CANADA

PROVINCE OF NOVA SCOTIA

IN THE MATTER OF THE

FATALITY INVESTIGATIONS ACT

S.N.S. 2001, c. 31

THE DESMOND FATALITY INQUIRY

TRANSCRIPT

HEARD BEFORE: The Honourable Judge Warren K. Zimmer

PLACE HEARD: Guysborough, Nova Scotia

DATE HEARD: February 10, 2020

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EXHIBIT LIST

February 10, 2020

COURT OPENED (09:39 HRS.)

THE COURT: Good morning.

COUNSEL: Good morning, Your Honour.

THE COURT: Mr. Murray or Mr. Russell?

MR. MURRAY: Yes, Your Honour, the first witness for this morning is Dr. Ian Slayter.

THE COURT: Thank you. Good morning, Dr. Slayter. Perhaps you'd just come over and just stand there for a moment at the witness stand, please. Thank you.

DR. IAN SLAYTER, affirmed, testified:

DIRECT EXAMINATION

MR. MURRAY: Can you state your name for the record, please?

A. Ian Slayter.

Q. And how do you spell your last name?

A. S-L-A-Y-T-E-R.

Q. And how are you employed, Dr. Slayter?

A. I'm a self-employed psychiatrist working at St. Martha's Regional Hospital.

Q. All right. And I'd like to bring up an exhibit, which is your *curriculum vitae* which you've provided to us, which I think is Exhibit 70.

A. Is that in here?

Q. Yes. So in Volume 1 of the exhibits it will be number 70.

A. Okay.

EXHIBIT P-000070 - *CURRICULUM VITAE* OF DR. IAN SLAYTER

Q. All right. So Dr. Slayter, you're currently working as a psychiatrist and that's exclusively at St. Martha's

Regional Hospital?

A. Yes.

Q. All right. And what's the nature of your relationship with the hospital? You said you were ... How did you describe it?

A. I'm self-employed.

Q. Yes.

A. We have an implicit contract with the hospital to be there and provide services.

Q. Okay. And do you maintain a private practice, as well, or ...

A. No.

Q. All of your practice is at St. Martha's?

A. It's all there.

Q. Okay. And so do you deal with inpatient services at St. Martha's and outpatients?

A. Yes. My main role is working in the Outpatient Department doing consultations and follow-up. I also, two days a week, I cover psychiatric needs in the Emergency Department, when I'm called down.

Q. Yes.

A. And I'm on an on-call schedule for nights and

weekends. I just did the weekend. And I, we do, we share, we rotate through Medical and Surgical units when there are consultations needed, and I cover inpatients when one of the inpatient psychiatrists is away.

Q. Okay. And we've heard some evidence from Dr. Rahman earlier about the complement of psychiatrists at St. Martha's. I believe there are three adult psychiatrists and one child psychiatrist, is that correct?

A. We have an approved complement of four, and there are three adult psychiatrists now, and the child psychiatrist will be an additional complement, and I think he's part-time.

Q. Okay. And you had mentioned that you are sometimes on call and again we've heard about that. There's always, I believe, a psychiatrist on call in St. Martha's, is that correct?

A. There is always someone on call on the psychiatry schedule 24/7. There are six of us on - three of us are psychiatrists, three are family physicians who have been doing it for a long time.

Q. Right. Okay. And you're, I note, as well, and you can comment on this, you're also working as an Assistant Professor in the Department of Psychiatry at Dalhousie?

A. Yes.

Q. And you teach there or is it more taking students at the hospital and ...

A. I have a family medicine resident with me one day a week.

Q. Yes.

A. We do clinical teaching.

Q. Okay. And you're also the co-Chair of the Eastern Zone Mental Health Quality Council?

A. Yes.

Q. Okay. All right. And Dr. Slayter, your CV is extensive. You've worked in the area of psychiatry for, obviously, a number of years. Do you have a specialty or would you consider yourself a general adult psychiatrist? How would I describe you?

A. General adult psychiatrist.

Q. Okay. There are areas of specialty in psychiatry, are there?

A. Yes.

Q. Okay. In a community like Antigonish it's more common, I guess, to have a general adult psychiatrist?

A. We do have a child and adolescent psychiatrist who

would be regarded as a specialty, so they do children and adolescents, which I don't do.

Q. Right. And so in the Outpatient Clinic, perhaps you can just give us a bit of an understanding of how that normally works, how would you see a patient, for what period of time and what would normally happen.

A. So the way I do my practice, and different psychiatrists are somewhat different, is a patient is referred. I most often see someone who's referred by a family doctor. Some are self-referred but, generally - or referred by one of our therapists - but generally they're family doctor referred. And so I do an assessment or consultation, I would call it. Typically, I would ... It varies how long I spend with them but, on average, it would be about an hour and 10 minutes, I would say. Most ... three-quarters of the people that I see in consultation I see only once and I send them back to their family doctor for medication, follow-up, and to a therapist, if they need therapy.

Q. And on some occasions you will see someone for follow-up, will you?

A. Some people who are more complex, that I think can't be so well managed by their family doctor, I will follow for a

while, and when I think they can be followed by their family doctor I will send them back. And that's a way of dealing with the demand for services, so ... I can't see everybody forever, so I try to see the ones most in need and most in need of my services.

Q. Okay. And the typical case, then, would be referred back to their family doctor with your recommendations for follow-up?

A. Yes.

Q. Okay. Your Outpatient Clinic, that is, you do that at St. Martha's Hospital?

A. Yes.

Q. Okay. That typical hour or so first visit with someone in the Outpatient Clinic, that would typically involve what, it's an interview or a discussion?

A. It would be an interview. I'd go out to the waiting room, meet the person and take them, and if they have a family member with them, I usually take the family member with me, as well, and we go back to my office down the hall and sit down and ask some questions, they tell me their story, and I make some conclusions and ...

Q. Um-hmm. Okay. When people come to Outpatient Clinic

meetings with you, do they typically have ... Well, let me ask you this first. You may have a referral from the family doctor. Do you have, generally, other information or is it a little hit or miss that way?

A. If they ... It varies. If they've been to our clinic before, then I would have their old records, generally, and I would look at those beforehand, go through them. I would ... If they've been - I don't always check; it depends - but often we have on our electronic medical record called MEDITECH if they've been seen before. If, for example, they've had admission to our Inpatient Unit, there would be some information on there and so I would go through that if I think they've been seen before.

Q. All right. And if, for example, they are currently prescribed some medication, is there a way to easily determine what they are prescribed?

A. Generally, I go by what they tell me. When it's not clear I'll sometimes call the pharmacy to find out directly.

Q. Okay. And let me ... In just reviewing your CV, Dr. Slayter, you've worked in a number of different places during your career. I wanted to ask you, prior to your current work at St. Martha's, which was from August '11 to the present day, you were about eight years at Capital District Health Authority?

(09:49:18)

A. Yes.

Q. And your work there or your title was Clinical Director of General Psychiatric Services?

A. Yes.

Q. And what did that entail?

A. For most of that time it entailed overseeing from a psychiatric point of view six inpatient units, two psychiatric services and two emergency departments, five outpatient clinics, and the on-call service.

Q. In your *CV* you made reference to some of the areas that you were able to achieve some improvement, I think, while you were Clinical Director at CDHA, including acute inpatient care, emergency care, community mental health care, and quality improvement. I wanted to ask you about one of those, in particular. In the area of acute inpatient care you make reference to suicide risk assessment and monitoring. You did some work in that area, did you?

A. I did. If I can go back a little further?

Q. Sure.

A. I did spend four years in the unit one time.

Q. Yes.

A. I was Chief of the Department there.

Q. Yes.

A. And I was interested in suicide risk, because we had to review whenever there was a suicide attempt, that sort of thing, and I did, along with the Director of Nursing, we did a study of 21 attempted suicides in the hospital over a 10-year period and reported on how they compared to a control group, in terms of what seemed to put them at risk and what to watch for. And I gave a talk on suicide and I began recommending at that time, for example, that every time we see someone we should record the suicide risk, in terms of whether it was low, medium or high. I've had trouble getting people to accept that, but I got interested at that time and in Capital Health, now Central Zone, I did a major talk with a review of a lot of papers in 2005, looking at what was important to look at. And in, I think, 2010, Accreditation Canada came out with an ROP, which, I think, means Required Organizational Practice, and they wanted something across Canada that everyone would have a protocol for assessing suicide risk and what to do when they found it. So I put together a group in 2010 to develop a protocol, a process, which ended up in our current form that you have.

Q. Okay. So the output, I guess, from that work was a

suicide risk assessment tool?

A. Yes.

Q. All right. And in ...

A. At that time it was part of Capital Health, but when the new Health Authority came it had merged into that.

A. And this was developed both from your own clinical experience then and also from an extensive review of the literature?

A. Yes, we had a committee put together and we looked at references from a number of journal articles and books, and we went through and identified risk factors in all the different articles and chapters, put them in a list. I found that some were the same thing using different words, so we collapsed them and we put them into sub-groups, and it eventually came down from 120-some different factors to approximately 25 or 30 of them.

Q. Apart from the fact that some were perhaps duplicative of others, did you find that some were more statistically significant than others or were they all relevant in that consideration?

A. I don't think anyone's ever done a statistical study where they said this one's present so many percent of the time.

It would be very hard to do that anyway.

Q. Okay. But these are all factors that, in your experience and again in your review, were useful in predicting suicide risk?

A. Yes.

Q. And so that tool, that suicide risk assessment tool was ... when was that completed or when was that put into practice?

A. Well, in Capital Health we came out with it as a policy in 2011, several months before I left there, and it's been, you know, evolved since then a little bit. It's not greatly different.

Q. All right. When you came to St. Martha's to, I guess, what was then GASHA, you began to use the tool there, as well?

A. No, because we weren't part of Capital Health. We didn't have a tool then ...

Q. Okay. Did you ...

A. ... that was broadly used.

Q. Okay. We have seen reference, though, to a suicide risk assessment tool being used in this case. When was that, when did that come into use?

A. I don't recall what was used. I guess it was an

early version, when I think about it, the one that I saw our Crisis nurse use, yes. So that was an early version.

Q. Okay. And perhaps I can just get you to reference Exhibit 67 in your binder. And there's pages or page numbers at the top there. I think if you go up to page 9 ...

A. Right.

Q. ... you'll see the suicide risk assessment tool there, the one that Heather Wheaton completed in this case.

A. Yes.

Q. Is that similar to the one developed in Capital District Health?

A. It's similar. The current form is a whole page long now.

Q. Yes.

A. This is a shortened version but the idea behind suicide risk assessment is that you take a patient's history, their story, their symptoms, so on, their situation. One considers factors that are thought to be associated with risk of suicide, and this is a list of such factors, and then one subjectively makes a judgment as to whether this is a low risk, a high risk, or somewhere in between, which would be a moderate risk. That's basically what happens. So this is a list of some

of the factors to consider. I know some people refer to this as a checklist. It's not to be a checklist that you count them and give them weights; it's just to help jog your memory as to what to consider and then each one, its weight, depends on the particular situation and you come to a judgment. We used to have a fourth ... This one, I don't think, has on it levels of risk - at least, I can't see it. So we judge the three - low, moderate, and high. At one time there was one called "no risk" but decided that everyone is, theoretically, at risk, so we dropped that and just have low risk.

Q. I think actually on the one that was used there, the category under Suicide Risk Management of "None" is still there. Are you on page 9 there?

A. Oh, on the right, yes, Low, None.

Q. Okay. Right. So you say in the newer tool the category of None has been removed?

A. Is gone, yes.

Q. Why is that, again?

A. Some people would argue that you can never say there's no risk, so if you said it's absolutely zero, that would be wrong. But we used to say no used to mean we would not have to think about it at all. Low risk meant ... At one time the

way I defined it meant that they needed treatment but you didn't have to follow the risk as long as you were doing the treatment, whereas moderate risk implies that they run a risk. Most importantly, it means one has to monitor the risk to assess whether it's getting worse or not and address that as needed.

Q. Okay. So the tool that was used, and we'll talk more about this in a bit, but the tool that was used here is an earlier version of the tool that's used now?

A. Yes.

Q. The tool that's used now has been expanded somewhat?

A. It has, it's easier to read.

Q. That's always helpful.

A. Yes. So, essentially, it's the same. I think it's a similar list. The items on the list haven't changed much over the last 10 years. One or two or three have changed, that kind of thing. The space used to say Mild, Moderate, or Severe has changed and the space to write in your comments has changed.

Q. And maybe just briefly we can bring up Exhibit 105. I think we may have, at the end of that document, the new ... Just the last page, I think, of that document.

(09:59:00)

A. Yeah, so it's, essentially, similar.

Q. All right. So you say some of the factors on that have been modified somewhat and ...

A. I'd have to go through and compare them to tell you which ones but they're, essentially, the same.

Q. Okay. All right. And that tool is still in use?

A. The one that's on the screen is what's in use right now, I believe.

Q. Exhibit 105. Okay. So if I may also ask you, Doctor, in your practice now in this area, do you have occasion to see patients who have been diagnosed with post-traumatic stress disorder?

A. Yes.

Q. And how often do you see patients with that particular diagnosis?

A. PTSD covers a wide range of different people. In one sense, I probably see it a couple of times a month. Some of those, a lot of them, the majority of them relate to women who've been sexually assaulted at some point in the past or as children. At the other, I call it end of the spectrum, but it's not that, in principle, not different, I see first responders, like, paramedics who have PTSD relating to the kind of situations they have witnessed. I see fishermen who have

been involved with drownings and situation like that, people they know or near-drownings themselves. I see police officers and retired police officers. I tend not to see very often veterans from the Canadian Forces but I do see sometimes.

Q. Is that a function perhaps of where we are in the province as much as anything?

A. It's a function of I don't think there are any veterans who've had active service around us, yeah.

Q. In this area?

A. Yeah.

Q. Okay.

A. That's a speculation but ...

Q. And to your knowledge individuals who have been diagnosed with post-traumatic stress disorder, there are therapists, I think, in the area that do work with those patients, as well?

A. We have therapists who do.

Q. Okay. There isn't a sub-specialty that deals specifically with post-traumatic stress disorder, though, is there?

A. I have two answers for that. First of all, with therapy, there are different kinds of therapy, but it is

evolving into a sub-specialty. So a trauma therapist tends to do primarily PTSD cases, and they've developed special skills. Sort of ordinary cognitive behavioural therapy, which is often used, in general, by itself isn't that effective in PTSD, so they've developed therapies and skills that are particularly helpful and there are different approaches. So we have, for example, in Antigonish two people who - I think it's two - who do that. We have other resources - the Antigonish Women's Resource Center in Antigonish had someone who does trauma therapy. I think in Port Hawkesbury there's one. So those would be our resources, some private therapists who may or may not do trauma therapy.

The other part I was going to answer ...

Q. Sure.

A. To go back to my role, ordinarily, with PTSD - I said that I'd see most people once and only follow people who were complex - I generally see patients with PTSD once, I make the diagnosis, I'm able to make the diagnosis, and I recommend medications, if needed, and medications, essentially, are not specific to PTSD but to some of their symptoms. If they're depressed, then we would treat their depression; if they're anxious, there's anxiety; if they're an insomniac, then

something for insomnia. I make those recommendations and then send them back to their family doctor for follow-up of the medication piece and if they don't have a therapist, put them on a waiting list for a trauma therapist.

Q. Okay. And to the extent - and I appreciate you said you've not seen as many soldiers or veterans who have suffered or are suffering with PTSD, in part because of our geographic location - but to the extent that you have any knowledge of that, is their presentation any different perhaps than other patients who are suffering with post-traumatic stress disorder?

A. The main thing I've come across, and I saw a little bit of this when I was working in the US, is that soldiers who've been in combat and have their PTSD relating to combat can have very violent nightmares and sometimes sort of wake up sort of under fire or being bombed, and if there's partners next to them, they can get hit until the person wakes up. That has stood out to me on a couple of occasions.

Q. Yes.

A. Sometimes soldiers are a little more sort of regimented in their presentation.

Q. And when you say they're "more regimented", what do you mean by that?

A. Well, they're used to, you know, following orders and ... In my role people sometimes present to me a little differently than they do to somebody else; for example, my secretary or crisis workers will say, you know, They were like this when I saw them, but, with you, they were calm and respectful and polite, that kind of thing.

Q. Um-hmm.

A. So that it's ... I have to get past that to assess what's going on.

Q. Okay. And do you have any experience or have you treated individuals who have attended at the OSI, or Occupational Stress Injury Clinic, in the province or in any other province?

A. Yes.

Q. Okay. All right. And I meant to ask you as well, Doctor, just with respect to St. Martha's, there is a mental health crisis team at the hospital, is there?

A. Yes.

Q. And how is that made up presently?

A. It has three people in it. One's off on sick leave right now, so leaving two. They cover our ... they work in our Emergency ... As Crisis staff, they work in our Emergency

Department from - I'm not quite sure of the exact hours - but, say, 8:30 to 6, I think, Monday to Friday, so on regular days. They're not there at nights or on weekends. They also are ... we now have what we call an Urgent Care Clinic for short-term follow-up of people they've seen in Crisis or who've just been discharged from Inpatients and they follow them for a short time if needed.

Q. And the makeup, the professionals that are on the Crisis Team are a mental health nurse, a social worker, I believe, and ...

A. Yes, two mental health nurses and one social worker.

Q. When you see a patient in the Outpatient Clinic, would any member of the Crisis Team be involved in that?

A. Only if they were already involved.

Q. Yes.

A. And they would only be following short-term through Urgent Care, because Crisis is a one visit phenomenon.

Q. Right.

A. And Urgent Care might be two or three or five or six.

Q. The Urgent Care Clinic, then, is as many as up to five or six visits?

A. I forget the upper limit, but something like that.

Q. Okay. And what type of service would be provided, to your knowledge, in the Urgent Care Clinic?

A. They would see someone, according to need, let's say, weekly for a short time.

Q. Yes. Okay. With some therapeutic involvement or more social ...

A. They would be providing supportive counseling and whatever else kind of help seems to be needed that they're able to provide.

Q. All right. Okay. Dr. Slayter, I'm going to refer you to Exhibit 67.

A. Okay.

Q. And page ...

A. Actually it is easier to read on the screen.

Q. Okay. Perhaps we can start with page 6.

A. Can you magnify that a little bit?

Q. So from a review of the records, Dr. Slayter, it would appear that you did have some involvement with or interaction with Lionel Desmond at St. Martha's Hospital, is that correct?

A. Yes.

Q. And the first time that that occurred was on October

24th, 2016?

A. Yes.

Q. Did you know Lionel Desmond prior to that, had you ever met him, to your knowledge?

A. No.

Q. Okay. And you'd never treated him?

A. No.

Q. Okay. So on October 24th, 2016, Lionel Desmond attended at St. Martha's, it would appear, and the page that we currently have up is the Emergency triage record. That's a document that would be completed by the triage nurse in Outpatients, is that correct?

A. Yes.

Q. All right.

A. In the ER, to be specific.

Q. Sorry. I have to be clear in my terminology. ER, okay. And I appreciate that you didn't complete this document and it's not your document but, to your knowledge ... We've heard some evidence about the description that patients who present at the Emergency Department, how their conditions are sometimes described. In this case, the triage nurse used the term "situational crisis". I appreciate that's a triage term.

Does it mean anything to you, from your perspective, or does that tell you anything about how Lionel Desmond presented that day?

(10:09:28)

A. Well, if you're asking me about the term, it means to me that someone is in a situation they're finding difficult and they're experiencing distress in some form.

Q. Right.

A. I would expect to see someone with some sort of acute emotional symptoms and something going on in their situation. He, when I met with him later - he saw the triage nurse first and then our Crisis nurse, Heather Wheaton, and then saw me - the complaint was that he couldn't sleep because of nightmares.

Q. Okay. So this document indicates that he attended for triage at 12:40, I believe, in the upper left-hand corner there, and the triage nurse also used a numerical triage level. In this case, it would appear to be a "3", and I think you had said to us that the triage level, the numerical triage level, is not something that's particularly relevant to your consideration of a patient in Emergency?

A. Most of the time, I don't see or don't look at the triage note and that's simply because someone else will have ...

I don't see anyone till they've seen either our Crisis nurse or the ER physician and who will have written much more extensive notes, so it's usually those notes that I look at before I see the patient.

Q. Okay. So in this case, given that Lionel Desmond appeared at the hospital at 12:40, which I take to be p.m., during the day, the Crisis team was available to meet with him that day?

A. Our process has evolved over time. At one time, we would sometimes intercede when we knew there was someone who had been to triage and was waiting with a mental health concern and our Crisis nurse would see them before the ER physician.

Currently, the process is they have to wait until the ER physician has seen them, which is often a considerable wait, and so I don't remember what we were doing at that point in time.

Q. Okay. The triage record, so when you did see him, that would be something that would be available to you, would it?

A. I'm sorry. Would you repeat the question?

Q. Sure. This Emergency triage record, when you did see Lionel Desmond that day, you would have that document?

A. It would have been available. I have no recall

whether I saw it or not but it would have been available.

Q. Okay. All right.

A. I do recall that I had the Crisis note available and I probably read that and didn't look at the triage note.

Q. Okay. So if we go over one more page to page 7, so this is the Crisis note that you're referring to, or the Crisis ...

A. Yes.

Q. I guess it's entitled "Crisis Response Service Mental Health Risk Assessment". This is the document that would've been completed by Heather Wheaton?

A. Yes.

Q. Heather Wheaton is a mental health nurse, is she, at St. Martha's?

A. Yes.

Q. And was at the time?

A. Yes.

Q. So would Heather Wheaton had seen Lionel Desmond prior to you seeing him?

A. Yes.

Q. And would she have completed this document before you saw him?

A. Not necessarily, and I don't recall ... sometimes there will be ... she will have, or whoever is doing that role, will have completed the note before I see them. Sometimes they won't have started it and sometimes it's partly done and they finish it after they've seen me. It partly depends on when they call me and when I'm available to come down and see the patient, so it varies a little bit.

Q. Okay. And in this case, do you recall how much of the risk assessment tool would have been completed?

A. No, I don't.

Q. Okay. Whatever was completed, you would've had at your access, though?

A. Yes.

Q. Okay. When you see patients - and I'll ask generally first - in a circumstance such as this, does the mental health nurse work with you or do they see the person separately from you?

A. They see them first by themselves. More often than not, when I come down on her floor, when I come down and see them, usually, they sit in with me and we do a joint reinterview or at least a new one for me.

Q. Okay. In this case ...

A. She was present when I saw him.

Q. Heather Wheaton was present?

A. Yes.

Q. Okay. And do you have a recollection of how long she would've been with him prior to you coming down to see him on that day?

A. No.

Q. Okay. I assume you would have an opportunity to speak to the mental health nurse before seeing the patients?

A. Yes.

Q. And get their impressions of the person?

A. Yeah.

Q. Okay. Typically, a mental health nurse will complete a document. Now this is the one that was in place in 2016, but this will be a guide for their use?

A. It's likely she had it all completed or most of it completed.

Q. Okay.

A. But I don't remember.

Q. Now when you saw Lionel Desmond on the 24th of October - and perhaps we can go back to page 4 - this is the chart that you would have completed when you saw him?

A. Yes.

Q. All right. And the handwriting on this document is yours.

A. Pretty ... obviously I ...

Q. All right, and so again, just if you could review for us again, what was the nature of the information that you obtained and the nature of the concern that Lionel Desmond presented with on October 24th?

A. What I remember of that time, and I remember left more of an impression than anything, his wife did most of the talking and they were both somewhat emotional.

His complaint was that he was having trouble sleeping because of nightmares and wanted some help with that. Along the way came the story that he was having PTSD-types of symptoms such as flashbacks and the nightmares and so on.

It was quite clear that there was a lot of arguing going on between them. There was some - a little bit, I think - in the interview itself and they were talking about years of that going on. I could go into that a bit more.

He also, or she - I don't know who - it came up that his nightmares would sometimes relate to his military experiences but, at that time, more of them related to nightmares that his

wife was cheating on him and he would wake up angry or whatever about that and distressed. And she was annoyed with him because he was often away when she expected he would be home from military deployments.

And so we talked a bit about that, I think, but the underlying reason he was there was to get something done about his sleep so I increased the medication that might, or usually, helps nightmares and PTSD. I gave him something to help him sleep.

Q. The interview you had with Lionel Desmond and his wife, that was in an interview-type room, was it, in the Emergency Department?

A. I don't think so. As I remember it, I think it was in one of the regular ER rooms that medical patients go to with curtains around. I'm not sure about that but I think so. I vaguely remember sunlight coming in which would've come in through one of those rooms.

Q. Did you know Shanna Desmond at that time?

A. I don't think so. She, somewhere around that time or shortly after, joined our nursing staff in the Inpatient Unit, but I think I saw her there once. I have no idea when that was.

Q. Okay. So not sure if she had started ...

A. I didn't really know her. I don't normally work in Inpatients and she was new around that time or shortly after.

Q. Okay. And it was just the two of them then that were present?

A. And Heather.

Q. And Heather, okay. The sense you got of the interpersonal conflict between the two of them, you said you saw a little of that in the interview, did you?

A. Yeah. They were ... I think they were ... I vaguely remember they seemed irritated with each other. They weren't yelling at each other but he was frustrated with her and she was frustrated with him.

Q. To the best of your recollection, did either of them describe that interpersonal conflict that had been ongoing in their relationship?

A. Oh yeah. She took it way back to when he was in Germany and he got called to Germany to play in the military band and he had said he'd be home for that week but he got called away and she'd be disappointed that he wasn't there and he was frustrated because he couldn't help being told to go somewhere else. That kind of thing.

(10:19:00)

Q. And he said that the nightmares that he was experiencing at that time were predominantly about their marriage and his wife's fidelity moreso than his ...

A. Yes.

Q. ... experience in war?

A. Mm-hmm.

Q. What did you make of that? Anything?

A. Clearly, jealousy was one of the problems. Can't say any more than that at this point. I didn't, at that time, go into it. I don't know that I did a lot later. It was a problem. It wasn't ... So that was an issue. I didn't spend a lot of time going into that. I just noted that that was there. I didn't note it on here, but I noted it and it's something that would have to be dealt with later. There were other things I was more focused on to start with. The PTSD.

Q. Do you have a sense of how long you, yourself, were with Lionel Desmond?

A. I don't know. I would guesstimate that it was somewhere between 15 to 30 minutes. It wasn't an hour, it wasn't ten minutes.

Q. Do you remember anything about his presentation that day? His mood or affect or demeanour? Any of that?

A. I think he seemed ... the word that comes to mind is subdued.

Q. Yes. Right.

A. Because she seemed to be doing the majority of the talking and had a lot to say about things.

Q. Okay. So his complaint at that time was the nightmares and how they interfered with his sleep.

A. It also came out that he would get angry at times and sort of pound tables, maybe throw things, that kind of thing. But the important thing, I think, for me is that he said and she said he never hit her or physically was violent toward her and she said she wasn't afraid of him.

Q. Okay. Did that information come ... was that volunteered by one or the other of them or did that have to be elicited with questions?

A. I think we would've asked whether he hit her. I think she would've volunteered that she wasn't afraid of him.

Q. So his chief complaint was the nightmares and his inability to sleep because of them. Did you know at that time whether he was on medication and did you change his medication?

A. He was on something we call quetiapine to help him relax and sleep, and he was on a sleeping pill, zolpidem, and so

I believe those were the two.

Q. You said "quetiapine" and "zolpidem"?

A. Zolpidem. Uh-huh.

Q. Quetiapine is for what?

A. It's used for different things. In that dosage, it's used for helping people relax if it's taken during the daytime and to sleep at nighttime. At much higher doses, it's used for psychosis.

Q. Okay. His dosage wasn't being used as an anti-psychotic drug?

A. No. He was on about 75 milligrams a day. It would have to be up around 800 to be an effective anti-psychotic.

Q. Okay. I see reference to another drug. Prazosin. What is that?

A. That's an alpha-adrenergic. It's sometimes used for blood pressure and that kind of thing, but it has been found often effective for nightmares from PTSD. It doesn't help any other kind of nightmares and we don't know why it helps but it does.

Q. Nightmares only from PTSD?

A. Yes.

Q. Interesting, and we don't know why that is?

A. It is interesting but I don't know why.

Q. Okay. And I think when you first started to discuss that drug, you referenced the category of drug it is. What was that again?

A. I believe it's an alpha-adrenergic drug. That just means that it stimulates receptors, which receptors it stimulates (on neurons?).

Q. Okay. In this case, it would appear that you increased his dosage of prazosin?

A. Yes.

Q. So is that from two to four milligrams? Am I reading that correctly?

A. Yes.

Q. Okay. Why the increase in the dosage of that particular drug?

A. The dosage that I consider for that purpose is somewhere between a milligram and five milligrams a day. Most people respond to two. Sometimes go up to three. He was having quite a bit of difficulty but had gotten some benefit, so I thought we'd go up to four.

Q. He indicated some benefit from the prazosin?

A. Yes.

Q. Okay. And given that he indicated he had a diagnosis of post-traumatic stress disorder, but his nightmares also related to his marriage situation, was it your opinion that prazosin might still nonetheless be of assistance to him?

A. I don't recall what I thought about that but he said it helped his nightmares so I increased it.

Q. Okay. And then you started another drug, trazodone.

A. Yes.

Q. What is trazodone and why did you start that?

A. Trazodone is used a lot for sleep, particularly for people who wake up in the middle of the night and have trouble going back to sleep. In higher doses of 200 milligrams or more, it used to be used as an antidepressant, but it made people too sleepy so we stopped using it. But as a side effect, it does help people sleep then, so most people are on 50 to 100 milligrams of it to help them sleep and it's particularly focused more on staying asleep than falling asleep, whereas the zolpidem is more for falling asleep and not so good at keeping asleep.

Q. Okay. So two different aspects of sleep, I guess then.

A. Yes.

Q. And the quetiapine, though, that doesn't assist with sleep so much?

A. That helps with sleep, again with the sort of staying asleep side of things and it has some advantages like trazodone that it's not addictive and one doesn't develop tolerance to it, whereas zolpidem, one can develop some tolerance to it but then doesn't work quite so well.

Q. Was your thought or advice to him that some of these sleeping medications would be taken as needed or would he take them regularly?

A. Yes, you can do that. Usually, we would use the zolpidem that way. The quetiapine and the trazodone less so because it's harder to tell whether you're going to wake up in the middle of the night or not, whereas you kind of know better if you're likely going to fall asleep or not. So it's a bit subjective.

Q. Right. Okay. To your recollection or from what you understood, did he have a family physician at that time?

A. I'm not clear about that. I know he was later referred by one of the family doctors here in Guysborough, Dr. Ranjini Mahendrarajah. I don't recall if he was actively involved at that time, but they had one practice anyway, so

everyone in this area would, I think, go to that practice, so I'm not quite clear.

Q. Okay.

A. And he had just come back to Nova Scotia from being away for a long time, so I'm not sure.

Q. Right. From the information that either you gleaned or Heather Wheaton did, you understood that he was a veteran. Did you have an impression of whether he was, at that time, in October, obtaining services through Veterans Affairs Canada or whether he had attended at the OSI Clinic? Anything like that?

A. He said that he had been followed in New Brunswick by OSI Fredericton, as I call it, and I don't know the details of what that involved, but he had been followed by them and he was told when he came to Nova Scotia he would be followed by OSI in Cape Breton, but it hadn't been set up yet, he was told, and so he had to wait for them to open up before he could get services. That's what I understood.

Q. Okay. And that was from him, to the best of your recollection?

A. That was from him.

Q. Okay.

A. And his wife, I guess.

Q. And his wife. Right.

I note in page 8 of the ... this is in Heather Wheaton's document and, again, I appreciate it's her handwriting, but in the "Social History" at the bottom, she had written, "He had trouble navigating Veterans Affairs system. Worries about what they will offer and what they will cover. Waiting for a Veterans Affairs case manager in Nova Scotia. Transfer not complete."

Does that accord with your recollection?

A. That's the same thing, yeah.

Q. Okay. When Heather Wheaton saw him, she completed the suicide risk assessment and categorized him as low on that occasion on October 24th. I don't know whether she would've completed that particular tool when you met with him or not. You may not remember that specifically. Did you have an impression about his suicide risk, if any?

A. I did. I thought it was low.

Q. Okay, and why do you say that?

A. He said he didn't have suicidal thoughts. That's what I heard. And he didn't have any acute risk factors that I was aware of. Anyway, he said he wasn't having suicidal thoughts. He was having trouble sleeping. He was mildly depressed. There

was nothing to indicate that there was an acute risk or a high risk or moderate risk.

(10:29:23)

Q. The suicide tool that was completed indicates suicidal ideation but no intent or plan.

A. When I was with him, he said he had no suicidal thoughts, so I can't comment on that part of it. Though, looking at the suicide risk tool that you put up there, so he did have intense emotions and he was depressed. There was a history of trauma, but nothing that makes you think this man, in the near future, is at risk of doing something.

Q. Okay.

A. We see a lot of people. Almost everyone I see has ... when I first see them has some degree of suicidal thoughts, usually very mild, what we call "passive" suicidal thoughts, without any intent or plan. So it's an every morning/afternoon thing seeing people like this. And so some people have ... you know, it could happen but this doesn't look like something we need to worry about at this time ...

Q. Right.

A. ... unless things change.

Q. I guess one could say everyone in this room has

suicidal ideation right now because we're discussing it. I guess ...

A. Well not ... Most people will say, Well, I wondered about it once or twice but ... but most people who say that never ... and know this, never seriously thought of doing something, they just think about it but ...

Q. The distinction, and it may be clear, but the distinction between suicidal ideation and actual intent and a plan, can you just ...

A. The only ...

Q. ... how do you differentiate those?

A. So I've said that the vast majority of people have had some sort of suicidal thoughts. Very uncommon for me to find someone who never has when I ask them. A much smaller group have actual intent and a much smaller group go on to plan it. So there's a huge spectrum.

And we can't ... as some ... one person once said to me, Why can't you lock him up and keep him there forever? Can't do that. I can put you in the hospital today and say you might have had a suicide thought once but that doesn't make any sense.

Q. Right. No, understood.

There is a reference in the social history, sorry, in the

crisis document in "Substance Use and Addiction History" about previous medical marijuana. Did you ... at that time in October, did you discuss that at all with him or did that come up at all?

A. Yes, we talked about it both times I saw him so I don't know which was which, but he said that he had been put on medical marijuana by one of his military physicians to treat the PTSD or to treat the nightmares. He said it helped him sleep but he also said that, and then it wasn't it wasn't clear to me now anyway, that the nightmares of his wife cheating on him either started at that time or became worse at that time.

Q. Yes.

A. It's probably they became worse but I'm not sure.

Q. All right. In your experience, does cannabis, can it increase or exacerbate paranoid thinking?

A. Yes.

Q. In Heather Wheaton's mental status exam, she ... again, many of the things you've said there are recorded:

> 32-year-old male; black; slightly unkempt; in sweat clothes; angry outbursts that occur suddenly and are followed by return to low mood; anxiety; paranoid thoughts about wife;

general distrust of all people; feeling tired and overwhelmed and unsure about how best or how to best get or receive help; suicidal ideation but no intent or plan; affect downcast and speech tangential; wants to talk to about military experiences.

A lot of things there but is that the way that you saw him that day?

A. Yeah, that was the impression. Yeah. And I should say perhaps that when someone comes in and seeing a crisis worker and we're discharging him home, not admitting them, then my notes are usually short because I use the crisis note as my larger record of what's gone on.

Q. Sure. Okay, no. And just one small thing there, she described his affect as downcast. You described him as subdued, I think. She also said his speech was tangential.

A. Yeah.

Q. Did you find that or do you recall?

A. I don't recall that part of it.

Q. Okay. He did want to talk about his military experiences or ...

A. I don't recall that. I see a lot of new people each

week. I don't remember clearly from years ago this ...

Q. Sure. No, understood, Doctor, I ...

So you had made the changes to his prescription medication and he was discharged, I guess, to home? Is that the way ...

A. Yes.

Q. He was sent home basically?

A. Yes.

Q. Okay. Was there any discussion of follow-up at that time?

A. I said to him that I thought he needed services and I was concerned when he said that he was waiting for services to be set up in Cape Breton my expectations that that was going to happen soon were pretty poor, so I thought that he should be followed by somebody. So I said to him that if he ... he was expecting a phone call or something from them I think a couple of days later, and I said that if services weren't going to start very quickly then I would be happy to see him again to dig deeper into what was going on and look at what we could do to help him as a cover up, not a cover up, to cover until he was picked up by OSI, but he would need a referral from his family doctor. So if nothing was going to come after this phone call to get a referral and that's what he did.

Q. Okay. And the anticipation was that that would be in the outpatient clinic, is that correct?

A. Yes.

Q. Okay, all right. So he did, in fact, get the referral from Dr. Mahendrarajah, which I think is on page 13 of Exhibit ...

A. Yes.

Q. ... 16, and he would then have contacted the clinic to arrange an appointment. Is that typically how it would work?

A. No, the letter would have gone to us and we would have called him.

Q. Yes, okay. And the individuals who typically do the scheduling in the outpatient clinics are whom?

A. It probably would have gone to what was then our intake nurse. We had a nurse who looked at referrals and ... called the intake nurse, and she would have either assigned him to somebody, which was me, or she might have called him to get some more information, but I expect it just went straight to me.

Q. I see.

A. That is to say, to our secretaries to book. Somebody booked it, she did or administrative staff.

Q. Understood. So just because you had seen him in

Outpatients, it wasn't necessarily going to be you that he would see at the appointment at the Outpatients clinic?

A. No, we ... our rule has been that we assign them to see whoever seems the most appropriate as well as being available.

Q. Okay.

A. But it made sense that he see me so he saw me.

Q. Okay. And that appointment was on December 2nd ...

A. Yes.

Q. ... 2016? All right.

And so what can you tell us and I'll ... maybe just you can go to page 26.

A. Which number is that?

Q. Same exhibit, we'll just go over a couple of pages to your page 26 in Exhibit 67.

A. Okay.

Q. So this is your note that was created as a result of your meeting with him on December 2nd, 2016?

A. Yes.

Q. All right. So when you saw him on December 2nd, 2016 at the outpatients clinic, where would you see him? How would that be set up? And can you just describe the physical layout?

A. I ... we're at one end of the hospital on the third floor. We have a waiting room, a front office where the clerical staff are. And I would have gone out to the waiting room and found him and then walked him down the hallway to my office at the other end of that section. And I would have sat down in my office and I would have sat in my chair and we would have had an interview, he came by himself.

Q. Okay. Now you see, I assume, a number of patients, new patients, in the outpatient clinic on a regular basis ...

(10:39:07)

A. Yes.

Q. ... do you? Like how many, for example, in a week might you see?

A. I ... when ... on days that I'm not covering the ER when I have to allow a little extra space I see two new people, one in the morning, one in the afternoon ...

Q. Okay.

A. ... and then follow-ups after each of those.

Q. And you had said earlier that the appointments are usually an hour or a bit more?

A. I schedule two hours. The length varies, but I would say that most people take about an hour and 10, 15 minutes ...

Q. And ...

A. ... that I'm with them.

Q. Right. And during the time that ...

A. He was probably longer.

Q. This particular one was longer you said?

A. I'm thinking from what I've written in here he would have taken longer than that.

Q. Okay. The information that you obtained on December 2nd compared to what you might in some other appointments leads you to think that this appointment was longer?

A. He was quite complex in terms of a number of different problems. Each problem takes a certain amount of time to kind of get into and so there was quite a lot going on and I didn't really get it all done.

Q. Okay. So, in general, when a person comes to an appointment like that, they will have ... you said earlier you would have access to the records if they were seen in hospital. Do they come with other material or generally not?

A. Well, the patient themselves walks in and doesn't usually have anything.

Q. Mm-hmm.

A. Sometimes they've written notes to ... they want to

pass over to me but generally they come with nothing.

And if they have hospital records from our own hospital, I can get those quite easily. If they come from somewhere else in the province I would sometimes ... not always but quite often request through our secretary that the health records department of that hospital and now the Health Authority, that they send certain records that I would identify that I want.

Q. Okay. And you might or might not know that those records exist prior to the appointment, I take it?

A. I wouldn't. Unless the referral has indicated or I ... something in the referral has indicated they might have been in a hospital recently which makes me look at MEDITECH then I wouldn't know until they tell me.

Q. Right. So when someone comes in for an appointment in the outpatients clinic, if you know in advance that, for example, they've seen a psychiatrist in another province ... well, I guess there's really nothing you can do until they come in.

A. Usually, I ... if I did know that I wouldn't get the records beforehand. I wouldn't know usually what province or what psychiatrist or what ... more importantly what hospital and ... or how it would fit into things. So I see them and then if

I need records I go looking for them.

Q. Okay. And again, speaking generally, when a person comes for an appointment at the Outpatients Clinic, how do you approach the interaction with them to begin? What types of questions do you ask them and how do you get them to begin to describe their problem to you?

A. Okay, walk in. I walk in first because they don't know which door to go in, and I point to the office and say, Have a seat. We sit down. I might say I understand such and such from the referral letter, usually I will do that. Sometimes I'll ask them for ... you know, what brings you here or what are you wanting, but usually it's I just do a short summary to show I've actually paid attention to what I've gotten already and I'm very broad and vague because I want to hear what their perspective is.

And then the first while is predominantly focused on listening, encourage them to tell their story, whatever has been going on, and then ... because it's important to me that people come to see me with a story or context. It's not just about, say, symptoms or illness, so I want to know in particular what's contributing to, triggering, what's helping, that kind of thing. So I try to get them to talk to me for a while and then I start

getting more specific with my questions.

Q. All right.

A. Something like that.

Q. On this particular day when Lionel Desmond attended at Outpatients, at the clinic, was he alone or with someone?

A. He was by himself.

Q. And ...

A. I also should say I absolutely do not remember the interview, so all I have is this consult.

Q. You have your notes which appear comprehensive. They assist you in ...

A. I ... I can tell from the way I write them whether ... what I meant by ... because I sort of have standard ways and when I differ from that that tells me something.

Q. So, again, having reviewed your ... the note that you created on December 2nd, what do you recall of Lionel Desmond's presentation when he came in, his ... and how he appeared to you?

A. Well, I essentially have to go to mental status examination on the second page which said that he presented as pleasant; depressed; he was calm and appropriate; rapport was fair. That would be the usual way I would record that for most

people. His affect was depressed. His speech was articulate and normal in rate and amount. Most people with more severe depression I would say the amount was shortened but I didn't here so that to ...

Q. Sorry, I just didn't hear that. What was that?

A. I'll say that again. His demeanour, his affect was to somewhat depressed ...

Q. Yes.

A. ... that can vary a lot in severity. I did note ... I usually talk about whether someone is articulate, and when they speak if I can make out what they're saying, for example. I talk sometimes about how fast they're speaking or how softly, and whether they talk a lot or very little or kind of the normal amount and I've got him down here as normal amount.

Most people with a significant depression I have found I record them as speaking a small amount, a reduced amount. They don't talk a lot.

Q. That's typical of patients who present with major depression?

A. Severe ... more severe. Well, major depression covers a wide range; a very mild depression despite the name up to very severe.

Q. Okay.

A. But if it's more severe people tend to talk less. They give very short answers.

Q. You found him, though, more willing to speak and express himself?

A. Yes.

Q. All right. And ... go ahead.

A. Well, as I just said, so his ... I say his thought process coherent and rational. In other words, he's not tangential as we heard in the ER visit in October, so he's speaking logically, that sort of thing, not psychotically.

He did report jealousy again. We see people with ... who are jealous in our practices. That ranges very widely from sort of a little bit to a lot and I judged his thoughts of jealousy to be what we call overvalued.

It's hard to explain, but some people would have a thought of something that is more a little irrational and held more strongly than the average person would have and so to a certain point we call that overvalued, so you might say it means over-emphasized. And so I thought his thoughts of jealousy were like that and I don't know if I said it here.

I said bordering on delusional. I wasn't writing that for

the Inquiry. What I meant ... mean by that is not that he ... he does not have ... did not have delusions in my mind. Delusions is a fixed belief that doesn't change and persists and is unrealistic. So his weren't within that circle that we would call delusions, it was outside the circle, but it was approaching the circle moreso than someone with very minor thoughts of being ... just lack of confidence that their partner was being faithful.

Q. So a delusion is a firmly-held but false belief? Something that's ...

A. Yes.

Q. ... unshakable in the patient?

A. Yes.

Q. His thoughts of jealousy and concerns about his wife's fidelity were not in that category you say or not to that extent?

A. No.

Q. But you thought that they were overvalued. So the impression you had was that they were not based in fact but not held as ... with the same degree of force or regularity. Am I putting that correctly?

A. I thought he got more concerned and anxious about the

possibility of her being unfaithful than was probably warranted.

You have ... the problem with jealousy you never actually know what the truth is, whether the other person is, and one has to make a kind of a ... sometimes it's hard to say. I've had people where you know, maybe she's right, I don't know. But in this case it was my sense that that probably wasn't true, but he was more concerned about it than that he had any evidence for it. It was based on nightmares for the evidence, where his imagination presumably was going. And yet once ... after the nightmare passed for a while he was able to let that go and see that that wasn't true.

Q. Okay. Did you have the impression that he had those thoughts while awake or was it solely when he was having nightmares?

A. No, he would have them for a while when he was awake otherwise it wouldn't matter if he was asleep when he had them. But they would last ... I don't have down how long, but I think it was a number of hours. I don't know how many hours but for a while. After he'd wake up he'd have them for a little bit and then they would gradually go away.

(10:49:08)

Q. Yes.

A. Something like that.

Q. Okay.

A. I don't remember specifically but that was the impression I had.

Q. Was this something that he talked about a lot, I mean ...

A. He talked about it and his wife talked about it as well when I saw them in October.

Q. She was aware of it in October?

A. Oh yes, yeah.

Q. All right.

A. They could both talk about it.

Q. So there ... I think you've described his presentation or his various conditions as complex or a number of different conditions ...

A. Yes.

Q. ... going on at the same time. And I assume there's some inter-relationship or ...

A. Well, yes.

Q. ... overlapping, I guess, of those various ...

A. And ...

Q. ... conditions?

A. ... that, I think, is the problem. Why I later say he needed a higher level of service. Any one of those things by themselves would be one thing but all of them together are a big problem.

Q. So one of the things that he had discussed with you and had previously been diagnosed for was the post-traumatic stress disorder.

A. Yes.

Q. To the extent that you do ... was he willing to talk about the genesis of that, I guess, and his war experiences and ...

A. Oh yes.

Q. All right. So the symptoms that he endorsed, they were consistent with post-traumatic stress disorder?

A. Yes.

Q. Okay. He had a variety of those symptoms beyond ...

A. It was quite clear-cut. So he described he spent seven months in Afghanistan, I think, in 2007 and he described his main role was retrieving bodies, which to me sounds pretty awful. And so he would be ... they would be going out on patrols at night. He seemed to emphasize they would be looking for land mines in front of them, they would have gunfire going

overhead he described, or they would be in a little building with gunfire going on. So he was often under fire, watching out for land mines, couldn't see very well, and retrieving, you know, blown-up bodies. That was his job. And he'd be firing back too, I'm not quite sure about how that worked. And though he had a lot of horrific memories of that, that's basically what I got about that.

Q. And you had made a note of the various symptoms: flashbacks, nightmares, anxiety, high alert, depression, difficulty coping with noise and avoidance. Are those all symptoms that ...

A. Yes.

Q. ... are consistent with that ...

A. Yes.

Q. ... diagnosis and with his experience?

A. Yes.

Q. All right. To the extent that you could, were you able to form an opinion on whether that diagnosis of PTSD was an accurate one?

A. He had clear-cut PTSD. I would add, though, that he described his symptoms as improving to some extent from what they used to be earlier closer to the war. So he said the

flashbacks and nightmares were less frequent ...

Q. All right.

A. ... but he still had all of those symptoms.

Q. When he saw you on October 24th, I think you said earlier, that those symptoms were lessening and his thoughts of perhaps jealousy with his wife were increasing or ...

A. So the nightmares were less often about combat experiences and more often about his jealousy. I didn't ask him what exactly he imagined or had experienced in the nightmares for jealousy but that's what he said they were about, infidelity.

Q. There are a number of symptoms, I would assume, consistent with a post-traumatic stress disorder diagnosis, is paranoia one of them?

A. Yes. It's not a specific symptom of PTSD but PTSD is essentially kind of a severe fear, reaction to a traumatic event ...

Q. Yeah.

A. ... that persists and doesn't go away. You don't lose the memories and you tend to avoid things that cue recall of those experiences. The flashbacks are memories but it's not just a memory but you relive the experience as though you're

right there.

The nightmares are remembering the experiences or similar types of experiences and so you avoid situations that will trigger that, that re-experiencing type of thing. Along with that, this ... you can have quite a wide variety of other kinds of that I call negative symptoms in a sense of like depression or anxiety or paranoia or withdrawal from people, things like that.

Q. The paranoid thinking with respect to his wife, did you get a sense whether there was a relationship with his post-traumatic stress disorder or were they more distinct?

A. I didn't get into quite where that related. I made a note of that I think somewhere in there. I suspected that it was a response to different things going on. What I didn't have a good handle on was to what extent he might or might not have had that beforehand. It's possible that there was some degree of being a little bit unsure of his wife before that, not that there was any evidence but I didn't know if there was or there wasn't. But a lot of people at his age that felt their wife was being unfaithful would have been like that at age 20 as well, so I ... there was so much to cover that day I didn't ... the jealousy part I didn't get into in detail.

Q. All right. I had asked you earlier about your recollection either on October 24th or December 2nd about his history of substance use and abuse, if any. He had a history of medical marijuana. Did he discuss that with you or did you get into that with him?

A. He said that he had been started on it for ... I think, for the nightmares, the PTSD, and he had stopped it because he found it might have helped his sleep, I think, but it made him feel worse and the jealousy was worse so he had stopped using it. He might have started ... I'm not clear, I think he ... I have something about early 2016, and I think he started a bit and by the time he saw me in October he had stopped it.

Q. Okay. And do you have a recollection of how long he had stopped using?

A. No, I don't.

Q. Had he stopped earlier in the year, I think there's actually a note in your ... a reference in your note to him having stopped early in 2016. Would his previous use of marijuana ...

A. Okay, I'm getting the dates then mixed up. I thought he started in ... anyway, he had stopped it before we saw him.

Q. Yes. If it had been a number of months prior to his

seeing you, would that still be having an impact on him?

A. I wouldn't expect it to be, no. So we see a fair number of cases each year of people who become psychotic on cannabis ...

Q. Yes.

A. ... and we admit them. Most people can use cannabis without problems but some people become psychotic on it. We would usually expect that to settle down over several weeks at most and then it'd be back to kind of normal after, assuming they stop using. A few people it might trigger an underlying psychosis which would continue on but we would usually expect the symptoms of cannabis use to go away.

Q. Okay. And did you see an underlying psychotic disorder in Lionel Desmond?

A. No. No.

Q. If, on the issue of his paranoid or jealous thinking regarding his wife, had she accompanied him that day would you have had a collateral interview with her?

A. Yes, I probably would have. If I had continued to follow him or if he had continued to come back, I would expect that I would have. If she didn't come in with him I would have asked for her to come in because I would usually do that.

Q. All right. There were other medical issues that he presented with. He had difficulty noting information processing and what was that related to in your opinion?

A. I was quite concerned about that. He described having three falls while he was in service/on service, and I wrote ... described two of them and the third I didn't ask or I forgot. But anyway, he had three falls with head injuries that were probably of the nature of concussions. There was nothing more than that. And he described some symptoms that I associate with people who have had head injuries. I'll explain what I mean by that.

I'm not an expert in head injuries but at one time when I was practicing in New Glasgow I had several young men, four young men, who all had been in motor vehicle accidents, all had had head injuries and all had, curious to me, the same kind of symptoms from that. And they all had difficulties like I've described here: difficulty processing information, their emotions were labile meaning they were reactive to situations and so on, and they all were struggling with this and secondary depression.

And at that time, I had a group where they attended once a week so I ... (I mean?) once a month where I tried to help them.

At that time there were no services in Nova Scotia to help them so that's what we did. Anyway, he had that kind. And I've seen this in other people since. So he had difficulty processing information.

(10:59:14)

For example, if you would give him multiple instructions, you know, do this and then go do that, then go do that he would not be able to remember them all. The example I often use is if you have to assemble a barbeque, and I have trouble assembling barbeques, and have lots of directions and sub-steps within steps and somebody like this would be totally baffled by that.

He described having difficulty with conversations. If there was another stimulus such as a television or radio playing then it would be hard to follow the person. If the person talked fast he would have trouble processing and remembering it or if it was a long conversation so he would lose it. He said that most of what I said that day he couldn't remember.

So you can imagine someone with those kind of difficulties that ... well, as people ... his wife is talking to him fast or upset or somebody else is, that he's losing a lot, not picking it all up and we don't know what he's processing, but it's only bits of it. And if he's emotional at the same time, it gets

harder to deal with those things.

Q. And the difficulties, were those primarily from him describing them to you or were they also observable just in your interactions with him?

A. I don't recall that. But sometimes I will see people who seem to not be following me is what I would pick up.

Q. Okay.

A. I remember one person, not him but the same kind of thing, who would say when he would drive into town, he would get very rattled because his wife would be talking to him when he came to heavy traffic or a red light. We don't have any lights in Antigonish either. He would not be able to track what was going on in traffic and track his wife's conversation. So he would really have trouble and start getting irritable and angry because he had to pay attention to the traffic but couldn't because there was this conversation going on. So he would be sort of like that, I think.

Q. All right. The deficits, I guess, that he described to you or that you observed, or both, I guess you can't say with certainty but those quite possibly were related to the concussions that he suffered in combat?

A. I would suspect they were from concussions.

Concussions in my ... most concussions don't do that over a long period of time. They clear up over days, weeks, or months. But some people seem to have deficits like this long term, in my experience.

Q. Okay. You, I think, ultimately used the term post-traumatic brain disorder. Is that the term that you used to describe what you saw?

A. That's a term that I came up in the 1980s to explain what was going on with these patients that I had because there wasn't much I could ... we didn't have internet then. I couldn't find much on it other than the word "concussion" or "head injury". So I called it that because it seemed to describe what was going on. Nowadays, it would be a subset of traumatic brain injury, sort of a post-concussion type of symptom. But I ... as I say, I've seen it ... see it sometimes in people who are post-concussion, but I see it when all the other symptoms have gone away.

Q. So traumatic brain injury or post-concussion syndrome are similar terms to ...

A. I would see post-concussion syndrome as a subset of TBI.

Q. Okay. And your term "post-traumatic brain injury",

would also be a subset of traumatic ...

A. Yes.

Q. ... brain injury?

A. Yeah.

Q. Okay. Because obviously ...

A. And I'm just describing a dysfunctional thing in terms of their information and emotional processing.

Q. All right. And I think you said in your document that, ultimately, a neurocognitive assessment would be beneficial for him?

A. I thought so.

Q. What was it ... what is a "neurocognitive assessment"?

A. So there's such a thing as a neuropsychologist and they specialize in people who have neurocognitive problems. They have trouble processing information as a result of a brain disorder or an inherited or acquired disorder and this is something that can take one or two days to do. It takes a long time and then they read it and put it together, it helps understand very specifically what specific cognitive tasks a person can do and which ones they have difficulty with. And then you use that to try and put together a rehabilitation program which help them use the strengths that they have and

work around the deficits that they have; in some cases, perhaps to improve their deficit area.

Q. Okay. And, to your knowledge, in this area, are neurocognitive assessments available?

A. No.

Q. And I guess ...

A. We don't have that in rural Nova Scotia. So in Halifax and ... the last time I ... I haven't tried for five years. The last time I tried looking for one, I was told, Well, you know, we're only doing them within what was then the Capital Health zone because we don't have enough of them. There's too much of a demand. And private ones, I think, are ... well, it used to be $2000 to get them and people like him don't have that kind of money.

Q. So privately you may be able to access it more quickly but there's a significant expense.

A. Yeah. It's still quite a few months, but you can get it.

Q. All right. His PTSD symptoms and is there an interrelationship with those and his traumatic brain injury or traumatic brain disorder?

A. I'm not clear about that but there ... PTSD can,

through anxiety and other factors, interfere with some information processing, so there's probably ... I don't know, probably a little bit of overlap. But certainly ...

He also described having some difficulty in school, what he called "stumbling". I didn't have time to get into that but he also described difficulty paying attention through his life, so there were hints that he might have attention deficit disorder. And that would clearly overlap with ... that's separate from what I'm describing, but it would ... the two would not work well together.

Q. And since you raised it, in your documents you had ... you make reference in the assessment to attention deficit disorder and you have the initials "R.O.". I assume that's "rule out," is it or ...

A. Yes.

Q. Okay.

A. I didn't know that he had it, but he certainly was suspicious that he might have it, so it needed to be ... I ... when I have something that I haven't ruled out and I'm considering might ... there's a possibility, I put them on my list of diagnoses in the parking lot as an R.O. or "rule out" so that I don't forget to look into it a little more.

Q. The suspicion you had about a possible ADD diagnosis, that was from the oral history he gave you and, in particular, his education experience or ...

A. That he said he stumbled in school and always had trouble paying attention. And I was ... labeled it may be possible, check it later.

Q. Okay. Had you seen him again, he would have been tested for it?

A. Would eventually have ... The jealousy and the ADD were down my list in the sense that my immediate focus that day was on his PTSD, the depression, and the apparent cognitive problems.

Q. All right. You also diagnosed him with major depression.

A. Yes.

Q. And tell us, first of all, what is "major depression" and then tell us how you diagnose depression.

A. So depression means a syndrome or collection of symptoms. It's not "a" symptom. And so we define depression as being a set of symptoms or collection of symptoms. DSM, Diagnostic Statistical Manual, has a number of symptoms listed. The World Health Organization, ICD, has another set of symptoms

as in a different paper suggesting various symptoms.

So, anyway, there's sets of symptoms. And the ones I use are probably listed in the note here. But it ... for me, it means that a person's mood is low. Usually, their appetite is affected. Usually, it's low and they lose weight. Some people have what we call an atypical symptom and their appetite is increased and they gain weight. Sleep is usually reduced and so they have trouble sleeping. Again, some people have an atypical hypersomnia where they sleep more. Their energy is generally reduced. They can't enjoy things. They don't take an interest in things. Their libido is reduced. Their concentration is poor. Their memory is poor. They have suicidal thoughts. Their self-esteem is low. They feel guilty. Those would be the things I would usually consider.

Q. All right. And Lionel Desmond exhibited some of those characteristics?

A. Most of those. Yeah.

Q. All right. And I think on the first page, actually, of your note, in the third paragraph, you said ... near the very bottom you said: "He reports low mood, low appetite with weight loss, poor sleep, low energy, low enjoyment, low libido, and poor concentration." So a number of those particular

characteristics?

A. Yes.

Q. What distinguishes depression from a major depression or a major ...

A. So a major depression means that you have the majority of the symptoms on the list. It has ... the major has got nothing to do with the severity of it. A lot of discussions in the past about what to call it, but it just means that you have a depression marked by a number of depressive symptoms. And some people are very mild and some people are very severe.

(11:09:08)

Q. I take it then that the diagnosis of depression in his case was more easily made? Is that ...

A. Yes. Because he was able to describe those symptoms. Well, the PTSD was easy. He described ... they were all fairly straightforward.

Q. Okay. And when he presented, obviously he had previously had the PTSD diagnosis. Did he indicate to you, to your recollection, other diagnoses or did he just talk about symptoms or how he was feeling?

A. I don't recall. I think PTSD was either the only one or the only one that he emphasized. He did say he had been on

antidepressants before, which implied that someone must have treated him for depression.

Q. All right. You were ... you expressed a concern in your note that he was not taking an antidepressant at that time or you found it ... I think "striking" may have been the word you used.

A. "Concern" would be the wrong word. I thought that if he had been treated for depression, he likely would still be on an antidepressant. It wouldn't necessarily be appropriate that he would be, but I thought he likely would be. And so, to me, I had to ask myself, What does that mean if they don't work, as he said they didn't, or that they're not treating him for it or ... it was something where I would have expected someone with a history of depression, with the kind of level of service he had, most times would be still on one.

Q. If a person has a diagnosis of depression and they try an antidepressant without success, is it typical that they will try other varieties of drugs?

A. Usually, one will ... there are, I don't know, 20-odd antidepressants available in Canada. Research would say that if someone presents with a moderate major depression, that the chances of responding to an antidepressant the first time is

about 60 percent.

Q. 6-0, you said?

A. 6-0.

Q. Yeah.

A. That's not very good. And if you try and switch to another one and maybe another one, by the time you've gotten to two or three of them, it might get up to 70, possibly 75 percent, if you're really lucky. And it doesn't go much above that if you keep trying other ones later. So, in other words, some people respond and some people don't, to them. And he may have been someone who they weren't going to help anyway. But, usually, people would try other ones since a tendency to keep trying people on things.

Q. And it was your understanding he had been previously on two antidepressants?

A. He said he'd been on antidepressants and he thought he remembered two, that he could name. But I thought there might be others that he ... it sounded like he'd been on others but he couldn't remember the names. That's how I think I saw it.

Q. Just on the second page of your note, under "Past Psychiatric Medications", you said: "He says he tried several antidepressants but cannot clearly remember which ones he

tried."

A. Yeah. So the way I've ...

Q. Fluoxetine and ...

A. ... written that ... the way I've written that, he thought he had been on fluoxetine and sertraline, but that was a subset of a larger set that ... was my impression.

Q. I see. All right. And those ... the names of those two medications, were those suggested to him or did he actually remember those names?

A. I can't remember. But when I ... what I do is I ask people, Can you remember what you've taken, and see what they tell me. And if they think ... some people don't remember. I'll just start running off the list of names and if they say, I think that one I tried, then I put that on the list.

Q. Okay. All right. And ...

A. That's why I say "may" have been included because I probably did that.

Q. Understood. He had a history of having seen two psychiatrists in the past. You say: "While in military service and/or while attending the OSI Fredericton clinic but he did not know or remember the names of those psychiatrists."

A. Probably didn't ask.

Q. You may not ...

A. I probably didn't ask because I wouldn't have known who they were.

Q. Okay. All right. So the diagnoses or assessment, I guess ... I don't know whether it's appropriate to call these all diagnoses at that time but the assessments were major depression, post-traumatic stress disorder, post-traumatic brain disorder, borderline delusions regarding his wife, and the possibility of ADD. If you had had access to other records at that time, would any of those diagnoses or would those assessments have been easier to make or would they have been clearer or ...

A. It would have been clearer. Sometimes additional information is confusing because somebody else might have gotten a different picture. And then you've got to put them together, so ... but basically, yes, it would have helped and I would have liked some past information, because they would have picked up things that he didn't remember or maybe didn't want to tell me. And it's always interesting to read reports of what was going on at the time, because I presume a record written at the time is fairly accurate, whereas memory ten years later is not.

Q. Right. At that time you felt his suicide risk

continued to be low?

A. Yes.

Q. Okay. And, again, why did you feel it was appropriate to rate it as low at that time?

A. I don't recall my thinking then, but there were no red flags that I saw as red flags to make me think that. I would have asked him about whether or not he had suicidal thoughts. I went into depression. Most people who are depressed don't ... are low risk in terms of suicide.

Q. This is perhaps a bit broad, but when you say there were no red flags, what type of red flags might you have seen that would have caused you concern?

A. Well, if he said, I tried to hang myself last week, would be one. If I ... I think I might do it, would be another. Very acute distress, high anxiety is ... I didn't used to think that, but I now think is a very serious red flag. That would ... really bad insomnia is another one. Acute psychosis mixed in with one of those is a major red flag. There are lots of them on the list, but those are the things that I always ... I'm particularly concerned with.

Q. Okay. Would you have had recourse ... and may not have needed to because you're familiar, obviously, with the

things on the risk assessment tool. But would you have had reference to the risk assessment tool when you met with him or ...

A. No, I wouldn't have. The way we've taught people to use that tool is to take a history to find out what the person's story is, their symptoms and so on. And those items on that list should all come up from doing that. It's not expected that you will need to specifically ask questions based on that list. They are all intended to come up from the story. The list is simply to jog your memory as you go ... as you think about what you've just learned from the patient.

Q. All right. A history of suicide attempts or threatened suicide attempts, would that have ... if that existed, would that have had an impact on your opinion regarding his risk?

A. Yes. Particularly if we thought there were serious ones. There are ones we regard as not serious, not ... with no suicidal intent. If someone took five pills and ... as like I said, a cry for help kind of thing, no. But if ... a serious risk ... a serious attempt in the past would make a big difference.

Q. Okay. So there was an incident in New Brunswick

approximately a year before this where Lionel Desmond was visited by police because of a concern about threatening suicide. That's not something that he disclosed to you.

A. No.

Q. And there's no way you would have known it from your conversations with him, I take it?

A. Well, he would have to tell me.

Q. Again, not knowing perhaps how ...

A. And people usually ... when I say, Do you have suicidal thoughts or have you had suicidal thoughts? People will often say, Well, back when I was 16, I did this, or something like that, so ...

Q. Okay. If you had known that, though, would that have impacted on how you assessed his risk?

A. It would have affected my assessment. What I would have concluded, I can't tell without more. But, yes, that would have increased my assessment risk and what I would have ... if ... and just to be clear, if it had gone ... probably if ... if all I had was what I've got on the notes here and I had that, that he'd made a serious attempt ... I forget what you said. A year or two before? I would probably want to know ... I would want to know more information of what was going on then, what

triggered it and were those triggers present now or not, and how was it dealt with, et cetera.

But let's just say it seemed like a serious intent and the situation at present isn't the same as then, then I would probably raise him to a moderate risk, and a moderate risk that focus in that is that one is going to monitor the risk. So when you ... that you're going to follow them and will follow the risk so that you can address ... do whatever you need, to keep the risk down. It doesn't necessarily mean that you put them in hospital. Sometimes you do, but most of the time we don't.

(11:19:16)

High risk would generally mean they're going to go to hospital. But that would have probably ... given what I had then, that he seemed like he was managing, not managing happily or well but managing, with that history I would not have changed the treatment but I would have elevated him to a moderate risk and which meant that we would follow him.

Q. So even knowing about an earlier incident, you really need to know more about, as you said, what triggered it ...

A. Yeah.

Q. ... other information about it ...

A. Yes.

Q. ... to be able to factor it into your current assessment.

A. Yes.

Q. Okay. That type of information though, generally, I assume would be useful to you when you're doing your assessments?

A. Yes. That's why I asked him for his records.

Q. And just on the point you made a moment ago, a person who is assessed as moderate ... or moderate risk for suicide, that person is typically not hospitalized either? They're just monitored in the community? Is that ...

A. The majority of people that I see with moderate risk are being followed in the ... as outpatients, yes, in the community. And we didn't have this as a rule at that time, but we have it as a rule now that if someone is a moderate risk and they don't show up for their appointment, then we try to contact them. If we can't reach them to confirm they're okay and they're going to come back another day, then we send the ... ask the RCMP to go out and do a wellness check.

Q. That's for a person assessed as moderate risk?

A. Yes.

Q. Okay.

A. That's a requirement now of all our staff.

Q. And where does that requirement come from? Is that ...

A. I'm not sure if I'm allowed to say that, Your Honour.

THE COURT: Can you say there have been reviews that have taken place and as a result policy is changed?

DR. SLAYTER: Yes.

MR. MURRAY: Okay. I guess my question ...

THE COURT: And leave it at that. I think I know what the problem is.

MR. MURRAY: Right.

THE COURT: Okay?

MR. MURRAY: And I do, too. And I actually ... I guess what I was inquiring, it's policy now is ...

A. Yes.

Q. Okay. That's fine. And that's ... at the time ... and, again, I appreciate Lionel Desmond was rated as low in any event, that policy has come into place since ...

A. Yes.

Q. Okay. If a person is rated as a high risk, are they typically hospitalized?

A. Yes.

Q. Okay. Always hospitalized?

A. All of mine are.

Q. Okay. And is that ...

A. I would expect so, yes.

Q. Okay. All right. And is that more often under the **Involuntary Psychiatric Treatment Act** or sometimes just voluntarily?

A. That depends on whether the person is willing to go into hospital and stay there. It generally will tend ... if someone seems willing and seems like you can count on them doing what they say they're going to do, we would just admit them voluntarily.

Q. All right. You also made reference in your letter to his concern about financial issues. Does that play into a person's suicide risk, those concerns about financial pressures?

A. Yes. Financial stress plays into it and financial stress is one of the big ones.

Q. All right. So as you meet with an individual such as Lionel Desmond you begin to, I guess, develop a treatment plan or a go-forward plan and that involves medication and whether there's going to be future visits, that type of thing?

A. Yes.

Q. Okay. Perhaps just generally, first, what are the types of follow-up that might come from an appointment such as this? I mean I know you said earlier that you often don't see the person again, but sometimes will.

A. Well, he was complex in terms of having several different diagnoses going on at the same time and which interacted with each other. And as I said earlier, I tend to follow people with complex problems, although I don't normally follow PTSD. But he didn't ... I'm on a tangent from what you're asking now.

Q. That's all right.

A. Followed him partly because he was complex and needed help and partly because he had PTSD and needed help for that, too. And I thought he needed OSI level of service and we'll, I presume, come back to that. So I was following him until that could be done.

But in terms of what I might do or we might do for follow-up, so I would look at the ... I generally ... when I talk to patients, at the end of the interview, I say, There are three kinds of ways of managing this that we can talk about. One is medications. I would look at his medications, what we might do or not do. I would look at therapy and whether that would be

appropriate or not, and it was in his case.

And I thought that he needed a trauma therapist. And I'm not sure if this matters, but I thought ... think it's better for someone with military experience to have a military trauma therapist. I've talked with trauma therapists at our own clinic who would agree that that's different in some ways, not the PTSD as such, but the character of the people involved, et cetera. So from someone who treats, you know, women who have been sexually assaulted as children or adults, there's a different sort of aspect to it than someone harmed by military combat. And they probably do better with someone who does that every day like in an OSI clinic. I'm not sure if I'm being clear. The ...

Q. A military trauma therapist, meaning someone who does trauma therapy with people who have been in the military? Is that what you mean?

A. Yes.

Q. Okay.

A. That's what I mean. So you get to know how to work with people who have a sort of similar background and experiences. It's just how you work with the person who's got the PTSD. PTSD is the same, but it's the character of the

person may be different.

Q. Yes.

A. This is somewhat speculative. And I also talk to people about what they can do for themselves; hence, he told me that he found yoga helpful and something else helpful ... the gym helpful. And I often prescribe exercise for people anyway, so I said, Well, then you should go and do yoga and go to the gym regularly.

Q. Okay. So with Lionel Desmond you discussed those general issues; medication, therapy, and ...

A. Self-help, as I call it.

Q. ... self-help. Yeah. Okay. And you made recommendations in all of those?

A. Yes.

Q. All right. You said that you thought that he would benefit or need an intensive treatment and rehabilitation program?

A. Yes.

Q. What did you conceive that as being? What did you think he needed?

A. Well, I thought he needed more trauma therapy and needed ... it would ... I felt bad for him. He was, seemed to

me, been let go of what he had been getting and wasn't getting and he was having a hard time and his wife was having a hard time. And I thought that he's put his life on the line for people, that he deserved to get the full service that the military, the veterans, I get those mixed up, could provide.

So I thought he should get a full level of trauma therapy. He had these other problems. I didn't know if they had been identified. Well, the depression probably had been identified because he had been through the antidepressants. The head injury aspect, I had no idea whether that had come up before but I thought he needed help with that, which would include the neuropsychological assessment and some kind of rehab program to help him learn how to work with that and sort out all the other issues.

Q. Okay. Was it your understanding that that type of an intensive treatment and rehabilitation program would be available through the OSI Clinic in the province or ...

A. I assumed it would be. I'm gathering from what I hear on the news it might not be, but I assumed it was.

Q. Okay. So fair to say it wasn't clear to you what resources might even be available to him in the province?

A. No. I assumed certain things, that they would be

available if he got reconnected with OSI.

Q. Okay. And you said a moment ago that psychotherapy would be something that he would need and would benefit from? Did I understand you correctly?

A. Yes. Not just with PTSD. The jealousy issues were the other major thing where that would likely be helpful. And when I saw him on December 2nd, he told me he had an appointment in the afternoon with a therapist appointed by Veterans Affairs or something like that. And she's someone I know of and have talked to before and I knew that she's done work with people with PTSD, women with PTSD. I didn't know what her military experience might or might not be and I thought she would be helpful in general. I still thought it would be probably beneficial to work with someone with military PTSD experience.

(11:29:19)

Q. Okay. And that was Catherine Chambers?

A. Yes.

Q. The therapist that he ...

A. And she may well do that. I don't ... just don't know.

Q. Okay. So the specific treatments for PTSD, and I appreciate a complex picture, but there are some treatments I

think that may work well and some that ... not so well? Is that ...

A. Yes.

Q. And what treatments would be offered locally and which might work or not?

A. At our clinic, our trauma therapists do something called EMDR, Eye Movement Desensitization and Reprocessing. And the way I simplistically understand that is that people with PTSD essentially have difficulty handling their memories of the trauma, the traumatic event, and that greatly distresses them and they can't really process them because they're so frightening that they just back right off dealing with those feelings.

And I think what the ... as I understand it, the people during these sessions have ... get involved in some sort of eye movement back and forth. And what the eye movements are doing is taking their conscious attention away from the memories, because it's hard to move your eyes without ... I think we're evolved to pay attention to what our eyes are looking at. And through constant moving, you're focused your attention on that. And if a therapist asks you to recall one of your combat experiences while your eyes are trying to focus on something

moving, you can more easily tolerate the experience and start to put it into words, which is how we learn to detach from the memory and our feelings about it and then be able to handle something like that.

Q. And that's the EMDR treatment ...

A. Yes.

Q. ... and that's available at St. Martha's?

A. Yes.

Q. Is there a wait for that?

A. Yes.

Q. Is it a significant wait?

A. I'm not sure. It varies. I'll say six months.

Q. Okay. And more general psychotherapy would be available, as well, at ...

A. Yes.

Q. ... St. Martha's?

A. Yes.

Q. All right. Other treatments and ...

A. And I should say, too, that most people waiting or in need of PTSD treatment, because they have trouble tolerating their memories, before they can get trauma therapy they need general therapy to help stabilize them so they're a little more

calm and stable, so that they don't start getting into the history of their trauma and then sort of become extremely agitated and distressed and can't do anything, go home feeling worse.

Q. Right.

A. So there's often a preparatory phase that.

Q. Okay. Of stabilization ...

A. Yes.

Q. ... before you can actually even begin to ...

A. Yes.

Q. ... address those issues.

A. So some people will be put into that first and then go on to trauma therapy.

Q. Okay.

THE COURT: Mr. Murray?

MR. MURRAY: I'm good either way, Your Honour, whether you want to take a break or keep going.

THE COURT: It's 11:30, so let's take a short break, maybe 15 minutes or thereabouts.

DR. SLAYTER: Thank you.

THE COURT: All right. Thank you.

COURT RECESSED (11:33 HRS)

COURT RESUMED (11:52 HRS)

THE COURT: Mr. Murray?

MR. MURRAY: Dr. Slayter, before we broke we were discussing the forms of treatment that might be available for a PTSD patient in the Antigonish area or at St. Martha's and you had referenced the EMDR treatments and then more generally psychotherapy which would be available, including initially stabilization therapy, is that correct?

A. Yes.

Q. All right. More comprehensive treatment might be necessary though elsewhere such as at an OSI clinic?

A. Yes.

Q. One of the other things that you said that you ... or part of the treatment plan or going forward is medication. The medications are listed in your report. Am I correct that those are the same as what he was prescribed on October 24th?

A. Yes.

Q. So he was already taking, when he saw you in October, the quetiapine and I believe quetiapine XR, is that ... although it doesn't specifically reference that?

A. I presume it was not the XR.

Q. Okay, just quetiapine, okay. And so we understand,

again I think we've had these explained to us, but *t.i.d.* is three times daily, *p.r.n.* is as needed, and *h.s.* is at bedtime?

A. Yes.

Q. Okay. The prazosin was going to continue at the four milligrams that you had prescribed on October 24th?

A. Yes.

Q. The trazodone, the same dosage, zolpidem which he was already on. We had talked about this before but you noted, I guess at least, that he was not on an antidepressant, you weren't prepared to make a prescription for an antidepressant that day?

A. Yes.

Q. What would have been necessary or what was going to happen going forward for you to determine if an antidepressant was appropriate and which one?

A. I would like to have known what antidepressants he had taken before, what his response to them was, and that would guide me as to whether and what I would use so I didn't know. There's no point in me giving him something today that he's already been on so ... and there was not ... nothing was urgent at that time in the sense of acute so we could take time to get the records and do it properly.

Q. That was the intention to get the records of what he had ... that would include what he had been taking before?

A. Yes.

Q. Did you feel that he ultimately would be needing an antidepressant?

A. I felt likely he would.

Q. Okay. His comment to you was the effect of the drugs or the benefits of the drugs that he was taking were, I think, "modest at most" is the phrase you used?

A. Yes.

Q. Okay. Was there any other pharmaceutical treatment that you might have contemplated beyond an antidepressant?

A. That's a very broad question. There are lots of options but I guess I wanted to see what he'd been on before that we would try. So some things we'd use for depression that aren't an antidepressant, *per se*, that might help, for example, some anti-psychotic agents are helpful for depression, some mood stabilizers are helpful for depression, some amino acids are helpful for depression, so there's a wide variety of tools that we could use.

Q. For depression?

A. Yes.

Q. Anything else about his presentation that might require a prescription at that time were you considering?

A. For the PTSD, we would treat just symptoms so we'd be looking at anxiety in particular. The quetiapine would be a major player there. There are other things we can use including antidepressants. Antidepressants are called antidepressants but they're also anti-anxiety in most cases. For the brain disorder, as far as I know, medications would not be helpful for that. If he ADD, stimulants might be helpful for that. There were a lot of options. I wanted to know what his past treatment had been, also what problems he'd had before that I identified with.

Q. Right, okay. One of the things that you had wanted him to do and you say in your note: "I had asked him to obtain his military medical records so that I can review his medication history before considering medication changes or additions." I take it from your conversation with him and what he told you of his history, you thought there might be medical records from his time in the military?

A. Yes.

Q. And you would not have had easy access to those?

A. I had no idea how to get them so I had a sense I

didn't have easy access.

Q. All right. With other patients who perhaps have a military background, I guess was that your experience, you would ask them to obtain their records?

A. I'm not sure. I certainly have done that before, I can't remember every one as to what I did but some people volunteered their records. I remember someone once gave me a CD or DVD with 200 pages of notes on it.

Q. Okay. And just on that point, apart from what we might describe as military medical records, if you wanted to obtain a patient's medical records in this set of circumstances from another province, what would you normally do to do that?

A. From a regular hospital, not military?

Q. Yes.

A. We would get the patient to sign a consent form and send it to the hospital's medical records department and ask them to send us x, y and z and they would always send it.

Q. Since this time, did you become any more familiar or did you find any easier route to accessing military records or have you had occasion to do that?

A. After this incident, we talked about the difficulty getting records and I understand that the then provincial

director of mental health, Linda Khoury, talked to Veterans Affairs and I believe we were told that the best way to do it was to ask the veteran to go get the records themselves.

Q. That's your understanding is still the process that's followed?

A. Yes, I think I've seen something more recently that says you can phone a certain number but you still have to have the patient's consent so it still comes down to it's easiest just to have them call up and do it to get their records. And they also indicated that they don't have a record, as such, so I'm not sure what they actually send you but ...

Q. All right. You used the phrase in your note that you felt Lionel Desmond was or seemed to be "falling through the cracks"?

A. Yes.

Q. Falling through the cracks in terms of follow-up by military and veterans programs. What were you thinking of there when you said that?

A. It was my impression that for some period of time he was being followed by OSI in Fredericton and I assumed getting a high level of service so he was sort of going along and then all of a sudden the service stopped when he came to Nova Scotia,

well probably when he went for three months to Ste. Anne's Hospital outside of Montreal where they do rehab programs for veterans and disabled police and he went through that program. So I don't know if he was still part of the Fredericton program or not but anyway, when he got to Nova Scotia he was no longer being covered by anything military or veterans related and he was told to wait until they developed a service, they didn't even have a service to take him, according to what he was told, they did in Halifax. So to me he was going along with service and all of a sudden it stopped and there was some promise of service later so it was a crack between what he had and he was going to get.

Q. And obviously a gap in service is always going to be a concern with respect to a patient. Was there anything in particular that caused you concern relating to that gap in service?

A. No, just I thought it could have been organized better and he deserved it, needed it. He would get by and we could provide him with a level of service that would be helpful but if they had all the resources I thought they had, it would have been even better for him.

Q. You had said as well in your note that you felt

further elucidation of his disorders needs to be done at a higher level of service. What did you mean by that?

A. I was particularly thinking of the head injury issues such as a neuropsychologist getting involved. That was the one thing that really didn't have anything for him.

(12:02:09)

Q. Okay. I think you had said when I asked if he was forthcoming with his experiences and symptoms that you felt he was.

A. Mm-hmm.

Q. Is there any concern, and again I appreciate you don't treat a lot of military individuals, but is there a concern about either soldiers or veterans masking their symptoms or being unwilling to disclose those symptoms?

A. There can be. This is based more on what people tell me and I've read but historically soldiers were taught, I believe, to kind of suck it up and just ignore all their symptoms, go back onto the battlefield and I've certainly read lots of that in the past. That was an issue I think that's changed a lot in recent years but that was a problem. I was involved a little bit at the Westray mining disaster and there there was a problem getting the miners and the firefighters to

talk about their experiences there because they felt it's not something you talk about. So some people have been sort of trained not to talk about their experiences.

Q. All right.

A. But that didn't seem to be an issue with him, he was talking about different things. We talked about some which are uncomfortable topics such as jealousy with his wife and so I felt he was being, you know, sincere and open.

Q. Right. Are you able to comment, Dr. Slayter, on the ... in your experience or from what you've read, is there a link between post-traumatic stress disorder and family violence?

A. Not that I'm aware of in terms of something I've read or learned. I would think that it would be sometimes. The only part I was particularly aware of was that sometimes people would have nightmares or hear loud noises or whatever and they would go into sort of a I'll call it kind of a battle position, ready to be attacked, and it would take them, if they were wide awake, a moment or two to realize it's okay and so anyone immediately around them could get hit or something like that.

Q. More generally ...

A. But not in terms of some sort of ongoing violence, no.

Q. Okay. And more generally, PTSD, well let me ask you

this first. I assume that there can be a risk of suicide with PTSD or a risk of self-harm?

A. Yes.

Q. Is there an increased risk of more generally a violent behaviour other than to one's self with PTSD that you're aware of?

A. Not that I'm aware. Not to say there isn't but I'm not aware of that, no.

Q. Okay.

A. I don't see a reason why there would be unless you were attacking someone with PTSD.

Q. Okay. In terms of the self-help piece, he had mentioned that yoga had been of some assistance to him.

A. Yes.

Q. And you recommended that he continue with that and also that he go to a gym ...

A. Yes.

Q. ... to get some physical exercise. Did he express any concern regarding financial barriers to those things?

A. Yes, he said he could not afford them so I said I can write you a note and you can ask Veterans Affairs to pay for it.

Q. Okay. And I think you did that, did you?

A. Yes.

Q. Okay. So those were the three, I guess, general areas of treatment, kind of the go forward piece.

A. Yeah.

Q. You said typically you don't see a patient a second time but with him you were going to follow up with him?

A. A patient with PTSD.

Q. Because of the PTSD?

A. Because the medications could be easily followed by a family physician and a therapy could be done by a therapist. I don't do therapy.

Q. Okay, all right. So typically a PTSD patient you wouldn't necessarily do follow up but with him you were?

A. Yes, because I thought he deserved some kind of follow up until he got going and because also he had complex problems which I could help with to some extent.

Q. So he was going to make another appointment, was he?

A. I asked him to make another appointment.

Q. Okay. Did you have an anticipation of when you would want that to be, within what timeframe?

A. I don't recall but I think I would have seen him somewhere between two and three weeks, four weeks later. I

believe he did have an appointment for actually somewhere around the 18th or 20th which he didn't keep.

Q. Which he did not keep?

A. He did not keep.

Q. All right. I think it may have actually been in the records, the 21st of December?

A. Okay.

Q. And that was ... that appointment was just a no-show to your knowledge?

A. It was a no-show.

Q. Okay. In his case, given the history and given your interaction with him and what you had learned of him, after his not showing for an appointment would there have been follow-up?

A. What I generally do in such a situation is decide whether the person's at relatively high risk of something like becoming psychotically ill or suicide and so on or they're not and if they're not, it's up to them to return if they want to or don't want to. I was available so he could call back.

Q. Okay. So in his case given it was not an active psychotic illness or some other factor that you referenced?

A. So he seemed to be someone, he could call back if and when he wanted to.

Q. Okay.

A. I did my bit by being available and his was to come back.

Q. And then he did make another appointment to your knowledge?

A. Yes.

Q. And when was that?

A. I think it was the day after he left hospital in early January, January 3rd.

Q. Okay. And the person with whom he saw to make that appointment, do you know who that was?

A. Joan Hines, one of our secretaries.

Q. Okay. Joan Hines works in the Outpatient Clinic?

A. Yes.

Q. And it would be her role, among other things, to make appointments for outpatients?

A. Yes.

Q. And it's your understanding and Ms. Hines is going to testify obviously about this so ...

A. Yes.

Q. ... I don't expect you to have a perfect memory of it but it's your understanding that he did attend on the 3rd of

January and make an appointment?

A. She told me he did, yeah.

Q. All right. Obviously the appointment that he made on the 3rd of January he didn't attend for that appointment given what transpired.

A. Yes.

Q. Did you have a thought when you learned of the tragedy that had occurred?

A. Sorry, was that a question?

Q. Yes.

A. Did I have a thought?

Q. Well, what was your thought?

A. I was surprised, first of all, and kind of horrified, that wasn't what I was expecting. Dr. Rahman called me that evening and told me he had learned that.

Q. All right. It may be impossible ... obviously it's impossible for you to know what may have happened in the intervening time. Do you have a thought about whether there was any obvious clinical explanation for what happened based on what you had seen of him?

A. All the things I've heard, I've heard bits and pieces of the story after he saw me, I can't explain in terms of what I

knew and we knew later, we were not expecting suicide so I have trouble explaining it that way.

Q. Right. Dr. Slayter, perhaps I can ask you, I guess, a go-forward question. Are there additional resources or supports that you feel might assist psychiatrists or mental health professionals, especially in our area in rural Nova Scotia, that may not be in place?

(12:12:00)

A. In terms of resources, yes, we can always use more resources. We're not going to get more resources but we could use more resources in terms of different kinds of staff, things like neuropsychological assessments. Some of these things could be done, you know, some other location if we had access to them and so on. But I think in terms of resources, I think right now at St. Martha's we're doing relatively well compared to our neighbours who have less than we do so it's hard.

Q. In terms of cooperation or information sharing with any other health care providing agencies or anything that may be of benefit?

A. I would like to have an easy way to access OSI services and Veterans Affairs records and military records, I think those are separate. So the same way of getting hospital

records, it's very straightforward. If we had a place to go, we'd just send a consent to, and they would send us something back the same day or the next day as I expect from hospitals, even across the country, that would make sense.

Q. You said that there are therapists available in the area both at St. Martha's and private therapists. Any thought on, again, the obvious answer is more is always better, but is there either training or resources that might be available for the therapists?

A. Training is an issue, we don't have enough training in the province, particularly I think for social workers because I don't believe that training, clinical therapy is not the focus at Dalhousie as I understand it, I may be wrong. It's more difficult to find people to work in a rural area than it is in an urban area for probably obvious reasons so there are challenges and probably more could be done to make it more attractive to work rurally.

EXHIBIT P-000072 - LETTER DATED DECEMBER 2, 2016 FROM DR. SLAYTER

Q. Okay, all right. Exhibit P72. Is that the letter you made reference to that you'd given to Lionel Desmond?

A. Yes.

MR. MURRAY: Thank you, Dr. Slayter, those are the questions I have.

A. Thank you.

THE COURT: Ms. Grant?

CROSS-EXAMINATION BY MS. GRANT

(12:15:21)

MS. GRANT: Thank you, Your Honour.

Dr. Slayter, my name is Melissa Grant and I represent the Attorney General of Canada. We represent various federal entities that are engaged by the Inquiry.

Dr. Slayter, I think you said earlier and it's fair to say that when you wrote your report on December 2nd, you weren't writing it for a group of lawyers to pick apart so I appreciate that and just have a couple of questions about, you know, what you were thinking at the time.

So first of all, there's one thing that I wanted to clarify. That what you were hearing from Lionel Desmond was, as far as you knew it, you only had his story, you didn't have records and that sort of thing?

A. Correct.

Q. So in your report when you say, it's under "Substance

Abuse History", that he was taking high doses of marijuana as prescribed in the military and then you said earlier by military physicians, the evidence that we expect to come out is that it was not a military physician that was prescribing that it was, in fact, during his time in Fredericton with a private physician so you don't have any evidence that that's not the case?

A. No, I have no trouble with that.

Q. Okay.

A. It would have, for me, Veterans Affairs and military overlap, et cetera and all that.

Q. Okay.

A. I didn't know what exactly he had had or what was available.

Q. Fair enough. And there may also be some confusion, and I'll take a bit of an opportunity to clarify what we can in this setting, but Veterans Affairs is not a direct service provider and so direct care to veterans is provided through provincial and private health authorities. So is that your understanding as well or do you not have an understanding of that?

A. It wasn't my understanding at the time, I thought they at least contracted. Yeah, I think I thought they provided the

services. And I understand … I learned later that actually by that time the Nova Scotia Health Authority was providing or operating the OSI Clinic in Halifax beginning early in 2015, I think, but I didn't know that at the time and it's still not clear to me that is a regular service that we can just phone up and get records from or if it's different.

Q. Yeah, and I think that there's maybe an opportunity to do some … an education piece and certainly we'll hear later on from exact witnesses and people that can talk about that but since VAC is not a service provider, they may have some records in the normal course, they're not a repository for, say, all of the records like if I went to St. Martha's, you would have a record for me at St. Martha's, if I went to an OSI clinic in Quebec, there would be a record for me in Quebec.

A. Correct.

Q. So that's kind of the difference whereas when somebody is actively serving, when they're a member of the Canadian Armed Forces, they are seeing doctors and medical professionals on the base and are getting that direct health care directly from CAF. So that's just sort of the piece that I feel like is maybe missing in our discussions but ..

A. Could I just comment?

Q. Sure.

A. It would be good to have something on paper, I suppose, some clarification how all that works.

Q. I think that's totally fair.

So within that context and you've noted in your report a couple times that Lionel Desmond was a complex case and had many overlapping issues and that you felt like he needed a … I think you said a higher level of service that you could not provide for him.

A. Right.

Q. So I want to sort of back up and talk a little bit about where you said you identified a gap in service. In the background, and I appreciate that you would not have known this because as we stated earlier, all you know is what Lionel Desmond was telling you. So we expect to hear evidence from Lionel Desmond's VAC case manager. So a case manager is somebody that we'll hear eventually, not every veteran gets a case manager, it's only those cases that are somewhat complicated where a case manager is there.

So Mr. Desmond had a case manager throughout the life of, she was his only case manager, and I think that that's important for you to know for your context because somewhat like you said

earlier, it's generally a policy to see a person once, that you don't often follow up unless they actually have a complicated set of needs. This particular case manager, when Mr. Desmond moved from New Brunswick to Nova Scotia, asked her manager to keep him on so that, in fact, there would not be a gap, that there would be a bridging of services until he could get settled in Nova Scotia. Now that's not in your records so it's clear that Mr. Desmond didn't inform you of that but we do know from your testimony earlier that you were aware that Catherine Chambers had been assigned to Mr. Desmond. So that was part of the case manager's goals in terms of trying to get Mr. Desmond settled here in Nova Scotia.

One other piece of this is that sometimes if a veteran has very complicated needs like Mr. Desmond, the case manager can ask for a clinical case manager to be assigned and while that's also not reflected in your report, that was also going on in the background and so we'll see evidence later that Mr. Desmond did get that clinical care manager, social worker, who could coordinate things for him.

So that's a lot of background to kind of get to the question that a case manager who's responsible for coordinating care, approving requests like maybe a gym membership or

something like that, where they're looking for that higher level of service, they're going to run into, I would suggest to you, Dr. Slayter, the same kind of problems that you identified in your report that the services that he needs were not available in this area. Would you agree with that?

(12:22:16)

A. Yes.

Q. Speaking about the OSI Clinic, for example. So Lionel Desmond spent time at the OSI Clinic in Fredericton and then he had an inpatient experience in Quebec. You had noted that he would benefit from the type of comprehensive treatment that you would get at an OSI treatment, correct.

Did Lionel Desmond say to you that he did not want to attend an OSI clinic?

A. No, I don't think so.

Q. So in the evidence that we expect to hear from the case manager …

A. Excuse me, something … he might have been offered something in Halifax, I can't remember, there's something that makes me think that's possible and he didn't want to drive to Halifax but was okay with Cape Breton which is what he told me he was told he would get anyway.

Q. Okay, and that's exactly it, that was exactly my point because he did, it'll be our anticipation, that he will have said to his case manager that he thought Halifax was too far and he didn't want to go there.

THE COURT: Excuse me, but that's in the context of him having some expectation of being advised or told by somebody that this OSI-type services were ultimately going to be available to him in Cape Breton?

A. That was my understanding is he was waiting for services in Cape Breton anyway but he had been … vaguely I don't … something about Halifax might have been made available an alternative or temporary.

THE COURT: So I appreciate, Ms. Grant, you're asking the question but that's the other part of the context his expectation that if he's saying he's not interested in traveling and then you say he's not interested in traveling because his expectation is somehow created that it was going to be available to him here on some hopefully timely basis, that would be his expectation in that context? Thank you.

A. It was my expectation anyway that he should have something soon.

THE COURT: Sure, I appreciate that, thank you.

MS. GRANT: Dr. Slayter, you would agree that Lionel Desmond did not meet the criteria for involuntary hospitalization?

A. Correct.

Q. Correct. And you had talked about that he had missed an appointment with you, you had mentioned earlier. Is it fair to say that if there's somebody who is presenting with the kind of picture that Lionel Desmond had is not subject to involuntary hospitalization, is if fair to say you can't force people to engage with their treatment in circumstances, that there needs to be some … that that can be a problem?

A. I agree, yes, you can't force someone who's capable to engage in treatment and that can be a problem, yes.

Q. And did Lionel Desmond talk to you about when he went to the OSI clinic in Quebec there's some indication that he didn't complete it and that the noise and the group setting bothered him, did that come up in the conversation?

A. I don't recall really discussing it but something about noise bothering him there sounds familiar and noise sensitivity was one of his concerns in general with his PTSD and that's not uncommon.

Q. And our understanding and this will come up later, but

our understanding that to obtain medical records from CAF as opposed to VAC but that that can be a form that a doctor provides or a consent form that they have that can be filled out, is that not … has not been your experience?

A. What's CAF?

Q. The Canadian Armed Forces.

A. Okay. Again, I don't really know how to access them.

Q. So like you said, some education perhaps on that point would be helpful?

A. Yes.

MS. GRANT: Thank you, Dr. Slayter, those are my questions.

THE COURT: Provincial Crown, any questions?

MS. LUNN: No questions from the Attorney General of Nova Scotia, Your Honour.

THE COURT: Thank you. Ms. Bennett-Clayton, I understand ... I'm sorry, Mr. Macdonald.

MR. MACDONALD: I do have some questions, Your Honour.

THE COURT: So we're at 25 after 12 and we normally take a break at 12:30 for lunch so I think we'll take our break now rather than have you start and stop just so we can control the timing of this. We'll come back at 1:30 then, thank you.

DISCUSSION

MR. MACDONALD: Your Honour, I'm wondering if I'm once again beating the drum about the caution to the witness about discussing evidence with anyone during the break. If we could have it, please?

THE COURT: Doctor, you've been to court before and testified previously?

A. Yes.

THE COURT: Well, typically there's an instruction that's given to witnesses that if they're in the middle of their testimony you're generally directed not to have discussions with anyone before they return to the stand and that's not to suggest that witnesses would but might inadvertently wind up engaged in a conversation that might be better to not engage in. I'll give you that direction.

A. I understand.

THE COURT: Thank you.

A. If they think I'm avoiding you, I'm avoiding you, yes.

THE COURT: It does not mean you cannot have discussions with your own counsel but counsel would know the limitations of what they can discuss with you.

All right, thank you.

COURT RECESSED (12:29 HRS)

DISCUSSION

COURT RESUMED (13:32 HRS)

THE COURT: While we're waiting for Mr. Rodgers. Ms. Lunn, with you is Mr. Norton, Adam Norton, do I have that correct?

MS. LUNN: Yes, Your Honour, Adam Norton from the Attorney General office.

THE COURT: Do we know where Mr. Rodgers is?

Counsel, I'll tell you that there is a couple of documents I'm going to refer to, they've been marked as Exhibits 115 and 116, they'll be pulled up on the monitors. Document 116 would be CAN001902 for your purposes and Exhibit 115 is going to be CAN001909. And I may also refer to it would be document CAN and the last four digits would be 2251, I may also refer to that in some questions for Dr. Slayter. Thank you.

Mr. Macdonald?

MR. MACDONALD: Thank you, Your Honour. Your Honour, I should say before I start that Dr. Slayter and I had a very brief conversation because we both attended the same school together many years ago and Mr. Hayne was part of that discussion so ...

THE COURT: Even after the admonition you were requesting you still found time to have a discussion with Dr.

Slayter.

MR. MACDONALD: Absolutely. Full disclosure.

CROSS-EXAMINATION BY MR. MACDONALD

(12:28:07)

MR. MACDONALD: Good afternoon, Dr. Slayter, so my name is Tom Macdonald and I'm counsel for Thelma and Ricky Borden who are the parents of Shanna Desmond, the grandparents of Aaliyah Desmond and Sheldon Borden who is ... was Shanna's brother and Aaliyah's uncle and I share co-representation of Aaliyah's estate with Tara Miller who is in the front row today.

I just wanted to ask you what you would have looked at and reviewed to prepare before you came to give evidence today? If you could sort of take me through the materials you would have ...

A. I looked at the notes that I made in 2016, that's primarily it.

Q. Yes.

A. I viewed some notes on suicide sort of assessment system, that's mostly it. I made a point of not looking at any records following my December 2nd visit so that I wouldn't colour my memory.

DR. IAN SLAYTER, Cross-Examination by Mr. Macdonald

Q. Okay. That December 2, 2016, I guess we can call it a note, but the psychiatric assessment ...

A. Yes.

Q. ... the one that Mr. Murray was taking you through, would that have ... I assume you didn't type it yourself. When would that have been prepared in relation to when you saw Mr. Desmond?

A. I would have been done the same day. I dictate into Dragon to make my notes.

Q. Okay. I know you said, again it was in response to a question by Mr. Murray, that you heard the unfortunate news because Dr. Rahman called you that evening. Other than that, have you ever had other conversations with Dr. Rahman about this what I will call the Desmond incident if I can put it that way?

A. We talked quite a bit about it at the time.

Q. Okay. This is after January 3, 2017?

A. Yes.

Q. Often? Do you have any idea how many times you may have spoken to him about it?

A. No, just several times.

Q. When would the last time have been that you can remember? Maybe let me help you, was it in 2019 or 2020?

A. 2019.

Q. Okay.

A. I think when the Inquiry was coming up, we talked about it a little bit ... I think when the Inquiry was coming up in November before it got canceled.

Q. Do you remember where that conversation would have taken place? On the phone or in his office?

A. It was probably in my office.

Q. Pardon me?

A. Probably in my office.

Q. In your office, okay. Would he have come to see you and have the discussion, Dr. Rahman?

A. Well, he often comes by in the afternoon and we chat about whatever's going on.

Q. Okay. And do you remember any specifics of the 2019 conversation or what would have been said?

A. No, I don't think anything new has come up from before.

Q. Okay. Well, I want to take you to Exhibit 67 and the portion of it that is your, I'm calling it a report. Sorry, so I think it's exhibit actually 71.

EXHIBIT P-000071 - PSYCHIATRIC CONSULTATION REPORT–REGARDING

PTSD BY DR. SLAYTER

Q. That's your report. Standalone.

A. Yes.

Q. Yes. So I see the assessment and I've read it several times. You met with Mr. Desmond and as a result of meeting with him you prepared this assessment, correct?

A. Yes.

Q. When you were meeting with him, would you use any kind of a physical checklist to help remind yourself or tick off boxes or symptoms?

A. I usually have a paper in front of me that has the different sections as outlined in my notes so that if someone tells me something that's sort of out of sequence for how I'm going to record it, I can jot my notes down in the right spot to sort of pre-organize myself. So I have sections like "PPH" means past psychiatric history so if somebody says something about the past while I'm talking about the present, I'll stick in a note there.

Q. Okay. Do you remember whether you ever discussed with him firearms or his access to firearms or his possession of firearms?

A. I don't think that came up, no.

Q. Is it something that, because I know it was part of the assessment was assessing that his suicide risk was low so when you're, and please tell me if I am attributing anything to you that is not the way you said it, but as I understood today, many people, if not most who come to you, at some time or another may have had some kind of a suicidal thought?

A. Yes.

Q. Is it common at all that you would explore with those individuals specifics in terms of whether they might have a weapon or access to a weapon?

A. I would discuss that when I thought there was a serious risk ...

Q. Yes.

A. ... but not for the sort of casual suicidal thoughts that are low risk.

Q. Okay. Any specific discussions for delving into hurting others other than himself, so homicidal ideation, or just saying I'm thinking about hurting somebody else or have you ever, that kind of a thought?

A. I don't normally ask that unless the story includes issues to do with abuse or violence or something along those lines.

Q. Yes, okay, I understand. Did you ask him whether he ever hit his wife?

A. Yes.

Q. Okay. And the answer was no?

A. He said no and that was when I saw them together.

Q. Oh, so that's in October 24th?

A. Yes, and he said or she said it was just hitting things and that she wasn't afraid of him.

Q. I noticed, and now I'm over at page 27 of your report, and I'm just going to read a few parts from what at the top of page 27 is the continuation of your history section, his history, and then also into the mental status examination. And so I note that you say: "He cannot retain multiple instructions. He cannot follow a conversation which is rapid or sustained. He says he picks up only a little of what is said and forgets the rest. He cannot follow a conversation when there is a distraction present such as a television on. He is easily rattled." And then at the bottom under the mental status examination: "Cognitive difficulties were evident in that he reported difficulties with information processing and said during the interview with me that he missed and could not retain many of the words I was saying." You put that in your report,

you remember that?

(13:42:33)

A. Yes.

Q. I'm just wondering and I'm not in any way suggesting this is on you, but under the homework section, of course, and you didn't call it homework this morning in response to the questions, but you were asking him to get his records. A person with those qualities that you note in your assessment, Mr. Desmond, so he's having trouble retaining things, could you see that possibly, whether it was with Mr. Desmond or someone else with his kinds of qualities that you know, does that become a barrier to someone? It may seem simple to you or to me, but who just cannot get it together to get their medical records without some kind of outside assistance, a navigator or a support person to get through the process of helping them access things?

A. Yes, that could be a barrier.

Q. Okay. Would that be something that might be worthy of review by the Inquiry so that people in his situation and maybe a combat veteran with specifics with PTSD severe like he had, could use assistance to help them obtain records?

A. Yes. If I can add something?

Q. Yes, of course.

A. Generally with patients, if I make two or more suggestions and I'm prone to making that, more than one suggestion, I usually always write down what I want them to go home and do so they can remember.

Q. Okay.

A. When it's only one item I tend not to do that in hopes that they can remember one thing but I don't know, in his case, but I would hope I wrote something but I probably didn't.

Q. Sure.

A. But you're correct, it would be helpful in a situation like this to write it down.

Q. The December 21, 2016 missed appointment that he missed, the purpose of it I wasn't quite clear this morning, was it to think about putting him on depression medication?

A. So it was two parts. I said the focus would be on treatment but I still had a little homework to do. I think I mentioned this morning that the jealousy issue and the ADD issue I didn't think I finished really going into those because I didn't have time after dealing with what I thought were the more important or at least more immediate issues.

Q. Yes.

A. So I would have, I think, gotten into that a little

more as well as checking how he was doing on the depression side and the sleep side and then I would have wanted to get into the treatment but I would had to have had his record present to do that properly.

Q. Yeah. I heard this morning when you spoke to Mr. Murray about borderline delusions and were you here, I think you were here for some of Dr. Rahman's evidence last week?

A. No, none of it, I wasn't here.

Q. Okay. So Dr. Rahman was of the view there is no such thing as a delusion and I heard your evidence this morning and am I right in saying you may be both on the same page now?

A. It's my own term.

Q. Yes, okay, okay. And do you ... is it possible that someone could be borderline delusional, that other psychiatrists, some would see it your way, some would see it Dr. Rahman's way?

A. It's semantics. It's the term I was using and that's why I was thinking when I said earlier today that I didn't write this for lawyers.

Q. Right.

A. The way I wrote it in the assessment list, it sounds like it's a type of delusion but what I was really getting at is

what I spelled out a little longer in the text saying that his thoughts border at times on delusions, they aren't delusions but they're kind of near it.

Q. Yes, okay. One of the things Judge Zimmer last week with Dr. Rahman, played a video of Mr. Desmond in the firearms store Leaves & Limbs, choosing the weapon that he ultimately used and at the end of it, Judge Zimmer asked Dr. Rahman to the words to the effect, tell us what you see and I know you haven't seen the video and I'm not going to ask ...

A. I have seen the video.

Q. Oh, you have seen the video, okay. My question is this. So my understanding of what Dr. Rahman saw and his comments, and with a room full of lawyers and a judge I'm sure I'll hear about it if I get any of it wrong, so he's in a gun store, there are other customers. He is walking, he's looking at guns, he's looking at used guns that are behind the counter, he's looking at new guns that are behind the counter, he's interacting with maybe it's the owner of the store but a store clerk. He sites the guns, he physically handles them, one of each, he finally chooses a gun that happens to be a used gun, he chooses ammunition and looks at the box of ammunition. He thinks about, my word, getting a gun case, handles it, ends up

not buying that. Helps the owner of the store put the gun he purchases into a plastic sleeve and, of course, completes, is interacting with the owner, but also completes, as Dr. Rahman put it, a financial transaction, he pays for the weapon.

You're not a forensic psychiatrist, I know that. Is there anything you could offer by way of as a long-term practicing psychiatrist, to offer any little glint of examination in terms of how a person could present like that less than three hours before he then takes his own life and his family's life? What happens to their state of mind or triggers or just speculation, I know, but informed speculation from a psychiatrist.

A. I ...

MR. HAYNE: Your Honour, I appreciate that Mr. Macdonald addressed that it is speculation and I just wanted to raise the concern, I guess, that Dr. Slayter wasn't there at the time so it's in that context if he's going to provide any evidence on that point subject to Your Honour's thoughts on that question.

MR. MACDONALD: And that's fine with me, Your Honour. Of course, Dr. Rahman was not there at the time either.

THE COURT: Dr. Slayter would understand the question. Do you understand the question and the point? Go ahead.

A. If we can agree it's not area of expertise exactly,

it's experience you said in knowing people and working with people.

MR. MACDONALD: Agreed, Dr. Slayter, absolutely.

A. Okay. So I did look at it late last week and when I go shopping, I'm a bit of a people watcher and I watch a lot of the other shoppers especially when I'm waiting for something and he looked to me like a lot of people I see when they're shopping. He's just kind of bored, the first part, a long section for the first part he was waiting for the salesman or manager, whatever, to come and attend to him and he was walking back and forth, kind of kicking his feet about a little bit. He looked very bored and he also looked a little bit like he had something on his mind. I didn't find he was flat particularly but then I couldn't see his face very often so I was going more by body language but I thought he looked a little bored and like most other shoppers I see when they're bored waiting for something to happen.

I was struck that he was focused on guns with scopes since suicide doesn't require a scope and that he was worried about which gun to buy when, again, it doesn't really matter much which gun you get if you're going to shoot yourself, that kind of thing.

Towards the end when I could see the side of his face a little bit when he was talking at the back at the other side of the room, he seemed a little more animated, his arms were moving around and his face was moving a little bit it looked like having a conversation.

So I would think most people, if they're considering shooting themselves an hour or two later, would look a little different but I don't have experience in spending time with people who shoot themselves two hours later so I don't really know but I would think it would be different.

Q. Understood, thank you. I know you mentioned earlier in your evidence with Mr. Murray that you have had some experience with veterans when you were in the US?

A. A little bit.

Q. Yes. And you were in Pittsburgh and then you were in Maine. Can you offer any balancing of people you may have seen, veterans with PTSD, at those stops in your career in relation to Mr. Desmond's PTSD that you observed and made notes about on December 2, 2016 and October?

A. Not particularly. I remember one case who I saw for several visits unlike Mr. Desmond as I say, who I met, in particular had a lot of waking up in the middle of a firefight

or something in his mind and being very agitated for a couple minutes or so until he realized that everything was okay. But basically, no, I don't. Everyone I've seen, the PTSD is a little different but I could say the same with anxiety disorder or depression, people can have the same basic condition but it's a little bit individualized.

(13:52:14)

Q. And again, you weren't there and it's very clear I'm not asking you for an opinion on something that happened when you weren't there but in general psychiatric medicine mode, can you explain any of the kind of factors that could possibly trigger in a person who presents as normal a few hours before a tragic event happens, what kind of triggers might go off in a person to change them and get them to do an act like happened here?

A. I can simply say I would expect something upsetting would have to happen.

Q. Yes. It could be a life event or it could be many things?

A. It could be many things, yeah, but something upsetting ...

Q. Upsetting.

A. ... because if he was low risk immediately beforehand which I thought, or at least Dr. Rahman did and he and I do things much the same way, I would think something had to have come up that afternoon or he had something else on his mind.

Q. When you say he had something else on his mind, could you elaborate on that a little bit?

A. Well, I'm ...

Q. I don't mean with Mr. Desmond specifically but an individual who might have something else on their mind.

A. Well, this would be speculation ...

Q. Yes, of course.

A. ... but I his intent was to shoot his wife and not himself, that might have had a different look on his face during the gun shop time.

Q. In response to a question, it may have been Mr. Murray or Ms. Grant, it was about resources, about more resources, I think it was Mr. Murray, you made a statement something to the effect, Well, we're not going to get them, I'm not going to put words in your mouth, but do you ...

A. Yes, I said that.

Q. What do you see is the limit? It seemed like such a firm statement from you, I'm just wondering if you could expand

in terms of what you see, why so direct a statement in terms of resources aren't coming?

A. Well, for many of us working in health care, it's the impression that the Province, the Health Authority, doesn't have a lot of money to spend on new things. We see, to be fair, we have seen small increases at times, for example, our crisis service started, I'm not quite sure when, but maybe four years ago or five years ago and that was an add-on and it grew from one person to two persons to three persons so that was an increase. It's the only one I can immediately think of. There's a new intake service in the province which has taken some money but generally there's a not a lot of money, that's my impression anyway.

Q. Can you offer any suggestions or recommendations to the Inquiry knowing what we now know, what happened three years ago, in terms of something that would assist in your field or generally to help these situations from repeating?

A. I think that some education on domestic violence but particularly on serious violence and homicide would be helpful. These are forensic psychiatry issues which most of us don't get any training in or don't have any experience of. I've never had anyone who shot someone before in my care. So I think getting

some help in learning how to identify the red flags for that kind of thing would be helpful.

Q. And do you think would it be helpful if that training flowed through the broad body of health care professionals so whether it's the family doctor or the nurses at the ER or the emergency room physicians and the psychiatrists that that training would benefit that entire group and I don't mean to exclude others in the group?

A. Yes, sometimes physicians prefer it to be a little shorter and quicker when education comes and others tolerate two-day sessions, we would benefit from a half-day session.

MR. MACDONALD: Okay. Those are my questions, thank you very much Dr. Slayter.

THE COURT: Ms. Bennett-Clayton?

CROSS-EXAMINATION BY MS. BENNETT-CLAYTON

(13:57:46)

MS. BENNETT-CLAYTON: Thank you.

Dr. Slayter, I'm Karen Bennett-Clayton and along with my colleagues, Rory Rogers and Amanda Whitehead, we represent the Health Authority. I have just a few questions for you. You've been asked questions about the mental health crisis team, I

think that's the term you used, at St. Martha's?

A. Yes.

Q. Is that the term you would use?

A. Yes.

Q. Is it a crisis response team?

A. I think its formal name is crisis response service.

Q. Okay. And that service you described as currently having three people, is that right?

A. There's three positions, one's off on extended leave but yes.

Q. And what would those positions be, are they all nurses or are they different?

A. Two of the incumbents are nurses and one is a social worker.

Q. And I think I just heard you say that that team has grown ...

A. Yes.

Q. ... from its inception from one person now to a complement of three?

A. Yes.

Q. In 2016 was that team limited to one person to your recollection?

A. I think so.

Q. And that would have been Heather Wheaton?

A. Yes.

Q. So in 2016 the hours of that mental health crisis response service at St. Martha's, that would have been limited to the hours that Heather Wheaton would be working, is that correct?

A. Yes, and I think they were a little different then, they might have been 8 to 4 whereas now it might be ... it goes a little later.

Q. So that's Monday to Friday?

A. Yes.

Q. So it wouldn't be any evenings?

A. No.

Q. And it wouldn't be on weekends?

A. No.

Q. And it wouldn't be on holidays?

A. No.

Q. So during those times, the evenings, the weekends, the holidays, if the mental health crisis response person at that time was not working, who provided mental health crisis response service at St. Martha's?

A. So we have 24/7 coverage by psychiatrists including at nighttime and weekends and holidays. The three GPs I referred to earlier who have been doing it for a long time and they cover.

Q. Okay. So it would be the three psychiatrists and the three GPs?

A. Yes.

Q. That would be on the on-call rotation?

A. Yes.

Q. But during the weekdays when the mental health crisis response team member, at that point, was working, would that person be the person that was called to the ER if there was a need for a consult on mental health?

A. So during the daytime Monday to Friday from, we'll say, 8 to 5, it would be the person on the Psychiatry on-call... Sorry. The psychiatrists, the currently three - maybe two at that time - would cover the ER and we would go down when the Crisis nurse or social worker needed some assistance.

Q. Right. But, initially, would it be the nurse ...

A. Yes.

Q. Heather Wheaton at the time, would Heather be the person that would be called initially by the ER physician?

A. Yes.

Q. And she would come down and do an assessment?

A. Yes.

Q. If she was called by the ER physician?

A. Yes.

Q. Do you know whether she would be called on every occasion when there'd be a patient come into the ER, during her working hours, that required mental health care?

A. If I can rephrase the question?

Q. Sure.

A. Not everyone who comes in with a mental health concern or issue would be seen by the Crisis worker. The ER can deal with a lot of that.

Q. Okay.

A. But when they feel that, for whatever reason, it needs more than what they have to offer in the time that they have, then they would call in Crisis.

Q. Okay. And that would be at the time, in 2016, Heather Wheaton?

A. Yes.

Q. And once she does her assessment, to your knowledge, once she did her assessment or would do her assessment in the

ER, would she be the person that would call a psychiatrist to come and be part of the consultation?

A. Yes.

Q. And is that how you became involved with Mr. Desmond's care on October 24th?

A. Yes.

(14:02:00)

Q. The mental health crisis response team, is that a service that provides care to all patients anywhere within the hospital or is it limited to the ER?

A. Limited to the ER.

Q. Okay. And are they called in to consult in the ER?

A. How do you mean?

Q. Is it, when you get a call from an ER physician to come on a consult, that's the same for the Crisis response team, they're called to consult?

A. Yes. There was the time I mentioned earlier when we would sometimes have the Crisis worker just go in and identify who it might be, because we know we would get called eventually.

Q. Mm-hmm.

A. And it would speed up service to them. That's changed and now requires the ER physician to see the person

first and then they would consult with Crisis.

Q. Right. Generally speaking, what would be the occasions when the mental health crisis response worker would call in the psychiatrist to also be part of that consult in the ER?

A. The most common reason is because they think that an admission is needed and the psychiatrist needs to be involved in making the decision to admit. Sometimes it's because that that's not, it doesn't look needed, but the situation is complex in some sense and needs another opinion.

Q. Okay. So the mental health crisis response worker, as a nurse, they cannot admit patients?

A. No.

Q. Only a psychiatrist or a physician can do that?

A. Correct.

Q. If medication was required or thought to be required, can the mental health crisis response worker, as a nurse, prescribe medication?

A. No.

Q. And who can do that?

A. So a physician.

Q. Okay.

A. That's probably why I was called in that case.

Q. Okay. On the 24th of October?

A. Yes.

Q. And what about discharging a patient from the ER?

A. So they can discharge a patient from the ER with a physician's okay. So most people ... I should say most people they see the psychiatrist does not get called.

Q. Mm-hmm.

A. And they would report back to the ER physician, who would formally be the one behind the discharge.

Q. Okay. When you saw Mr. Desmond on December 2nd and you prepared your report, at that time you were aware that Catherine Chambers was involved in his care or would be involved in his care, is that right?

A. Yes.

Q. And that's information that came to you how?

A. From him.

Q. Catherine Chambers does not work in the Outpatient Department at St. Martha's?

A. No.

Q. She's a private therapist in the community?

A. Yes.

Q. And did you have any knowledge as to how Mr. Desmond came to be connected with Catherine Chambers?

A. He told me that - I don't know the exact words - but he told me what I took to be that the VA had arranged for her to see him.

Q. Thank you. Those are my questions.

THE COURT: Ms. Miller?

CROSS-EXAMINATION BY MS. MILLER

(14:05:47)

MS. MILLER: Dr. Slayter, we met earlier. My name is Tara Miller and I represent Brenda Desmond and also share with my friend, Mr. Macdonald, representation of Aaliyah Desmond. I am going to go through a few different topics, based on what you have shared with us in your evidence this morning.

As I understood your evidence, you talked about research that you did to help develop the initial suicide assessment criteria tool, is that correct?

A. Yes.

Q. And that has been a project, I think, that has evolved over time, and we heard evidence through Dr. Rahman last week that most recently there's been a policy that came out in

June of 2017 addressing that process and formalizing the checklist, making it updated?

A. Yes.

Q. Okay. When you were describing your role in that research work, I think you talked about you reviewed, with some other folks, a wide variety of publications and research papers and identified about 120 factors, but then you'd collapsed sort of them into 20 to 30 because there would have been repetition and different people saying the same thing in different ways. Did I understand that correctly?

A. Yes.

Q. Yeah. And I think I heard you say that despite all of the work that you'd looked at, the body of research that you looked at, no one had ever done a study where they could take those actual identified risk factors and identify that they were present a certain percentage of time. Did I understand that correctly?

A. I am not aware of such and it would be difficult to do, so I doubt that it exists.

Q. Okay. From your perspective, notwithstanding the fact that it might be difficult to do, would that be helpful in terms of getting the best evidence-based practice to assess

risk?

A. Not really. Let's say something ... Let's take blue eyes and brown eyes, if you will indulge me for a moment, and say that brown eyes are 80 percent of the time and blue eyes are 20 percent of the time - I have no idea - and someone comes to me with a blindfold on and I have to say what colour their eyes are from their symptoms. The fact that 80 percent have brown eyes, I could say, well, it's likely that, so I'm going to say brown. That would obviously fail some of the time. And I could say it's blue eyes, on a guess, but that would fail. So knowing something is very common you err on the side of assuming this is common. Someone has chest pain, so I assume it's just indigestion and miss the heart attack. Or it's the other way, I'll say it might be something rare but that's unlikely. So knowing statistics doesn't help you with the particular individual. It tells you out of 100 people or 1000 people what you would see, but when you have an individual in front of you they're all possibilities and they all have to be given sort of equal value.

Q. But if you had an assessment that looked at, you know, the 25 or 30 risk factors and rank them in terms of the most percentage - you know, this occurs in 80 percent of

suicides, this occurs in 60 percent - that strikes me as something that would be helpful in ...

A. You would keep an eye open for it but you can't rate it. That doesn't help you give it weight.

Q. Okay.

A. I'm probably a high risk of suicide because I'm an older white male - those are three risk factors and ... But that only tells you that of a group of 1000 old white men, that they might have a higher rate, not about me.

Q. Okay. The risk factor research work that you did you said was with respect to suicide. We heard evidence from Dr. Rahman there's no homicide risk factor policy tool that's been developed or is in the works through the Nova Scotia Health Authority.

A. No.

Q. Is that fair? Okay. You had indicated that one of the recommendations that you have is for further training with domestic violence, particularly training around serious violence and homicide. That's something ...

A. Yes.

Q. ... that you have identified, so, reflecting back, that would be valuable to you and your colleagues in this field

of practice?

A. I think so.

Q. I want to go back to my question about identifying percentages. Are you familiar with, Dr. Slayter, the Domestic Violence Death Review Committee 2017 Annual Report from the Office of the Chief Coroner out of the Province of Ontario?

A. No.

Q. Okay. I will, just for the record, to help you understand, the definition of domestic violence death is defined as "all homicides that involve the death of a person and/or his or her children committed by the person's partner or ex-partner from an intimate relationship". That study involved 311 cases following 445 deaths that met that criteria, and that study, as I understand it, identified risk factors by way of percentage that were present in a certain amount of those cases. So that's where I was thinking ...

A. Okay.

Q. ... that that type of information, particularly when you're looking for additional training about violence, domestic violence, particularly, serious violence and homicide, having access to an understanding of those risk factors with their percentages strikes me would be helpful in terms of your

colleagues' education on that piece.

A. Yes.

Q. Okay. Thank you.

I am going to get you to look at Exhibit 67 - this is the St. Martha's record - and, in particular, at page 22. I'll just bring that up for you. This is a document that we have not addressed, I don't think, with anyone yet, but it is, as I understand it, and I'll get you to confirm, Dr. Slayter, what your understanding of this is, this is a December 1st, 2016 ER Report, so the day before Lionel would have come to see you for your outpatient consult.

A. Yes.

(14:11:57)

Q. He appeared again in the Emergency Room, that's my understanding of this, and under the triage assessment it says: "He looking to speak with someone in Mental Health. Problems with home life, anger issues. He and his wife are having personal relationship problems. Frequent outbursts at home, and in a temporary separation. Sees Dr. Slayter, last saw six weeks ago. Wants to see someone in Mental Health." So I understand he came in at 11:28 and at 3:10 there's a handwritten note: "Not in the waiting room." I take from that that when it was time

for Lionel to be assessed in the Emergency Room someone would have gone to get him but he was no longer there. Is that a fair ...

A. I would assume that, yeah.

Q. ... understanding? Okay. When he saw you on December 2nd, did he share with you that he had gone to the Emergency Room the previous day?

A. No, and I wasn't aware of it at that time, so I didn't ask him about it.

Q. Okay. Would that have had any relevance to you in terms of you seeing him on the 2nd to understand and know that just the day before he had reached a point where he had gone to seek mental health treatment through the Emergency Room?

A. It would have been relevant. I would have wanted to know what was going on, et cetera.

Q. Yeah. And the note that he was experiencing, it said temporary separation, that strikes me as something different than what he would have conveyed to you on December 2nd. You understood there was interpersonal conflict with his wife?

A. I understood, I think, from the October visit that they did ... he did sometimes leave the house for a day and then go back the next day.

Q. Okay.

A. So I think this would have been one of those, but the fact that there was something going on, I would have, it would have been a chance to get more details because I had more time that day.

Q. Yeah. And would you have had access to that record, Dr. Slayter, in MEDITECH? This is an Emergency Room intake record from the day before.

A. The MEDITECH records are scanned.

Q. Yes.

Q. And, well, I know a year ago they were four months behind in being scanned. I haven't checked just lately but they take a while to get in there.

Q. Okay.

A. And I probably wouldn't have looked because I wouldn't have thought I had a reason to find anything there.

Q. Okay.

A. It wouldn't have been there, I don't think, anyway.

Q. And do you recall asking Lionel if he had recently gone to the Emergency Room ...

A. No.

Q. ... as part of your consult?

A. No.

Q. Your report of December 2nd identifies, as you've already gone over, under "Assessment", the different diagnoses that you were able to confirm, and also that you wanted to rule out attention deficit disorder. I wanted to ask you this question about anxiety. Was Lionel, from your perspective, ever diagnosed with anxiety or is that a symptom of the PTSD? What is the role of anxiety vis-a-vis ...

A. He was anxious, as a symptom.

Q. He was anxious.

A. And I saw that as part of his PTSD and part of the general difficulty he was having coping with getting his life direction and with his marriage and so on, so I ... He didn't come across to me that he had an anxiety disorder in the sense of what we call a generalized anxiety disorder or a social anxiety disorder. That sort of thing is more situational. So he sort of came under the other things that I identified.

Q. Okay. So there was no DSM diagnosis of generalized anxiety?

A. None was made. One could make that but I didn't think that was the issue.

Q. Okay. As I understand your evidence, the anxiety

that you saw with Lionel presented as a symptom of the PTSD?

A. From the other problems.

Q. Yes. Okay. A couple of other documents I just wanted to ask you for your information and perspective on in the St. Martha's records. This is a document that appears at page 11 of that exhibit. Can you help me understand, Dr. Slayter, what this document is. It says "Psychiatric Referral Disposition".

A. So what's the date on it?

Q. I'm not sure. It says, "Patient last..." There's a question, "Patient ..."

A. Okay. What it is or looks like is ... I mentioned earlier that the referral would have been received by our intake nurse.

Q. Yes.

A. So it would come through our intake process and those were the categories under which referrals to Psychiatry ... outpatient referrals to Psychiatry were being categorized.

Q. Okay.

A. So he was put in not as "urgent" but as a priority above regular.

Q. Okay. So you described earlier the process for a

patient to see you in Outpatients was the referral typically comes in through a family doctor.

A. Yes.

Q. And if we look at page 13 of that same exhibit, it's my understanding that this is the referral that would have come in from Corporal Desmond's family doctor, and it's dated November 16th, if I can read the writing under his handwriting. Does that ...

A. Yes, yeah.

Q. ... accord with how you understand that document?

A. Yes.

Q. Okay. So he would have been referred by his family doctor on November 16th. Then if you turn to page 12 we see a document, it says St. Martha's Regional Mental Health Wait Times Form. Can you help us understand this document?

A. Can you pull that further down, I can only see part of it. Can you go down the page? Okay. Okay, back up a bit. There. So at that time there were three official levels or wait times to wait for an appointment: urgent, within seven days; semi-urgent, within a month; and regular, basically after that. This was in flux over the past several years, that system, and I have created for Outpatient Psychiatry one called priority,

which was quicker than regular and later than urgent, so what that meant for me was that, if he was urgent, meaning he had to be seen within seven days, it would be done then. If I thought it ... And priority meant it would be next on the list after the urgent referrals were taken care of.

Q. Okay. So this is sort of an internal St. Martha's Hospital form?

A. Yeah. So it was in between the urgent and the regular, and I think we had stopped using semi-urgent, but it meant they were to be seen next, priority referrals were to be seen next after the urgent ones were taken care of.

Q. Okay. So who would have completed this document, because it says referral date November 3rd versus the handwritten referral from Lionel's family doctor at page 13, which says November 16th.

A. That's curious. I can't explain the dates.

Q. Okay.

A. Can you go back to page 12. The one that says priority on it, whichever one that was, the first one you showed me.

Q. Oh, at page 11?

A. Page 11.

Q. Yeah, page 11.

A. I'm going to guess the check mark on priority is my handwriting, the rest isn't.

Q. So this is page 11 of ...

A. Yeah.

Q. ... Exhibit 67.

A. I'm guessing that might be my handwriting that's checked on the priority one but not on the rest of it.

Q. Okay.

A. But why it would be dated before the referral is received I have no idea.

THE COURT: I might just make this observation, that when you look at page 13, that it looks like there's a fax header across the top and it has a date 11-03-2016. That would suggest November 3rd, as well, and not November 16th.

MS. MILLER: Okay.

THE COURT: And if it was November 3rd, then it would kind of coincide with page 12.

MS. MILLER: Just I was curious about the discrepancy, Your Honour, yeah.

So we know one way or the other that a referral was sent in either on November 3rd or November 16th from Corporal Desmond's

family physician. Do you ... Sorry, going back to page 11, do you review that initial referral and make a determination of how it's going to be categorized in terms of urgency?

A. I think I was doing ... I cannot remember what we were doing at that particular time, 2016, but there have been times when ... there was a time when our intake nurse retired and that's when I started vetting the Psychiatry referrals to make sure they seemed appropriate.

Q. Yes.

A. So it seemed to me that was earlier than that but I can't remember.

Q. Okay. You classified it as Priority 1, I'm sorry, 1 - Priority, and what would that have triggered in terms of the turnaround time for someone ...

A. As I say, we would address anyone urgent first.

Q. Yes.

A. They had to be seen within a week, and if there were none of those, he would the first on the list.

Q. Right. So he would be seen within ...

A. It would be quickly.

Q. Quickly. And he was seen on December 2nd.

A. And he was seen quickly.

Q. Thank you. My friend, Mr. Macdonald, reviewed this with you. You had given ... you had reviewed in your report and reviewed here today the concerns you had with the cognitive issues that were demonstrated by Corporal Desmond. You talked about that it was quite concerning to you that he had that information processing, and then you had indicated that, typically, when you give homework, using that term homework, that you would, if there was anything more than one item you would write out a list. I wanted to ask you to look at a document to see if this is, in fact ... A list was found in Corporal Desmond's vehicle.

A. Okay.

(14:22:29)

Q. And the author of which we do not know and I'm wondering if it is you. So I'm going to get you to ... We're going to go to Exhibit 42, and this is a document, it's in a series of photos.

A. And I don't record those documents, so I wouldn't know when I'd done it.

Q. Right.

A. But I usually do it.

Q. And I believe it is at page 24 ... it's photo 24 or

page 24.

A. That's my handwriting.

Q. That is your handwriting. All right. So this is, as you had earlier indicated, you weren't able to recall whether or not you had done a handwritten list, but you did write out a list for Corporal Desmond.

A. Yes.

Q. Dated December 2nd. One, to contact OSI Halifax. Two, we see "Start antidepressant". I'm going to get you first to read it and then, I know that it's been scratched out, but if you can read what you wrote and then explain to us why you scratched it out.

A. The scratched out.

Q. Yeah.

A. It says "Start antidepressant fluoxetine 20 mg. once a day, in the morning." I don't know why it was written.

Q. Okay. You don't know why it was written?

A. Why I wrote it and then unwrote it. I didn't ... I decided not to give him an antidepressant, so I don't know how that got on there.

Q. Okay.

A. Obviously I changed my mind or my mind was somewhere

else.

Q. Fair enough. Third, therapy, which you've talked about. Fourth, gym and yoga, and we reviewed the official letter that you had recommended for payment for that. And then the fifth thing, neuropsychological assessment re cognition.

A. Um-hmm.

Q. And that you indicated and identified in your December 2nd consult note. Then we see "Problem: PTSD, post-concussion syndrome, jealousy, question ADD." Those were your diagnoses, correct?

A. I left out depression, but yes.

Q. Okay. Any reason why you would have left out depression?

A. I might have thought about putting it in there ... My focus was on these other ones.

Q. Right. And then the final note is: "Get medical records."

A. Yes.

Q. And that is what you had left Lionel to secure those records. My friend had asked you about the value of, you know, having a system in place that would help clients, patients with cognitive issues, difficulty processing information, to help

them follow up on those types of things, which you indicated would definitely be helpful in the future. Is that something that the current Crisis team could assist with, or are they really only used in the front-line Emergency Room intake system?

A. Essentially, along with Urgent Care that I talked about, but that's sort of distinct from that service, but they do both, yeah. I think a lot of the things we learn is that people, a lot of people don't take their medications, they don't do what we suggest they do, and so on. We often ask people in surveys were you given anything to do and they'll say no. So I've been for quite some time, if it's more than one item, writing them down.

Q. Yes, so that ...

A. In hopes - it probably doesn't very often - but in hopes that makes a difference.

Q. No, it seems like a great resource for someone to take away.

A. Mind you, the way I've written it would be, someone with cognitive processing difficulties might have trouble with one crossed out and one not numbered, but, anyway, yes.

Q. So my question, again just to make sure I understand, the current crisis intake team, is the scope of their mandate

strictly within the Emergency Room?

A. Yes.

Q. Okay. So they wouldn't be working with you and patients in Outpatients to ...

A. No, only in the ER.

Q. ... to help follow through?

A. Yeah.

Q. Okay. You talked earlier about Lionel's post-concussion syndrome, the brain injury piece, and that although you'd identified a neuropsych assessment, that was nothing that could be done locally in certainly this region?

A. No.

Q. Were you aware of and are you familiar with the ABI Clinic, the Acquired Brain Injury Clinic in Halifax?

A. I know there is a clinic, yes.

Q. Okay. Do you ever refer ...

A. No.

Q. No. And is there a reason that you wouldn't refer patients to the Acquired Brain Injury Clinic in Halifax?

A. Probably largely lack of awareness of it, and, generally, head injury issues are not really in my area. They go ... we have a concussion clinic in Antigonish and they would

go there and they would process them, things like that, and so on.

Q. Okay. So I guess I'm hearing you say you would, as a first step, be referring to the local concussion clinic in Antigonish before you would be ...

A. I'd do that and, in the old days, Mental Health in Halifax had access to a neuropsychologist and we used to do that but that became unavailable.

Q. Did you have any thoughts of referring Corporal Desmond to the concussion clinic in Antigonish?

A. No. I was waiting also to see the records to see what I thought they would have identified before, but I couldn't tell from him.

Q. Okay. I'm going to talk now ... You talked about treatment options for individuals with PTSD both in the hospital and then in the private sector. I believe you said that there really is a sub-specialty of therapists developing specific to trauma.

A. Mm-hmm.

Q. And I think you said there were two in the Antigonish area, two or three.

A. I'm not sure of the number. I think we have two, it

might be three.

Q. Okay.

A. We have one or two in Port Hawkesbury, Mulgrave.

Q. And when you say you have, you think you have two in Antigonish ...

A. So the ones that have gone on and gotten some extra training in EMDR is how I identify that.

Q. Okay. Would Catherine Chambers have been one of those individuals?

A. No, she didn't work for us.

Q. Okay. Sorry. I ...

A. So she was doing some trauma work at the Women's Resource Center.

Q. Yes.

A. And went private. And so she had PTSD experience there. I don't know what form of therapy she was using. There's more than one.

Q. Okay. She wasn't the sub-specialty ...

A. No.

Q. ... treatment provider that you were referring to?

A. So on our own clinic in the hospital, yeah.

Q. Gotcha. Okay. Thank you.

And then my last sort of area I wanted to just touch on - it strikes me that ... First of all, I'll say this. Do you know that, did Lionel share with you that on December 2nd - we know he didn't tell you he'd gone to the Emergency Room the day before - did he share with you that he was seeing, had seen, or was going to see Catherine Chambers on the same day?

A. He told me he was seeing her after he saw me.

Q. Okay. So you understood that he was going to go from ...

A. Yes.

Q. ... your office to see Catherine Chambers?

A. Yeah. I think that's in my report.

Q. Okay. And was there any direction to Lionel to take this homework sheet to Catherine? That's the one you looked at, it's Exhibit 42.

A. Not that I know of. Probably a good idea but I doubt I said that.

Q. So you would agree that it might have been helpful for her to have that list of homework?

A. Yes.

Q. And also probably to have your consult report? Would that be fair to say?

A. Yes. We haven't been doing that, but, yes, that would be helpful to her.

Q. It strikes me that when you're dealing with mental health, there are many different people who play valuable roles in that complex picture, and what I am hearing over and over from folks is that the more information the better, in terms of ultimately providing the best care. Is that fair to say?

A. Um-hmm.

Q. You're nodding your head "yes"?

A. Yes.

Q. Yes. Okay. So Catherine Chambers would not have been able to access your records, that detailed helpful consult report, correct?

A. Right.

Q. You were not able to access her records.

A. Right.

Q. And whatever she would've assessed that day. So you're both essentially working in the same direction, trying to do the best you can do but you're in silos. Is that fair to say?

A. That's worth looking at.

Q. Yes, yeah. And she, as we understand it, was retained

through the Veterans Affairs system which had its own case manager. And I guess we're going to hear evidence that there was also a clinical manager. So we have all of these folks who are trying to help Corporal Desmond, and certainly other military and veterans out there, I would assume, but nobody is able to share the information which would allow them to have the best evidence to make the best decisions and clinical treatment for those individuals. Is that fair to say?

A. Yes.

Q. Okay. And the last point on that. Your understanding, Dr. Slayter, was that Lionel had fallen through the cracks. That there was a gap in service to him.

As I read the records, and I think you have said this as well, the last time we understand he was in any active treatment would've been when he was admitted to Ste. Anne's in Quebec?

A. Yes.

Q. And it looks like he was released there in August?

A. I think so.

Q. So from August to December, a four-month span, other than going to the Emergency Room on October 24th and on December 1st, to the best of your knowledge, there's no other treatment that he would've been receiving in that period of time.

A. Yes, that would appear. Yes.

Q. Yeah. And for someone who is struggling with PTSD and the multitude of presentations that Corporal Desmond had, is that problematic to go for four months without any active treatment?

A. He would've done better, I think, to have had service, yes.

Q. Yeah. And, again, going back to the silos, it may have been that Veterans Affairs was working to try to get him that, but you didn't know that.

(14:32:02)

A. And they didn't know about us.

Q. They didn't know what was going on and, in the interim, he's left with nothing.

A. Right.

Q. Thank you. Those are my questions.

THE COURT: Thank you. Mr. Rodgers?

CROSS-EXAMINATION BY MR. RODGERS

(14:32:30)

MR. RODGERS: Thank you, Your Honour. Dr. Slayter, I'm Adam Rodgers and I'm representing the personal representative of

Corporal Desmond.

A. Okay.

Q. A few questions for you here. First, just picking up on something from your list. One of the recommendations or suggestions was a gym membership, and I guess I'll ask. We have some internet search records from Corporal Desmond that he was seeking out or searching for a gym membership, I think around January 1st. So I guess I'll ask. Does that surprise you to hear that or please you to hear that or not surprise you? Your reaction?

A. If the incident hadn't occurred, it wouldn't surprise me.

Q. Yeah.

A. No.

Q. Right. What I want to ask you, Doctor, is just to maybe discuss a little bit for us why it's a complex situation when you have somebody who is diagnosed with PTSD and post-concussion syndrome? Why is that more difficult in one or the other?

A. I think that you have two significant problems added on that interfere with how he processes what's going on around him, and they, I wouldn't think, interact with each other. So

if he can't make out what people ... sorry. If he has trouble following conversations or making out what people say, then, well, I think he has trouble processing things in two different ways. One from the PTSD which affects his emotions and his reactivity, and another from the cognitive processing issues of the brain injury. And so the two are added together and would make things more complicated. I'm not very precise about that.

Q. No, no. That's fine. It was a broad question.

One of the treatment options, it seems, in this EMDR, the eye movement desensitization and reprocessing, seems along this line is some form of exposure therapy for PTSD treatment. Is that your ...

A. Essentially.

Q. ... understanding of one good way or a broad ...

A. Yes. That's a ...

Q. ... framework of treatment?

A. That's a one-word explanation.

Q. Now would somebody with concussion syndrome or, you know, concussion symptoms have more difficulty exposing themselves to their own memories because of those cognitive issues?

A. I don't know the answer to that. I would think, and

this is speculation, that if they're dealing with very uncomfortable, distressing memories and they're trying to process them at the same time and put them into words, it would be more complicated, but I don't know what the research would say about that.

Q. Okay. Now, I want to ask you generally, I mean, so people come in to see you and then, generally, you see them once and refer them out to others, and I take it there are two ways that you refer people out. into the public system and then into the private practitioners. Is that correct?

A. Usually, it's in the public system.

Q. Okay. So who gets to see a private practitioner?

A. It would be someone who has an insurance plan and can access them. That's where it depends ...

Q. An insurance plan or the private means to do so?

A. That's what it's all about, yeah.

Q. Yeah.

A. The advantage of having that is you can get into a service quicker.

Q. What's your sense of the availability? When I do a quick internet search on the EMDR and people who do that kind of treatment in Nova Scotia, I get 30-some psychiatrists that pop

up right away that appear to be ...

A. You don't mean psychiatrists.

Q. What?

A. You don't mean psychiatrists. Somebody else. I don't think there are 37 psychiatrists who do that.

Q. Okay, sorry. Maybe some of them were counsellors.

A. Okay.

Q. But listing people that are using that methodology. If you're referring somebody to a private psychiatrist, what's your expectation in terms of how quickly they'll be able to see that person?

A. I assume, but I don't know, that it's a matter of weeks as opposed to months.

Q. Yeah. In your experience in referring people onward to either the public system and the private system in Nova Scotia, how would you comment, or what would your comment be, on the balance there and whether that's a good balance or something that should be examined?

A. You mean how many see private and how many go public?

Q. Yes. And, you know, whether there's room to think about whether the public system should be expanded at the cost of the private system.

A. I think the quality on both sides is probably equal. There's no reason why it wouldn't be anyway. It's all about access. I'm not sure I've answered your question. I'm not even sure what the question is.

Q. Well, I'm not a hundred-percent clear what the question is either, but I guess I'm trying to get a sense of, an insight into the system, if somebody needs to see a psychiatrist. We'll think of it from the perspective of a veteran.

A. You mean a therapist.

Q. A therapist, yes. If there's, you know, thousands of people trying to see a few psychiatrists in the public system versus hundreds of people trying to see hundreds of therapy providers in the private system, there seems to be an imbalance there.

A. So the point is there should be more therapists of either kind and people should be able to afford them.

Q. Yeah.

A. Whether it's through free public or assistance to pay for the private.

Q. Okay.

A. It's, you could say, an unfair barrier, but it's

there.

Q. Yeah. Well what do you see ... I guess the question is do you see significant negative implications of the way the system is structured now in that regard?

A. I don't know if it's a problem. It's just a lack of therapists. I don't know if more people could afford private ones if there were more private ones. I certainly ... if we were larger publicly, we would take more people because there's no barrier to seeing them.

Q. Yeah, okay.

A. If I had a choice, I would add ten new therapists to the public system because that's where the need is because of financial reasons.

Q. Yes.

A. Does that answer your question?

Q. It does. I guess what I'm trying to do for myself and, I guess, for the Inquiry, generally, is to get some insight into how that dynamic works and if there's a recommendation to be made in terms of Veterans Affairs being able to handle this kind of thing internally or not.

A. So it's interesting in this case. Veterans Affairs hired Catherine Chambers, so they contracted out to her.

Q. Yeah.

A. And I suppose there's no reason the middle ground, that the public system, if it had the funds, couldn't contract out to private people to provide so many hours a week or something like that.

Q. Yeah, okay. I'll switch topics with you, Doctor. A question on the suicide risk study and factors that you've identified, and I'll just ask you to comment on one thing. I notice in the reports that individuals are asked whether they have suicidal or homicidal ideations. And the question is whether that, in any way, implants an idea that wasn't there previously or whether that's just something you should ask and that's the only way to find out?

A. I've never had the impression that it's been implanted like it's a new idea. I mean it's something most people experience a little bit and moreso the people who would come to see me.

Q. Yeah.

A. It's a weakness of our suicide assessment that it does depend a lot on people saying they have suicidal thoughts, and we tend to assume, when they say no, that they don't, as I indicated earlier, there's some situations which might be

ignored, you know, a statement if, for example, they were very anxious and not sleeping, I would think that they would be high risk anyway. So there are times when we would not pay attention to that, but it does tend to be our primary marker for identifying who might be worth assessing further.

Q. Yes.

A. One of the studies I read some time ago, I think in Australia, looked at ... some group followed 800-and-something people with mental health diagnoses for a number of years, and 30-some of them, 32, I think, committed suicide. And they looked back and they found the majority of the ones who committed suicide had not voiced suicide thoughts. The smaller number had.

(14:42:03)

The point being that some people don't ... either ... maybe they don't get asked, but they don't volunteer that they have suicidal thoughts, and there's not much we can do about that. And if, otherwise, they seem fairly unremarkable in terms of not seeing acute risk, then we're going to miss those.

Q. It seems like a very difficult thing to predict.

A. It works most of the time but it doesn't work all the time.

Q. Yeah. I want to ask you about firearms regulation, Dr. Slayter, but not in the particulars, necessarily, of this situation with Corporal Desmond. But, generally speaking, is it something where, you know, you see somebody that you think shouldn't have a firearm, that does? What's your procedure there? How do you go about making that determination and then what do you do with that information once you have it?

A. Yeah. Usually if we think is at risk of suicide, they have access to guns, generally, in the house, it's something like that and so we would talk to them and their family about having the guns removed, and if they come up with a way of getting them removed that seems to work, then that's what we do.

Q. Yeah.

A. We don't usually end up, that I know of, going to sort of getting the police to remove guns, although sometimes we do that but it's usually ...

Q. Most of the time, families will agree with you and ...

A. The families will remove them and take them off to Cousin Joe's to take care of or something, and lock them up.

Q. Voluntarily, okay. All right. Now what about looking at that situation, I guess, in the other way around. Would you see some benefit when you see an individual, you see them for

the first time, being able to access their firearms history, history of anything, if they've had their firearms taken from them for mental health reasons? Would that benefit you?

A. I think it would be rare is the problem because, okay, I've been doing Psychiatry for about four years. This is the first time I've had someone shoot himself.

Q. Yeah.

A. So I would've had to gone through thousands of people to get at this one case, and that wouldn't seem to be effective.

Another thing is that in this area, in my experience, hanging is the most common form of suicide. That's readily available too.

Q. Yeah, okay. So the next thing I want to ask you about, Doctor, and you've talked about this already, is some of what your awareness is of the Veterans Affairs and OSI programs. And I guess what I want to ask is what is presented to you, if anything, about these programs as a practicing psychiatrist in Nova Scotia?

A. I never had anything presented until this happened.

Q. All right, so prior to this, if you ... I presume you've treated other veterans before. Nobody's made a presentation or had a seminar with you to say, All right, well,

here are the services that are available and how to do it.

A. Not that I can recall, no.

Q. Okay.

A. Which seems odd, but I think that's the case.

Q. Have you had occasion to make referrals to Ste. Anne's in Montreal?

A. One. Our psychologist did it with my backing, but yeah.

Q. Okay, or OSI in Fredericton or Halifax?

A. I talked with OSI Halifax about another case, that's all I can think of.

Q. Okay. Do you have a sense, even though you haven't done referrals, of how that process might work or how easily it might work?

A. Sorry?

Q. To refer somebody to OSI, that a veteran in your ...

A. It's not clear to me. Now that I better understand, it's under the Health Authority, and perhaps they operate like other facilities in the Health Authority in which case it would be quite simple. But I'm not sure.

Q. Okay, and you've talked about records and the difficulties in receiving records. How would you foresee that

system working well, from your perspective, to get the information you would need to make an assessment of a veteran that you hadn't met before?

A. It had to be the same with what I call a regular hospital or clinic or outpatient service, to be able to make a referral simply by writing a letter to them directly and have on the internet where to send it and all that kind of thing. And for records to be able to have a phone number or a fax number to contact their records department. And we would send in a consent with a request and they would send it right back.

Q. Is ...

A. That's what we do at the regular healthcare facilities.

Q. Okay. Now two questions from that. One is a timing question and, you know, if everything happened efficiently and you got the records in a couple of weeks or a week or so ...

A. So with any hospital in Canada I would expect to get something back by tomorrow.

Q. Okay, and is that fairly timely in your opinion?

A. Yeah.

Q. Okay. And I suppose if you thought the records were urgently needed and there was a serious situation you'd hold the

patient till then.

A. Yeah, and in his case, it didn't seem urgent, but I would like to have had them by the second visit before I saw him again.

Q. And the second barrier to that might be, as we've discussed or you've discussed today already, is having the patient sign the consent form. Now there's obviously reasons for that, but in a mental health context do you see that as a barrier and would you see it working any other way?

A. That's an old question because it comes up in other contexts. For most of the time that's not an issue but it can be an issue. You have to explain to the person the benefit of us having the information to treat them and most of the time we very seldom can't get that. But I guess that could happen. But that's their information and they have a right to it.

Q. Yeah. You are teaching some still?

A. Mm-hmm.

Q. Are you aware of anything within the university education program that deals specifically with military veterans and the specialty that that would entail?

A. To be fair, I'm doing clinical teaching. That means I see patients with a resident and see how they do it and give

them advice and help them learn. I'm not in the classroom in Halifax to see what they're doing ...

Q. Okay, and you're not ...

A. ... per classroom teaching.

Q. And you're not as familiar with the remainder of the education program.

A. Not at that part, no.

Q. Okay. Fair enough. The last thing I want to talk about is there was a part of your report, you talk about Corporal Desmond seemed to want to discuss his military experience or was at least open to it. Well, do you recall whether it was one or the other that he wanted to talk about it, or that he was open to it?

A. Heather Wheaton wrote that. So it probably came up when she was interviewing him.

Q. Yeah.

A. Just before I came in. So I don't know what was said exactly about that.

Q. Is it something you recommend to people dealing with PTSD or other diagnoses that would benefit them to speak to peers about their situation?

A. Generally, yeah.

Q. I wonder if in Corporal Desmond's ... you know, in his situation. Did you see it as an issue of him perhaps not having peers with whom he could speak about ...

A. Well, peer support ...

Q. ... his experiences?

A. ... is always helpful. So that would have been another service. Again, we don't have an organized peer support program here in the rural area but that would be helpful. He needed more than that, but yes.

Q. All right. And you mentioned yoga and going to the gym. Is nature itself something that you recommend?

A. Well, to be fair, not only did he say, I asked him what he had found helpful already and he said those things were helpful so, therefore, I thought they were a good idea. But let's take exercise. There's lots and lots of research to show that exercise is good for anxiety and depression and self-esteem and so on. So I recommend to most people doing that and everyone comes back saying that it's helpful. It doesn't cure by itself but it does help. And every little step you can take that helps is worth it.

Q. Very good. Okay. Thank you, Dr. Slayter. Those are my questions.

THE COURT: Mr. Hayne?

MR. HAYNE: Just a few questions, Dr. Slayter.

CROSS-EXAMINATION BY MR. HAYNE

MR. HAYNE: If we could first just go quickly to Exhibit P69.

EXHIBIT P-00069 - HISTORY OF VISITS DATED OCTOBER 24, 2016 TO JANUARY 4, 2017

So, Dr. Slayer, this is part of your record for Lionel Desmond. Correct?

(14:52:02)

A. Yes.

Q. And are you familiar with the term "cumulative patient profile"?

A. No.

Q. Okay. Then is it fair to say, though, that this particular document, this two-page document, is a summary of your interactions or your understanding of the interactions with Mr. Desmond? Is that fair?

A. Yes.

Q. Okay. And if we look at page 2, for example, the

entry at the very bottom, "ER crisis note 24 October 2016, Heather Wheaton, RN", is that your summary from Heather Wheaton's crisis note?

A. Yes.

Q. And then similarly, the box above that dated 24 October 2016, is that a summary of your notes in your interaction with Mr. Desmond?

A. Yes.

Q. Okay, and then on the first page, similarly, we have one for 2 December 2016. We've already looked at your actual consultation note but this is a summary of that consultation note.

A. Yes.

Q. Okay. Just a couple of quick other questions to clarify a few things. You were asked about asking the question about suicidal ideation, and you noted that some people will say no. And then I think you said that in circumstances, however, even with a no, you may follow up or probe further. Is that right?

A. Yes.

Q. Okay. And you use your clinical judgment as to when that's necessary. Is that fair?

A. Yes.

Q. Okay. You were asked a question just by Mr. Rodgers a few moments ago. He put to you that Mr. Desmond had conducted internet searches seeking a gym membership and he asked you whether that was surprising to you. And I think your evidence was, and correct me if I'm wrong, that you had said if the incident hadn't occurred it wouldn't surprise you.

A. Well ...

Q. And so my question is is seeking out a gym membership, would you consider that to be in the class of future-looking or forward-looking activities?

A. Yes.

Q. Okay, and that class of activity is something that would weigh against risk of suicide. Is that fair?

A. Yes.

Q. Okay. Ms. Miller asked you - I think it was Ms. Miller - regarding the records, that she put to you that Mr. Desmond was seeing Catherine Chambers and that she didn't have access to your consultation note. Is it fair to say that if a request was made by Ms. Chambers with the appropriate consent for Mr. Desmond, that you would have provided those records to her? Correct?

A. I have done that before in situations where a therapist has requested from me with consent, yes.

Q. Okay. You've been asked a lot about suicidal ideation. I have one question for you in that respect and it's regarding a statement that's in the records. Ms. Chambers' records, in fact. The statement - and I think I have it quoted correctly - is: "I wish I had just been blown up in Afghanistan."

So from your perspective as a psychiatrist, would that statement by itself constitute suicidal ideation?

A. No.

Q. Okay. Would it perhaps prompt follow up? We discussed earlier about when you may use your clinical judgment to follow up, but that's something that may prompt you to follow up further. Is that right?

A. I would look into it further, yes.

Q. Okay. Those are my questions. Thank you.

THE COURT: Thank you.

EXAMINATION BY THE COURT

(14:56:56)

THE COURT: I have a couple questions. So I'm going to

work my way backwards here. And the suggestion was that if Ms. Chambers had called and requested a copy of, for instance, your December the 2nd report that you prepared that would have been forwarded to her?

A. I have some ambivalence about the concept and some support for it but when therapists in the community have asked me I have forwarded, yes.

Q. Okay. That would require just, what, consent from Mr. ...

A. Yes.

Q. In this case, Mr. Lionel Desmond?

A. Yes.

Q. And what concerns would you have about ...

A. I'd feel more comfortable if I know the person that I'm sending to and I know what they're going to do with the information. I don't want to see it on the internet or something. That's the main concern of what happens to the information if you don't know someone.

Q. Once it gets out of your hands.

A. Yeah.

Q. Or the hospital's hands. Okay. The Exhibit 69 that was up, who would have prepared that?

A. I did.

Q. You prepared all of that?

A. I do my own typing by dictating into Dragon, yes. We have lots of discussions. The hospital system takes time to get things transcribed and this way I get it done right away and I have records if somebody calls back or something comes up.

Q. It's there, yeah.

A. Yes.

Q. But would you have formatted it that way? Or do you dictate your notes and so the ...

A. I have a template and I dictate into it.

Q. Yeah. Okay. Thank you, and ...

A. That was an easy one.

Q. They're all easy. Just give me a chance to see if I can collect my thoughts here.

When you were talking about whether it was Mr. Desmond in particular, or maybe just general comment, that when you see some patients ... the words you used were "regimented". So they might be more regimented in their presentation. Or maybe that was those with military background?

A. I was trying to get at two things. Some people sort of behave better with me than they do with other people because

I have authority and sometimes you don't get as much of a story. Or at least you don't see their emotions. So that's one issue. It makes it harder for me to read into what's going on.

Q. All right.

A. And the other is some people may feel like they're supposed to give you certain answers and which is almost the same thing.

Q. So would you see any variation between information you might get from an individual and what information nursing staff might have gotten from the individual?

A. Yes.

Q. Do you see those variations?

A. Yes. So Heather Wheaton, for example, and her colleagues, will sometimes say after I've gone in with them to do my part at the end of their piece ... say, Well, she was quite different with you than she was with me. And so we'll compare notes and try and make sense of what that tells us.

Q. All right. So when a third-party observer comes along and reads your report and reads the nurse's reports and there seems to be some different flavour and tone and attitude, that might be just simply because of the way the patient or the client perceived his audience. Or his or her audience.

A. Correct, yes. So two people will have different lenses. Or the patient will have different lenses with us. And we get somewhat different results. It's not usually a big problem, but it's there.

Q. Yeah. So if we could go to Exhibit 67, please, and it's page 8. It's the last paragraph. So if you could just maybe kind of make the last paragraph a little larger, and I was just having trouble reading it. So I was going to have the doctor read his own handwriting for me beginning with ...

A. It's Heather's.

Q. Oh, sorry.

A. Which normally is better than mine. But not this time.

Q. So it starts, "Travel" ... sorry. "Trouble navigating Veterans Affairs system."

A. Yeah. Okay: "Trouble navigating Veterans Affairs system and worried about what they will offer and what they will cover. Waiting for Veteran Affairs ..."

COUNSEL: Case.

A. "Case manager in (something) transfer not complete." New Brunswick, probably. Case manager in New Brunswick.

(15:02:03)

DR. IAN SLAYTER, Examination by the Court

THE COURT: So it's waiting for Veterans Affairs case manager in New Brunswick and so ...

COUNSEL: I think that might be, "Waiting in NS."

THE COURT: Newfoundland?

COUNSEL: NS.

THE COURT: Okay. Waiting for Veterans Affairs case manager in N ... so that would be Nova Scotia. But we can always ask Ms. Wheaton anyway. But thank you.

Now one of the topics that was discussed earlier was that ... it came up maybe a couple times about stability and stabilization programs. So I'm going to ask you to tell me if I have this, if I understand correctly. You have an individual who presents. In this case, you know, Mr. Desmond, or Corporal Desmond. Have PTSD. And there were a lot of things that were going on in his life and to the extent that you would look at trying to create some stability. Would you look at creating stability before you looked at therapeutic interventions or options so that he would then kind of be receptive to that opportunity?

A. Yes, the trauma part of the therapy in particular. So the general therapy would be helping with that stabilization, but before he can start dealing with his memories that are

terrifying he would have to ... the rest of his life should be stable.

Q. So we have Exhibit 115. It's document CAN001909.

EXHIBIT P-000115 - LETTER DATED DECEMBER 15, 2015 TO OSI CLINIC FROM DR. MATHIEU MURGATROYD

Q. And Dr. Slayter, this is a letter that was written on letterhead that would indicate it was written the Operational Stress Injury clinic in Fredericton and was written by Dr. Murgatroyd. It was a recommendation for Ste. Anne's stabilization and residential program. Are you familiar with Ste. Anne's stabilization program at all?

A. A little bit. I had another patient who went there.

Q. Mm-hmm.

A. And they were doing, basically, activities. They were helping them develop routine and develop activities and just sort of that kind of thing.

Q. Right. So it's actually page 3 of 3. If we go over to the next page. Partway down, the full second paragraph begins:

> The goals of admission are for medication reassessment, approving his coping skills, increasing his structure and daily

activities, and psychosocial rehabilitation. Once stabilized, the client will have outpatient follow-up with his psychologist, his psychiatrist here, and OSI clinic. He does not have a family physician. He is medically fit. Client's not actively suicidal or homicidal. He's not a risk for aggression or violence. There are no present legal issues.

And then there's a recommendation for a teleconference at the time of discharge for collaboration in relation to ensuring appropriate follow-up care.

So it would appear that at the time that this was written the idea was to get Corporal Desmond into the program at Ste. Anne's for stabilization.

A. Yes.

Q. Okay. Exhibit 116.

EXHIBIT P-000116 - RTCOSI DOCUMENT FROM STE. ANNE'S HOSPITAL

You have page 1. If you can go to page 2. Or the second page. It's entitled "Disciplinary Discharge Summary". This is from Ste. Anne's Hospital. It's the RTCOSI, which is the Residential Treatment Clinic for Operational Stress Injuries.

Appears that the corporal was admitted on Monday, May 30th to the stabilization program. He was transferred to the residential program July 4th, 2016 and discharged from the residential program August 15th of that same year.

At the very last paragraph on that page it indicates that: "Teleconference took place on August 9, 2016 with the RTCOSI team and Mr. Desmond's outside care team to share observations and recommendations in preparation for his discharge from the RTCOSI to ensure his continuity of care in the community."

So there had been a recommendation for the teleconference and they had that and it would appear that they were trying to facilitate Mr. Desmond's continued care back in the community. Okay? Because we know he didn't go to the OSI clinic in Fredericton because he wound up coming back to Nova Scotia.

A. Yes.

Q. One of the recommendations in relation to Mr. Desmond was - and you had, I think, kind of recognized it as well - that they recommended a detail neuropsychological evaluation. And they say in part: "The results of the evaluation did indeed indicate the presence of mild cognitive dysfunction. The nature of the test done does not allow the identification of the proportion to which different elements may have influenced the

performance." And there are some other things.

So they recommended that he have a neuropsychological evaluation to determine his cognitive capacities. That was recognised in August. And sorry, Doctor, if you want to just go over to the next page, which is page 3 of the report, under Recommendations. If you can stop there.

A. Okay.

Q. there. No. You've got the wrong page. And that's the page, yes right there. And stop right there. In the second paragraph they talk about:

> Having a clear portrait of the actual impact of cognitive deficits on the client's functioning, if any, will serve to orientate treatment in that it will support the process of setting realistic therapy goals which are to help Mr. Desmond attain a satisfying level of participation in his activities and develop a sense of having an improved quality of life.

So my question is really this. He's discharged in August and you see him in December and he still hasn't had that kind of an assessment.

A. And did not have it arranged.

Q. And did not have it arranged.

A. No one had referred him for that, I presume.

Q. And you continued to recognize that it was a need in his life. All right. I take it that it would have been certainly a lot better for Mr. Desmond to have had that done presumably shortly after he was discharged in Quebec.

A. May I ask a couple questions? One is rhetorically.

Q. Sure.

A. One is I'm wondering if he finished his full program in Ste. Anne's. I thought they were usually longer than five weeks.

Q. I believe he left a little early.

A. Okay. And secondly, it sounds like he didn't go back to Fredericton and that's why things probably got dropped at that point.

Q. Well, it appears that the plan was to go back to Fredericton but I think he sold his house and returned here.

A. Yeah, so that's probably where the breakdown came.

Q. All right. But appreciate that during this teleconference call on August the 9th, he was talking that people were going to be involved in his outside care were on

that call. I understand that, that would have included the case manager, his case manager at that time, Ms. Doucet. She was on the call.

And so to the extent that Veterans Affairs was assisting Mr. Desmond in moving through the system, I guess there might have been some expectation that that would not be a crack he would fall into if somebody was managing what he required.

(15:12:14)

A. Yes.

Q. All right. As I said, from August to December, that had not happened.

Now there is something else that I want to refer you to just briefly, and I was trying to pull that document up.

Can you pull that up for me? I need to go to a date, August. Let me see. It would have been August the 9th. I'm not sure if that was the date it was. You can just back up? Let me see.

It's in August. You have to go to the August date, probably around the 9th. No, back up a bit. Can you center that progress note right there?

THE CLERK: The top one or ...

THE COURT: No, the progress note. The second one. The

one that's at ... that one right there. Thank you very much.

EXHIBIT P-000117 - CASE PLAN

THE COURT: So just for the record, we're on page 10 of that particular document.

Now that would appear to be the note of PM Doucet, who I understand here is the case manager. It would indicate she participated in the case conference with Ste. Anne's Hospital, that at the same time Dr. Murgatroyd was involved in the phone call, and he had sent the original referral for the RTCOSI admission. It would appear that they're making arrangements and are prepared to deal with Corporal Desmond when he returns to New Brunswick in expectation that he'll be dealt with at the clinic there.

A. There's nothing specific there.

Q. No.

A. Other than how to transport him.

Q. How to transport him. Mmm. I know that there are additional notes, but I'm not going to ...

A. Okay.

Q. We won't bother with those. But my point being this, I guess, is that there was an expectation that if Mr. Desmond was involved in the call, then I'm going to suggest that Mr.

Desmond would have had some expectation that things were going to be managed for him once he returned to New Brunswick and then to Nova Scotia. And at least as it relates to that particular neuropsychological assessment, that never happened. And to the extent that that would have impacted his ability to try to get on with his life or overlap and compounded his PTSD symptoms. Then it could not have been addressed.

A. Sadly.

Q. There was a report that came out. It's called **Preventing and Reducing the Risk of Suicide: A Framework For Nova Scotia**. It was just published recently. Have you had a chance to see that?

A. I don't ...

Q. It's not there.

A. ... think so. I'd have to see it.

Q. Well, we don't have that in. Do we have that as an exhibit? I don't think we do do we?

A. I don't think so.

THE CLERK: And Exhibit 105 is the Suicide Risk Assessment and Intervention Policy. Is that ...

A. That's not it.

THE COURT: No, that's not it. I was going to ask a

couple questions but I don't think I will if you haven't read it. I'll ask you just a brief question about methods of suicide. You made a comment that hanging is the ...

A. I think so.

Q. Statistically?

A. You know, my experience from what I hear and what the police bring in for serious suicide attempts, hanging is the more common. More common than shooting for suicide.

Q. Well, the document that I have in front of me, it's called **Preventing and Reducing the Risk of Suicide: A Framework For Nova Scotia** dated January 2020. At page 5 under the heading "Understanding Suicide in Nova Scotia" it makes the following comment: "The most commonly used method of suicide is hanging, strangulation/suffocation, followed by poisoning and firearms in men." So it would appear to be ...

A. (Unclear.)

Q. ... fourth on the list.

A. Yeah.

Q. And poisoning and drowning/submersion for women. (Unclear) with what the observations were you made.

A. So we need to restrict firearms when someone has them who is suicidal but it's not the only thing, unfortunately.

Q. Statistically, it would appear to be clearly more lethal.

A. Mm-hmm.

Q. But not at the top of the list.

All right. Any questions, Counsel? No? All right. Thank you, Dr. Slayter. Appreciate your time.

WITNESS WITHDREW (15:18 HRS.)

THE COURT: Thank you. Mr. Murray? Or Mr. Russell? What do you have planned next?

MR. MURRAY: Our thought was to call some of the nursing staff. I don't know whether we wish to start with that today or not. I don't know if we need a short break to discuss that.

THE COURT: Well, we'll take a break for maybe 15 minutes and you can have a discussion whether it's fruitful to start your next witness today or not. All right? So you can discuss that amongst yourselves.

COURT RECESSED (15:19 HRS.)

COURT RESUMED (15:36 HRS.)

MR. RUSSELL: Yes, Your Honour. Inquiry counsel would call nurse Heather Wheaton.

THE COURT: Good afternoon.

HEATHER WHEATON, affirmed, testified:

DIRECT EXAMINATION

MR. RUSSELL: Good afternoon, Nurse Wheaton. I understand you have a bit of a cold today, so try the best you can to speak as loudly and clearly as possible.

A. Okay.

Q. If at any point you need a break, just sort of let us know and we'll see if Judge Zimmer will accommodate it. I can't promise.

So I just wanted to start with a little bit of background. So what is your full name for the Court?

A. Heather Wheaton.

Q. And what is your occupation?

A. I'm employed as a mental health crisis clinician at St. Martha's Hospital.

Q. How many years have you been a nurse?

A. 1992.

Q. And you said you were a mental health crisis clinician?

A. Yeah.

Q. At St. Martha's?

A. Mm-hmm.

Q. That's your official title now?

A. Yes.

Q. How many years have you been in that role as a mental health crisis clinician?

A. Wow. I guess it's almost four now. Four?

Q. So you would've started roughly in 2016?

A. It was the summer, I think, of 2016.

EXHIBIT P-000111 - *CURRICULUM VITAE* - HEATHER WHEATON

Q. I'm going to show you - and it's been marked as an exhibit so it's a document you'll be familiar with - it's 111. So it'll be on the screen in front of you and it'll also be in a binder that should be up front, perhaps?

THE CLERK: It's here on a table and it would be Volume 2.

A. Oh. I've got it here maybe.

Q. Okay. So I just wanted to start walking through your employment history. So if we look at page 2 of that document, 1992 to 1998, it indicates "Registered Nurse, CDHA." What's "CDHA"?

A. Capital District Health Authority.

Q. So that was sort of an old ...

A. What's the Central Zone of NSHA now. Yeah.

Q. And the Central Zone today is what?

A. Halifax-Dartmouth, the HRM. Halifax Regional Municipality, I think.

Q. Okay. So from '92 to '98, what was your nursing specialty, I guess, at that time?

A. So I was working at the Nova Scotia Hospital as a mental health nurse in a variety of different areas.

Q. So acute care.

A. Mm-hmm.

Q. And forensic psychiatry, inpatient units.

A. Yes.

Q. What is that?

A. So I worked on acute care units, adult. So adult acute care units at the Nova Scotia Hospital, mental health inpatient units, and I worked for a time on the psychiatric ... on the forensic inpatient unit which, at that time, at the Nova Scotia Hospital on the fourth floor was the forensic unit.

Q. So what is the forensic psychiatric inpatient unit? How is it different than the regular inpatient unit?

A. So that would've been what existed before we had the

actual East Coast Forensic Hospital in Dartmouth.

Q. So that would've dealt with a number of people that would perhaps have been charged with criminal offences?

A. Yes.

Q. And you indicated that you completed a psychiatric nursing specialty program.

A. Yes.

Q. What is that?

A. So at that time ... I don't even remember who offered ... but at that time they had a post- ... so when we graduated from Nursing, they had a post-grad program that was specialized in mental health or psychiatric nursing. You are working at the time so it involved having a preceptor and some supervision in your workplace as well as some sort of classroom-style learning about mental health and psychiatry.

Q. So is it fair to say that not every nurse would have that specialized training?

A. No, that's right.

Q. And it says "completed CBT training program". What is "CBT" and what's the training program?

A. Cognitive behavioural therapy.

Q. And, generally, if you could indicate, what is

cognitive behavioural therapy? I know it's a broad term.

A. It is, yeah. So cognitive behavioural therapy generally focusses on two areas, cognitive and behavioural, for supporting people who have problems with things like anxiety and depression. So the guiding principle is that there are different areas or domains that affect. So our thoughts affect our mental health, our emotions or feelings and our behaviours. So it looks at targetting cognition and behaviour in order to support people to be more well.

Q. Okay.

A. Yeah.

Q. So I'm going to skip ahead a little bit in your employment history. At the top of page 2 of your CV, in 2003 and 2006 where were you working then?

A. Sorry. 2003 ...

Q. It looks like May of 2003 to May of 2006. At the very top.

A. Oh yeah. So I was working at the Nova Scotia Hospital on acute care and the short-stay psychiatric inpatient units.

Q. So what is "acute care" and "short stay"?

A. So at that time, there were a couple of acute care units. So adults requiring psychiatric stabilization for acute

psychiatric illness. So that tended to be ... it could be anything but, for example, people with psychotic illnesses.

The short-stay units at that time were focussed more on ... there was a presumption that the person would require a brief hospitalization. So that generally was people who were experiencing a crisis of some sort. Could include suicidality, psychosocial issues, difficulty managing their emotions and their behaviours. That type of thing.

Q. So I guess keeping with the mental health theme, if we look at page 1 of your CV, from May of 2006 and August of 2011 what were the various positions you held in part of your employment as a nurse?

A. Do from 2006 to 2011, I worked as a member of the Mental Health Mobile Crisis team which is located in Halifax and, at that time, it was a service that had mental health clinicians partnered with Halifax Regional Police officers, and the mental health clinicians could be employed by either Capital District Health or the IWK, and the service provided telephone support as well as a mobile response to individuals experiencing mental health crisis in the community. Generally, the HRM. There was a boundary on the mobile response. Yeah.

Q. And I plan to get into later of what the mobile crisis

unit is.

A. Okay.

Q. What it does.

A. Yeah.

Q. I understand, during this period of time as well, you had some involvement in triaging?

A. Yes. So part of that position required triaging, predominantly on the telephone. So triaging for a response. So was it something we would respond to in person? Go mobile? Or was it something that required us to call 9-1-1? Was it something that we could provide some sort of brief solution focus crisis support on the telephone?

Q. So would this be a situation which would be, rather than somebody showing up in the ER with some form of mental health illness or in a state of mental health crisis, they would call, I guess?

A. Yes.

Q. Is that what it was?

(15:46:00)

A. Yes. It was a 24-hour service that people could call if they were experiencing a mental health crisis.

Q. And you indicate psychiatric assessment was part of

your duties that you were trained in.

A. Yes. Yeah. So there was, at that time, if we saw somebody in person, we would complete a brief psychiatric assessment. So biopsychosocial assessment. And part of what we may be assessing, if we were mobile in the community, it would be accompanied by a Halifax Regional Police officer who worked on the team and so it would always be two of us. So a clinician and a police officer. That allowed for a situation where we may assess that somebody would meet criteria for the police, say, to arrest them under the **Mental Health Act**. We could support the police in that process and then perhaps transport the person to the emergency room.

Q. And you indicated there, finally, you said: "It provided education and support to families and to community members and agencies."

A. Yeah.

Q. So what did that involve?

A. So sometimes it would be families that would be contacting our service and so sometimes their visits would be to family homes. For example, somebody might call and be requesting some support for a family member in the home and we could arrive. That family member may not even be there, the

individual who was in crisis. So sometimes we'd be meeting with the family and trying to provide them with some education and support either about supporting their loved one who has mental illness or about how to get support and help when they needed it.

And, likewise, we would respond to community partners or community agencies like group homes or nursing homes. That kind of thing. And so there was a component about providing some support to the staff of some of those homes. Yeah.

Q. So August of 2011 to May of 2012, what is your role in, I guess, mental health nursing at this point?

A. So from 2011 to 2012, I was employed in, it was a recovery and integration model, so they called it "intensive case management" and, basically, I think there was a couple of us and we worked out of an outpatient mental health clinic, but the support we provided was in the community, so with people in their homes.

By and large, these would've been people with, say, persistent mental illnesses like schizophrenia, for example. And so sometimes it was about helping them get to appointments, helping them to integrate into their communities, connecting them with services, monitoring and supporting them and learning

how to sort of monitor their own wellness, I guess, and illness and symptoms of their illness.

Medication. We did medication in people's homes. So people who are on injectable medications. So long-acting medications for psychosis, that kind of thing, we did that in their homes.

Supported people going to court. Yeah.

Q. Okay. So from May of 2012 to November of 2014, I guess again, you're still involved in mental health nursing but your role again changes slightly.

A. Right.

Q. What are you doing at this point?

A. I was working in a mental health outpatient clinic in Dartmouth and basically as a community mental health nurse. And so there was a lot of different things I would do. So there's some group facilitation work. There was assessment, so people coming for the first time, doing an actual psychiatric assessment. There was medication clinics, so again providing long-acting injections, medication monitoring for clozapine, so we ran a clinic for people to monitor that. Then I got some, I guess, education. I did some training in a couple of different kinds of therapy, predominantly solution-focused therapy.

Q. What's "solution-focused therapy"?

A. So I struggle to remember the textbook definitions of things.

Q. That's okay. But, in general, what is it?

A. So, basically, it's a brief therapy that's actually ... it's fairly ... it's a therapy modality. So there's, generally, a certain type of interview or interaction you would have with somebody and it's brief and it's focused on setting goals with the person and ...

Q. And I guess ...

A. ... supporting them, I guess, and ...

Q. And I guess that particular mode of therapy would be patient dependent, I take it? Not all patients ...

A. So at that time, no, not all, although there was a system in place at that time where all people coming into the clinic for the first time would meet with a clinician who would basically do a solution-focused therapy session as your first visit with somebody. It's a good way ... it's a good approach to hear a person's story and help to kind of narrow down where the problems areas are ...

Q. So I get it ...

A. ... fairly quickly and ...

Q. It's a technique, I guess, at initial ... early phase to draw information out to sort of get a complete perspective as best you can?

A. Sort of. It's ... yeah.

Q. What was "group facilitation" that you were involved in? What was that?

A. So there was ... we would run groups for clients of the clinic. So there was ... so self-esteem, anger management, healthy communication. Those were the three that I facilitated that I recall facilitating. And then we ran ... there was an anxiety group, I think I co-facilitated once.

Q. So I'm going to ask you about 2014 to 2016. It has a reference to Alberta Health Services. So what were you doing in Alberta as your role as a nurse?

A. I was working on acute care and geriatric mental health inpatient units.

Q. So, again, your entire role as a nurse again is mental health related?

A. Yes.

Q. And then finally bringing us up to 2016 until today, and I plan later to go through what a mental health crisis clinician is, but you indicated you, as well, are crisis

coordinator? What is that?

A. So originally when I came to the position, the title of the position was crisis coordinator. So there was, I would say, a slightly expanded role to the crisis coordinator position in that there's ... there would be more time, opportunity, and expectation for things like case conferences and support to the role, maybe like some places have like a clinical nurse educator almost. So if crisis clinician needed ... if the crisis service at that early time in 2016, for example ... the crisis service was fairly new and developing. So the crisis coordinator would help to kind of establish those connections within the service and figure out what the service needed in order to be most effective.

Q. So this role of mental health crisis clinician ...

A. Yes.

Q. ... that ... you've held that title since 2016 at St. Martha's. Do you know if that was in place prior to 2016 or if it was something that was developed?

A. It was. So when I came into the position, the person who was leaving that position was the person who was the first person in it, sort of. And she had actually gone a long ways towards developing it and sort of advocating for that position

at St. Martha's. So I don't recall how long the position had been in place at that point and she was leaving that role. And so when I was hired there, I took that role and there was just the one person in a crisis role there.

Q. And that was ...

A. And so that would have been me when I took that role.

Q. Okay.

(15:56:00)

A. Yeah.

Q. So this concept of mental health crisis unit, we're going to get into what that is. In 2016, is it fair to say that was kind of early days for that sort of project?

A. So there was ... yeah. There was one mental health crisis clinician position. There was one.

Q. Was there such a thing as a mental health crisis unit back in 2016?

A. No.

Q. So I take it that it was one person and that was you.

A. Yes.

Q. And at some point that expanded, I believe.

A. Uh-huh.

Q. Do you recall when that expanded?

A. I think it wasn't that long, but I ... honestly, I don't remember. I'm pretty sure by ... I'm pretty sure it was just months and a second position. So the position that I took, I took as a ... it was a temporary. So it had to be posted or it was posted and nobody applied. I don't remember the ... I was new to Antigonish, I was new to St. Martha's, so I had it as a temporary position. And then at some point, within months, I think, somebody with more seniority was hired into that position. But by then, they had created a second position and there became two crisis clinicians. And so I was successful in my application for that position. Yeah.

Q. We'll go back to that later. So your work experience in your entire ... I believe 28 years nursing career, it's been entirely in mental health?

A. Yeah. There was about a four-and-a-half years where I left working publicly and ... or left working and worked in the private sector. And then when I did a reentry to nursing and tried ... I think I did six months with the VON and then back to mental health.

Q. So I'm looking at it ... your *CV* references forensic psychiatric nursing ...

A. Uh-huh.

Q. ... inpatient/outpatient nursing, community nursing, crisis nursing. You'd agree that that's a pretty broad sort of career to have in mental health nursing?

A. Yeah. Yeah.

Q. And are there any sort of departments or subspecialties in mental health nursing that you haven't been involved with?

A. I've worked with child and youth only in my role as a crisis clinician, so I haven't done any inpatient or outpatient clinic work with children and youth.

Q. But other than that?

A. Yeah. I can't think of anything.

Q. Can't think of any? So typically in this province, based on your experience and your knowledge of nursing throughout Nova Scotia, is it typical for a nurse involved with mental health to spend their entire career as a mental health nurse with that specialty?

A. I don't know, to tell you the truth. I'm sure there's a few of us.

Q. But if you were to follow say ...

A. But, yeah ...

Q. ... say 100 nurses, how many would you expect would

have spent their entire career focused strictly in mental health?

A. Maybe not a lot because there are so many different areas and there's so many different opportunities with nursing that people can move around. And, honestly, my experience is working with ... so I work with different specialties, not just nursing. So I've been ... you know, only in my maybe inpatient experiences would I be sort of working with just nurses. So I work with other mental health clinicians with all different backgrounds, so ...

Q. Okay.

A. ... I don't know.

Q. And during your period of time in various settings as a mental health nurse, have you had any sort of experience in dealing with either retired veterans ... military veterans or veterans that are temporarily not in active military service? Have you had any experience with those types of patients?

A. I'm sure I have. Yes. Do I remember specific ... actually, I don't recall any specifics other than a ... I've actually had a couple of more recent contacts with people that would fall in that category.

Q. Would you say ... if I was to suggest frequent,

infrequent, hardly ever, all of the time, in terms of your actual ...

A. Infrequent.

Q. Okay. So on your *CV* there's one particular aspect of your skills, experience, and training. It's at the top of page one. It's the third one down from skills and experience. It says, "Suicide Risk Assessment Course and Trainer for SRAI Tool".

A. Uh-huh.

Q. I guess what is the "SRAI tool"?

A. So that's the Suicide Risk Assessment Intervention Tool that is in place now that you would see.

Q. And what is the Suicide Risk Assessment Course?

A. That's a course that's offered by the RNPDC. So that's a course that's offered in suicide risk assessment. It's offered through the RNPDC. I'm sure you're going to ask me what that stands for. I'm going to struggle. So it's NSHA.

Q. So how long of a course is that?

A. And so I was just trying to think that. I think it's ... ooh, it was a couple of months anyways. I can't remember specifically how many ...

Q. The course ...

A. ... months ... the course. So a lot of it is study on your own and on your own time and then there are ... there's papers that you write and there's tests that you have to do. And then there's a component ... they call it in the "lab". But there's a component of clinical ... of interviewing. They use actors and such in order to ...

Q. And the actors are in a state of sort of mental health crisis, I guess, or ...

A. Or they would be people experiencing ... it would be to do a suicide risk assessment. So not necessarily just in a crisis situation but just in doing suicide risk assessment.

Q. Do you know when this course came into effect or when did it start?

A. Oh! I'm not sure. I'm going to say years now.

Q. Would it be earlier than 2016, after 2016 ...

A. Oh, earlier than 2016. Yeah.

Q. So who ... is this course ... who would normally take this course, suicide risk assessment?

A. When I did the course, I think there was ... there were nurses, social workers, occupational therapist. I think we may have had either a resident psychiatrist or an intern or something and ... or maybe it was a resident. So, basically,

anybody could apply to take it, but it would be people working in mental health and addictions program or people working in mental health and addictions.

Q. So do you know if it's mandatory for someone working in mental health, whether it's a nurse or a social worker, is that suicide ...

A. So my understanding is that it's mandatory, but I can't ... I don't know ... I'm not going to say that that's across every single area of the mental health and addictions program in Nova Scotia because I don't know that for sure. But I believe that it is mandatory for people working in inpatient, in crisis ... you know, in certain areas. And ...

Q. Is this ...

A. ... I don't ...

Q. ... particular to St. Martha's or ...

A. My understanding would be it would be beyond St. Martha's. The time I took it, it was mandatory I think in the position I was in and that was for Capital Health.

Q. And how long have you been involved in teaching that course in the SRI- ... or, sorry ...

A. So I don't teach ...

Q. ... SRAI tool.

A. ... the course.

Q. Okay.

A. I ... yeah. So I've completed the course, like participated or ... but I'm a trainer for the tool. So ... or I was a trainer for the tool. That was one ... I think I did one training session at St. Martha's but ...

Q. And ...

A. Yeah.

Q. ... the same groups of people have to take training in learning the tool ... the risk assessment tool?

A. Anybody who would have occasion to or be expected to complete the tool should get the training with the tool. My understanding is they've done ... when I did the training was, I think, early when they first brought the tool out and were implementing it. And then after that, I believe they developed a learning module online that I think people might be able to take if they missed the sort of initial go-around of training on how to use the tool.

Q. Are you able to say whether or not there's sort of mandatory training or whether or not ER physicians or psychiatrists have to take training in the SRAI tool?

(16:06:05)

A. I am not sure. I wouldn't ...

Q. Are you able to comment about nurses?

A. Outside of mental health or ...

Q. Within mental health.

A. Oh, within mental health? The tool ... so registered nurses working in the mental health program at St. Martha's, and I'm pretty sure it's provincially, have to use the tool; therefore, they should have training in using the tool.

Q. What about sort of a nurse working in the ER?

A. They wouldn't be completing the tool, so they wouldn't need training in the tool.

Q. Okay. So always ... I guess my question is if someone presents to an ER sort of after hours, whether it's 10 o'clock, say, on a Friday night is what I mean by "after hours," and they're presenting in some form of mental health crisis, various stressors, various symptoms, I guess, the nurse that they interact with, would they have training in this suicide risk assessment tool?

A. No, because it's ... no. It's a tool ... it's only mental health and addictions. Clinicians are people who would actually use this tool because it's a tool that aids in prompts and documentation of the suicide risk assessment. So if you are

not trained, comfortable, experienced, and it's not part of your job to do a mental health or suicide risk assessment, then you wouldn't use the tool.

Q. So I guess my question is if somebody appeared this Friday ...

A. Yes.

Q. ... at 10 o'clock ...

A. Right.

Q. ... to an ER at St. Martha's ...

A. Yes.

Q. ... and they have all the signs and symptoms of ... their chief complaint is mental health.

A. Okay.

Q. It's a situational crisis, let's say, does someone complete that suicide risk assessment while they're there?

A. I don't know.

Q. Would the ER nurse or the nurse that's on staff complete that?

A. No.

Q. No?

A. No.

Q. If there was a consult, say the ER doctor had called

for a consult with Psychiatry, would there be any sort of nurse involved in doing an assessment ... suicide risk assessment?

A. After hours? No. At St. Martha's, no.

Q. So if it happened at 1 o'clock in the afternoon on Friday ...

A. Right.

Q. ... same scenario, somebody presents, situational crisis, number of signs and symptoms relating to mental health, would the tool be completed at that time?

A. If the ... if mental health ...

Q. Mental health is ...

A. ... crisis response service was consulted, then yes. Yeah.

Q. Who makes the decision that there's a mental health crisis consult?

A. The Emergency Room physician.

Q. Okay. So if the ER doctor calls for a consult, presumably somebody would attend and administer that suicide risk assessment?

A. Yes. If the ER physician consulted crisis response, then presumably one of us would attend and we would do ... every time we see somebody in the Emergency Room when we're consulted,

if we attend, then we complete both the crisis assessment as well as the suicide risk assessment intervention tool.

Q. Okay.

A. Yeah.

Q. So as of now, I guess your understanding is if there's an ER consult requested after hours ...

A. Right.

Q. ... outside of what perhaps a psychiatrist might do, if they're present, there's no formal completion of a suicide risk assessment tool. Is that correct?

A. My understanding is the tool is not completed. Correct. Yeah.

Q. So we'll talk a little bit about your title as mental health crisis clinician. So what exactly is a mental health crisis clinician?

A. Would be a professional in a variety of different disciplines, so it could be a nurse or a social worker, an occupational therapist, that has training and experience and is employed in a mental health role where they have contact with clients.

Q. How many currently ... I guess we'll start at St. Martha's. Are you aware how many mental health crisis

clinicians there are at St. Martha's Hospital?

A. Yes. There are two of us. There are three positions but there are two of us working in the crisis service.

Q. And of the three positions, what are the relative backgrounds? Yours, obviously, is nursing.

A. Yeah.

Q. And what are the other two?

A. So my colleague who's on leave is a nurse. And then my colleague that I work with right now is a social worker.

Q. Is there a mental health crisis clinician in every hospital that you're aware of throughout the province?

A. No, there's not.

Q. For example, Guysborough Hospital here ...

A. No.

Q. There's no mental health crisis clinician?

A. No.

Q. The hospital ... Cape Breton Regional Hospital in Sydney, are you aware if there is ...

A. Yes.

Q. So if someone attends in the middle of the afternoon at say Guysborough Hospital in a form of ... symptoms again, I guess, with mental health related concerns, in a form of mental

health crisis, how do they get access to a mental health crisis clinician? Is there any way the mental health crisis clinician can get involved there?

A. So if an Emergency Room physician decides that they ... there's a need or that they want to consult mental health crisis and they're at one of the hospitals outside of St. Martha's that don't have that service, then they call us, basically. They speak to one of us on the phone and they give us a report and they let us know that they'd like to send the person to St. Martha's ER to see the mental health crisis clinician for a consult.

Q. So if the person isn't sort of admitted into the hospital, they're there, they attend, they're transported to the local hospital where the mental health crisis clinician is?

A. So I can ... yes. I can only speak to what happens really at our hospital. But, yes. So if somebody presents to Guysborough or Strait Richmond Hospital or Eastern Memorial Hospital and the ER physician would like a mental health consult, then the ER physician from that hospital calls our service. They give us a verbal report and they let us know why that, you know, they're seeking a consult and that they're going to send the person. And then we support that process.

And so they ... generally speaking, the person remains under the care of that physician and are transported, most often by ambulance because the referring physician is still responsible for their care and most often that is the way that they feel most comfortable, and they're transferred to our Emergency Room and then we would see them when they arrive. And then we would discuss our assessment with the referring ER physician at whatever hospital.

Q. Are you familiar with any scenarios where someone may attend for mental health crisis in a more rural area where there isn't the clinician present and they're looking to access services, but when they find out that they have to be transferred to another hospital in a more central location there's a resistance to that? And, if so ... if you're familiar with that, what takes place at that point? How is the situation managed?

A. I'm not aware that anybody ... so most often they're being transported by ambulance. There has been some concerns about how they will get back to their home area and that has, at times, been quite inconvenient for people. So if we can transport them back to that hospital by ambulance, they might have to wait for a very long time for that type of transport.

Q. And sometimes how long would they have to wait to get back home?

A. To get back to their home ... so if a person is not going to be admitted to St. Martha's Hospital and they're ... then they would ... we would help them ... or we would be responsible to transport them back to the emergency room from whence they had come, so to speak.

Q. Okay.

A. So we would ... our Emergency Room would call an ambulance and request that ... I don't even know the terminology. They do it. I don't call them for transport ... but just for transport. So it would depend on how busy ambulance services were but they could wait many hours.

(16:16:16)

Q. Okay.

A. Yeah.

Q. And you indicated, I believe, in 2016 and perhaps early 2017, you were the only mental health crisis clinician at St. Martha's?

A. Yes.

Q. And my understanding is a mental health crisis clinician, you are primarily based out of the hospital, I take

it.

A. So the role at St. Martha's of mental health crisis clinician, at that time in ... was carrying a cell phone, some borrowed space, and then at that time in an office, sort of a small sort of swing office, I think, for a while it was. And then we got a permanent sort of office space. And at the time of 2016, the crisis clinician would take calls from community, as well. So if somebody primarily from community partners, so ... but sometimes also from individuals, they would call through the mental health outpatient service and then they would get put through to the cell phone being carried by the crisis clinician.

Q. So I guess a crisis clinician's point of contact with people, I guess, in a mental health crisis, I guess, or symptoms with crisis or mental health, is not always just the ER.

A. At that time in 2016, there was also on the phone.

Q. Okay. And ...

A. And then in the ER. Yeah.

Q. And what about today?

A. Today, there's less phone because the ... it would be ... the mental health mobile crisis team has now expanded to be also a Nova Scotia provincial mental health crisis telephone line. So people have that telephone crisis support available to

them provincially 24/7 or 24 hours a day, seven days a week. So ... and, also, we just couldn't keep up realistically with the demand of trying to provide a phone service and an in-person consult service to the ER because we couldn't take calls when we were in the ER seeing somebody. So less phone now and more now in person. Yeah.

Q. So I guess that's going to be my next sort of logical question is, you have, in effect, two mental health crisis clinicians at St. Martha's right now.

A. Right now. Yeah.

Q. In terms of patients showing up in ER and patients out in the community where you say you attend from time to time ...

A. No. We don't. That ...

Q. You don't?

A. That's the service provided ... the mental health mobile crisis team ...

Q. Okay.

A. ... in the Halifax area.

Q. So mental health crisis ...

A. So mental health crisis at St. Martha's Hospital used to be on the phone and still could happen that a phone call could get put through to us, and we respond to consults in the

Emergency Room.

Q. Okay. So ...

A. Yeah.

Q. ... your role now as a mental health crisis clinician is based out of the Emergency Room at St. Martha's.

A. We're not physically in the Emergency Room ...

Q. No, I know.

A. ... but, yeah ... yes, we provide ...

Q. You are engaged at that point through the ER.

A. Now, yes. And ... yes. And the crisis response service now also has the urgent care component to it. So the crisis ...

Q. And what is ...

A. Crisis response services now covers both crisis response in the ER, like to consults in the ER as well as an urgent care service, which is providing ... it's providing brief intervention for people who come through, say, the Emergency Room in a crisis and it's believed that they do not require an inpatient admission but it's going to take longer than an hour or two to sort of support their crisis being resolved and that they could benefit from some brief, fairly intensive, support.

Those people can also get referred to urgent care from the

central intake. So when somebody is intaking for service, if Intake believes that they require some urgent support and that it looks like it might be something that's brief and doesn't require long-term therapy, then they can also refer to our service. So my colleague and I make up the crisis response service at St. Martha's Hospital and right now, we share ... we do half days. So half a day responding to consults in the Emergency Room and half a day with sort of booked urgent care appointments.

Q. So is there always ...

A. Yeah.

Q. ... a mental health crisis clinician at St. Martha's covering the ER except for after hours?

A. Between the hours of ... yes. Between the hours of 8:30 and 6, there's always a crisis clinician.

Q. What about weekends?

A. No weekends.

Q. And what about holidays?

A. No holidays.

Q. So I want to get into sort of how that role is slightly different than another service which you mentioned earlier was a mobile crisis unit.

A. Yeah. That's very, very different.

Q. Is that offered through St. Martha's?

A. No.

Q. No. Where is that offered?

A. No. So that's a one specific ... the mental health mobile crisis team is a specific service that is located in the Halifax Regional Municipality.

Q. And is that the only ...

A. Yes.

Q. ... municipality it's offered in, as far as you know?

A. As far as I know. Yeah.

Q. And, generally, what is their role? How does a mobile crisis unit ... how do they ever get involved in what it is that they do?

A. So that's a very ... my understanding is that it's a fairly unique service. And I'm not aware of any other ones in the province. So they would take calls directly from individuals in crisis. So as I said, that's ... they run the provincial ... or I don't know how ... but they operate the provincial mental health crisis line.

Q. I'll give you ...

A. So ...

Q. ... an example.

A. Yeah.

Q. Would they become involved if, say, a wife had called the police ...

A. Yeah.

Q. ... and said, My husband has a history of PTSD ...

A. Yes.

Q. ... he has signs of being manic today, he's not coping well.

A. Yes.

Q. Police are sort of actively looking for him.

A. Yes. They ...

Q. Is ...

A. ... might become involved in that situation.

Q. Is that the sort of scenario that a mobile crisis team ...

A. There would be multiple different scenarios covering any kind of ... yeah.

Q. But would that be one example?

A. But that could be one example of a scenario. Yeah.

Q. So sort of out in the community ...

A. Yeah.

Q. ... I guess, we'll say roadside, the patient or ... at the time, the person undergoing the crisis has access to mental health professionals along with the police?

A. Yes.

Q. And that mobile crisis team, could that involve a nurse, say, trained in mental health?

A. Yes.

Q. Could it involve a social worker trained ...

A. Yes.

Q. ... in mental health?

A. Yes.

Q. And as far as you know, that particular service is unique to Halifax.

A. Yes.

Q. Are you aware of any sort of rural regions within the province that that is available?

A. No.

Q. And do you believe that it's sort of a valuable service in terms of an interface with the person in the crisis and a mental health professional as opposed to just simply a police officer?

A. Yes.

Q. And why is that?

A. Because people who are experiencing a mental health crisis, I believe a ... somebody who is trained in mental health would be the best person to be providing intervention. And sometimes ... in my experience, sometimes police officers can struggle a little bit with the mental health ... like with interpreting the **IPTA, Involuntary Psychiatric Treatment Act,** the part that pertains to their ability to arrest people under the **Mental Health Act,** for example. Sometimes they struggle with that. And I think sometimes it might be a benefit to have a mental health clinician available to support that process in the community.

Q. So I'm going to go back to your role as a mental health crisis clinician and the mental health crisis team as it operates out of the ER at St. Martha's, for example. What does this crisis team comprise of as it exists ... I guess in 2016, you said it comprised of you, basically.

A. Yes.

Q. And what does it comprise of today?

A. So my colleague and I ... so there are three positions, but there are two people currently. The third position is not filled. So right now it's comprised of my

colleague and I. And we have office space in a building adjacent to the hospital ... attached to the hospital, so we have office space in the hospital. And we comprise the crisis response service and then we have support from other people. But it's ...

(16:26:29)

Q. I guess so what ...

A. Yeah.

Q. ... do you do as part of the crisis response service? So you at some point in today ... how do you first get involved with a potential patient that ...

A. So there's ...

Q. ... presents to the ER?

A. If there's a person ... so if an ER physician is making a consult to our service, then somebody calls to tell us that. Could be different people. Could be one of the nurses. Could be the ER physician directly. It might be the clerk or ... so somebody calls to say that there's somebody here who's consulted to your service.

Q. And so I take it you go down and eventually meet with the patient?

A. Yes. Oftentimes, if I'm ... yeah. If I'm not in the

Emergency Room or if we're not in the Emergency Room, sometimes I'll ask for the person's name and then I'll take a quick look on MEDITECH to see if they've had recent contact with anybody in the mental health program or if they've had recent Emergency Room visits. We do see children and youth, as crisis clinicians, at St. Martha's. So I would do that if it was a child or an adult. And then on my way to the Emergency Room may swing by either the child and youth or the adult outpatient service, if I've noted in MEDITECH that they're connected with those services, to take a look at the paper charts which are currently not scanned into the computer. So I may do that if it looks, from MEDITECH, like there's information there to see.

Q. So when you get a call for a consult, I guess before you get there, you're given sort of the role as well to sort of gather up and try to piece together what the patient's medical history has been up to that point?

A. Insofar as it might be helpful or applicable in the moment in the crisis. So I don't ... I can't dig into records from five years ago or go trying to track things down. It's only ... it has to be what's accessible if there's something accessible right then.

Q. So I guess if you said ...

A. Yeah.

Q. ... can't go digging and ...

A. Yeah.

Q. ... get records from five years ago, what's prohibiting you from doing that?

A. The time. I'm seeing so many ... if somebody was in the Emergency Room in crisis ... so I'm not going to take hours to try to, you know, track down records or call other hospitals. And the records wouldn't arrive in time for me to view them anyway.

Q. How long does it ...

A. So ...

Q. ... typically take say from another ...

A. ... I don't ...

Q. ... hospital in the province to arrive?

A. I don't know but it wouldn't be within the hour or two that ... I'm guessing.

Q. Yeah. And I ...

A. Yeah.

Q. ... certainly appreciate ...

A. I don't know.

Q. ... that an ER situation ...

A. Yeah.

Q. ... is sort of immediate here and now. So just before we, I guess, talk about the timing of things, when you're gathering up records sort of as you say you're on your way down, you're swinging by one place and another, can you get access to outpatient or ER records from other hospitals within the province right away?

A. So on the MEDITECH system ...

Q. Yes.

A. ... I can only view ... right now, anyways, I can only view ER ... like hospital or ER visits for a couple of different locations.

Q. What ... So is your evidence that you can't view from all locations across the province right now?

A. Not on MEDITECH. I believe there's a way to do it on some other system, but I don't have access and I don't know.

Q. So you, as mental health crisis clinician, you have even today a limited access to records from particular hospitals?

A. Yes.

THE COURT: Is that by somebody's policy or design?

A. I'm sorry, I don't even really know. I just know that

the computer ... the MEDITECH system doesn't show me if somebody has been to an emergency room in Halifax, for example. It will show me, I think, New Glasgow and Antigonish and Cape Breton and this area. But I can't see if they've attended an emergency room in ...

THE COURT: Any other ...

A. Yeah.

THE COURT: ... information that you would normally expect to see on MEDITECH from another location, you don't access anything?

A. I ... no. I can't see ... I can't even ... I can't see it to access it. So, you know ...

THE COURT: Yeah.

A. ... I don't know whether it's ...

THE COURT: Yeah.

A. Yeah.

THE COURT: You don't know if it's there or not.

A. Yeah.

THE COURT: It's just ...

A. It's not ... yeah.

THE COURT: You just don't have access.

A. No. No.

THE COURT: So you ... would it just be of the hospitals that would feed St. Martha's that you would have access to?

A. I guess so, yes. I know I can see the Aberdeen. Like I know I can see Pictou County. And I can see the ... like Strait Richmond Hospital in Port Hawkesbury. And I can see Cape Breton. Yeah.

THE COURT: Okay.

A. Yeah.

THE COURT: Sorry.

MR. RUSSELL: I'm wondering, Your Honour ...

A. I don't know why.

MR. RUSSELL: ... I notice it's 4:30. I know there are other people here other than me. At that point, I guess it's sort of ... I would plan to canvass access to sort of records. Given the nature of the topic and the time of day, I'm wondering if it's best to maybe try to read the room and get a sense of perhaps we could break until tomorrow?

THE COURT: I'll read the room for you right now. It's 4:30. We're going to break for the day. All right?

MR. RUSSELL: I guess I'll stop there.

THE COURT: Thank you. Ms. Wheaton, you're available tomorrow, please?

MS. WHEATON: Yes.

THE COURT: Thank you very much. So what time are we going to start tomorrow, appreciating that the weather that you had driving in this morning might not be the same weather you'll have driving in tomorrow? 9:30 or 10 o'clock? Where do you come from, Ms. Wheaton?

MS. WHEATON: Antigonish.

THE COURT: Antigonish? Okay. So ten o'clock, please.

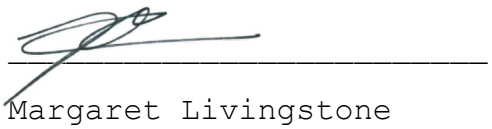
MS. WHEATON: Thank you.

THE COURT: All right. Thank you.

COURT CLOSED (16:33 HRS)

CERTIFICATE OF COURT TRANSCRIBER

I, Margaret Livingstone, Court Transcriber, hereby certify that the foregoing is a true and accurate transcript of the evidence given in this matter, **re Desmond Fatality Inquiry**, taken by way of electronic digital recording.



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