later effect than --
18 A Yes.
19 Q -- the dissipation of the high?
20 A Right.
21 Q Yes. And have you -- have you conducted any
22 studies looking at how withdrawal might deter drug
23 users, the fear of withdrawal or the desire -- or
24 the fear of the dissipation of the high might
25 deter drug users from accessing services like

1 healthcare? And I'm thinking here that a night in
2 the hospital without access to drugs would be
3 uncomfortable and could have a deterrent effect.
4 Have you studied that at all?
5 A Absolutely. There's a large body of literature
6 showing also that drug users often leave hospital
7 prematurely against medical advice because of
8 their inability to acquire drugs in the hospital
9 setting.
10 Q And they may fear going to the hospital in the
11 first place because once they're in it might be
12 difficult to leave?
13 A I suspect that's one of many factors that deters
14 people from going to hospital, yes.
15 Q And is there evidence that, in fact, drug users
16 are to a significant extent deterred from going to
17 hospitals?
18 A I can't point to a specific piece of evidence.
19 MR. DICKSON: Those are my questions, Mr. Commissioner.
20 THE COMMISSIONER: Thank you.
21 MR. MAJAWA: Yes. Thank you. Andrew Majawa for the Government
22 of Canada. I'd like to just take the opportunity
23 first to introduce my colleague, Judith Hoffman,
24 who is attending for the first time today.
25 THE COMMISSIONER: Thank you.

1 **CROSS-EXAMINATION BY MR. MAJAWA:**
2 Q Thank you, Dr. Kerr, for attending. I too only
3 have a few questions, I believe, but to pick up
4 where my friend Mr. Dickson left off or where he
5 had touched on with respect to the cocaine, crack
6 cocaine and heroin withdrawal, can you describe
7 for me if there is any kind of a difference in
8 terms of the desperation that a cocaine or heroin
9 addict would experience when they're going through
10 withdrawal from those drugs?
11 A Desperation for?
12 Q For the next dose of the drug.
13 A Well, I think it's a key feature of compulsive
14 drug using, so I think, yeah, people become quite
15 desperate.
16 Q With both?
17 A Yes.
18 Q And you had said that -- earlier in your testimony
19 you had said that or I understood you to say that
20 it was hard for a person to think straight when
21 they're in withdrawal, and I assume when you say
22 "in withdrawal", just based on what you've said
23 before, that you're really referring to -- are you
24 referring to heroin withdrawal or withdrawal also
25 from stimulants such as crack cocaine?

1 A I think similar effects apply to both.
2 Q So it would be similarly difficult for a person to
3 think straight when they are looking for their
4 next fix of either heroin or crack cocaine?
5 A I think we have to be careful when we say "think
6 straight". I would need something more concrete
7 and specific to comment, I think.
8 Q Okay. I think you had stated that a person would
9 seek to avoid withdrawal at all costs.
10 A At most costs, yes.
11 Q At most costs. So in that sense they would, and
12 your studies I think have shown this, would engage
13 in behaviour that would give -- be of increased
14 risk to their safety in order to avoid that
15 withdrawal?
16 A Yes.
17 Q And one of the things that you had -- one of the
18 factors that you had looked at was negotiating
19 condom use? Sorry, you're nodding, but --
20 A Yes.
21 Q And if you just turn for a moment to Appendix I,
22 which is -- Appendix I to Exhibit -- I believe
23 this was marked as Exhibit 9, this is a paper that
24 is titled "Offer of financial incentives for
25 unprotected sex in the context of sex work".

1 A Sorry, my binder is missing, so I'll just have to
2 find it within my own notes.
3 Q I think the Registrar has provided it to you
4 there. It's Appendix I.
5 A Okay.
6 Q And if you turn to page 147 of the journal
7 reproduction, at the top there under the heading
8 "Discussion" --
9 A Mm-hmm.
10 Q -- it says there that 73.7 per cent of individuals
11 engaging in sex work reported being offered more
12 money to have unprotected sex during a 48-month
13 period. Do you see that there?
14 A Yes.
15 Q All right. And then just lower down, not the next
16 sentence but the sentence after:
17 Among those offered more money for
18 sex...30.6% accepted.
19 A Mm-hmm.
20 Q Is there any differentiation there between someone
21 who is a drug user who is mainly a heroin user or
22 mainly a crack cocaine user or is that the overall
23 sample?
24 A That's the overall sample.
25 Q And down below further down on that left-hand

1 column on page 147 about two-thirds of the way
2 down just after a reference to Footnotes 28 and 29
3 a sentence that begins with the word "Indeed". Do
4 you see that?
5 A Mm-hmm.
6 Q All right. It says there:
7 Indeed, the findings from this study suggest
8 that indicators of higher intensity addiction
9 were common among the female CSW,
10 which I believe is commercial sex workers,
11 in this study, and frequent drug use was
12 associated with increased vulnerability and
13 risk taking.
14 A Yes.
15 Q And, again, that applies to both drug -- people
16 who are addicted to both stimulants and
17 depressants, such as heroin or crack cocaine?
18 A Actually, in this analysis crack cocaine
19 smoking -- yes, both.
20 Q You're referring to a table, I believe. I'm just
21 wondering where you're --
22 A On 146.
23 Q Okay.
24 A So both daily heroin injection and crack cocaine
25 smoking were independently associated with being

1 offered more money for sex without a condom.
2 Q And therefore both are related to an increase in
3 vulnerability and risk taking?
4 A Yes.
5 Q And then just below that sentence in the next
6 paragraph on page 147 a sentence beginning with
7 the word "Findings". It says:
8 Findings from another prospective cohort
9 study of commercial sex workers in our
10 setting additionally suggest that "dope
11 sickness" and the need to suppress withdrawal
12 impairs commercial sex workers' ability to
13 make decisions around commercial sex
14 transactions...
15 First of all, dope sickness, could you just
16 comment on if there's any difference between dope
17 sickness and withdrawal?
18 A No.
19 Q And so does dope sickness then apply to both
20 withdrawal from heroin or another depressant and
21 withdrawal from a stimulant such as crack cocaine?
22 A People more frequently use the word dope sickness
23 to refer to opiate withdrawal.
24 Q However, this statement here says that the desire
25 to avoid dope sickness, which is similar to what

1 you said earlier, that the desire to avoid
2 withdrawal will -- it will take that -- they will
3 try to avoid that at most costs, that it impairs
4 their decisions around commercial sex
5 transactions, and you would agree that that would
6 be impaired decision making for both individuals
7 on -- who are users of heroin and of crack
8 cocaine?
9 A Yes.
10 Q And I believe that you used the word or I read
11 them that they become less discriminating in terms
12 of their ability to evaluate potential clients?
13 A Yes.
14 Q And I think, in fact, you've kind of summed up
15 this at page 4 of your report. If we can go back
16 to your report. I don't believe there's numbers
17 on the pages, but it's the last page of your
18 report.
19 A Okay.
20 Q And in the first paragraph about three-quarters of
21 the way down that paragraph you say that:
22 Likewise, when eager to earn money to acquire
23 drugs and stave off withdrawal, sex workers
24 may be less discriminating when accepting
25 clients and may be more willing to enter cars

1 and other potentially unsafe places with
2 clients.
3 Do you see that there?
4 A I do.
5 Q All right. And other unsafe places, that would
6 include deserted areas?
7 A Yes.
8 Q Even if, considering the desperation that some of
9 these individuals will be experiencing and
10 potentially the dope sickness or withdrawal or the
11 desire to get another dose of the drug, even if
12 they had originally had plans to go to a safer
13 place, I assume you would agree that at that point
14 they may negotiate and go somewhere that isn't as
15 safe?
16 A I think there's -- there's more than one point in
17 the continuum of experience where the safe/unsafe
18 place comes into play, and it's -- it's outlined
19 well in the paper that I'm referring to, which
20 explains that as a result of people's desire to
21 continue to engage in sex work but avoid
22 confrontations with police they will go to more
23 remote areas in Vancouver, this is often the more
24 industrial, port-like areas, but they will also be
25 less discriminating in negotiating with clients or

1 assessing them prior to getting into a car with
2 them, and I think what the work that I'm referring
3 to shows is that once people get into cars they're
4 -- they give up a great deal of control about
5 where they end up and what happens to them.
6 Q Okay, but you did mention this. You just
7 mentioned some of the interplay with policing;
8 however, before we were talking about the
9 interplay of the desire to get the next dose of
10 drug or to avoid the withdrawal symptoms.
11 A Yes.
12 Q Something that someone will do at almost all costs
13 to avoid.
14 A Yeah. I guess my point is it's a multi-
15 factorial --
16 Q Right.
17 A -- phenomena.
18 Q So when you say multi-factorial, you mean what
19 you've mentioned before in your opinion, that
20 there's potentially an interplay with policing,
21 but also an interplay with the individual's desire
22 to avoid the symptoms of withdrawal also has a --
23 plays a role in the decisions that they make, that
24 those sex workers make in terms of their safety?
25 A Yeah, that's been made clear in the work that

1 we've done.
2 MR. MAJAWA: Those are my questions.
3 THE COMMISSIONER: All right. Thank you. Thank you, Dr. Kerr.
4 Thank you for appearing. Anyone else have any
5 questions? All right.
6 **(WITNESS EXCUSED)**
7 MR. VERTLIEB: Well, that appears to conclude the evidence.
8 That's actually quite helpful because I want to
9 speak with Mr. Ward about some matters for next
10 week, so I can use the time with Mr. Ward. I
11 think that's the end of it for today.
12 THE COMMISSIONER: All right.
13 MR. VERTLIEB: And remember tomorrow morning 10:30, Mr.
14 Commissioner.
15 THE COMMISSIONER: Yes. All right. What are we doing tomorrow
16 morning? Who's on?
17 MR. VERTLIEB: Tomorrow we have Dr. Lowman, and if he finishes
18 by the lunch break or shortly after, then maybe
19 Mr. Gratl can present his motion to you on
20 protection of vulnerable witnesses. There will
21 perhaps be other submissions and then that will
22 give you some time -- some time to reflect on it
23 and render a decision when it's convenient for
24 you.
25 THE COMMISSIONER: All right. All right. Thank you.

1 THE REGISTRAR: The hearing is now adjourned for the day and
2 will resume at 10:30 tomorrow morning.
3 **(PROCEEDINGS ADJOURNED AT 3:55 P.M.)**
4
5 **I hereby certify the foregoing to**
6 **be a true and accurate transcript**
7 **of the proceedings transcribed to**
8 **the best of my skill and ability.**
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