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 12, 2020

COUNSEL: Allen Murray, QC, Inquiry Counsel
Shane Russell, Esq., Inquiry Counsel

Lori Ward and Melissa Grant,
Counsel for Attorney General of Canada

Glenn R. Anderson, QC, Catherine Lunn and
Adam Norton, Esq.
Counsel for Attorney General of Nova Scotia

Thomas M. Macdonald, Esq., and
Thomas Morehouse, Esq.
Counsel for Richard Borden, Thelma Borden and
Sheldon Borden
Joint Counsel for Aaliyah Desmond

Tara Miller, QC,
Counsel for Estate of Brenda Desmond
(Chantel Desmond, Personal Representative)
Joint Counsel for Aaliyah Desmond

Adam Rodgers, Esq.
Counsel for Estate of Lionel Desmond
(Cassandra Desmond, Personal Representative)

Roderick (Rory) Rogers, QC, Karen Bennett-Clayton
and Amanda Whitehead,
Counsel for Nova Scotia Health Authority

Stewart Hayne, Esq.
Counsel for Dr. Faisal Rahman and Dr. Ian Slayter

Marjorie Hickey, QC,
Counsel for Catherine Chambers

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EXHIBIT LIST

February 12, 2020

COURT OPENED (11:03 HRS)

THE COURT: Good morning.

COUNSEL: Good morning, Your Honour.

THE COURT: Mr. Russell?

MR. RUSSELL: Yes, Your Honour. The next Inquiry witness would be Nurse Ellen MacDonald.

ELLEN MACDONALD, affirmed, testified:

THE COURT: Good morning, Ms. MacDonald.

MR. MACDONALD: Good morning.

THE COURT: Ms. MacDonald, in the event that you want a drink of water, just help yourself. There's water there, as well. There's going to be documents that will be brought up on the monitors. All of the documents, there's also a paper copy in either of the volumes in front of you. If you're more comfortable looking at paper, just open them as you might need them. All right?

MR. MACDONALD: Thank you.

THE COURT: Thank you. Mr. Russell?

DIRECT EXAMINATION

MR. RUSSELL: Good morning, Ms. MacDonald.

A. Good morning.

Q. Could you state your full name for the Court?

A. It's Ellen Maureen MacDonald.

Q. And what is your occupation?

A. I'm a registered nurse at the Emergency Department at

St. Martha's.

Q. And how long have you been a nurse?

A. 1981.

Q. So that's quite a number of years, I guess.

A. Yeah.

Q. And have you spent your whole career at St. Martha's or ...

A. No. I worked in Edmonton at the University Hospital '81 until '87. Started at St. Martha's in '88. Worked ICU/PCU for ten years. And I've been in the Emergency Department since 1998.

Q. So in your time in the Emergency Department, had you had many years of experience as a triage nurse in that department?

A. We started triage while I was in the department.

Q. And how many years would you have worked triage?

A. Would probably started it six years ago, maybe.

Q. So in your experience of being a triage nurse, are you able to ... I'm not going to ask you for an exact number, but are you able to estimate the number of patients you might have triaged over the years? Would it be hundreds, thousands?

A. I'm going to say hundreds, I guess.

Q. And in your experience, have you had experience triaging patients presenting with ... in some form of mental health crisis or mental health complaints?

A. I have.

Q. I'm just going to ask you a little bit about the general triage process. We heard quite a bit from various people that have testified already, but it's probably best to hear it directly from the person that actually does it. So would it be fair to say yours is sort of first point of contact between a patient that presents at the ER and ultimately the healthcare system as it is in the ER?

A. Yes.

Q. So what are some of the things you do when a patient presents to you in triage?

A. So a patient comes into the triage room, passes me his health card if he has one. I swipe the card and that generates an eTriage form.

Q. What's an eTriage form?

A. So that's the electronic triage system that we use at St. Martha's. So I will ask the patient why they're in the department, what's their presenting complaint. I'll take a little history from the patient, get a medication history from

them, if they know what they're on, and check their vitals.

Q. How long does this typical triage ... I know it can probably vary, but typically how long does the triage process last, the interaction between you and the patient?

A. It's supposed to be three to five minutes. Some take longer. Most don't take any less time than that.

Q. And I understand that there are five different levels of triage priorities.

A. Right.

Q. One being the most urgent, I guess, and five being the least of ...

A. Right.

Q. ... urgency? Are you able to give sort of an example of someone with mental health symptoms ... presenting for mental health-related concerns that would be given priority number one, the most urgent priority?

A. I would say a patient that's psychotic or not in his right frame of mind, not making I guess wise decisions for himself.

Q. Anything sort of ... what would be an example of a patient presenting with mental health-related concerns that would be a five, the least urgent?

A. I don't think I ever give fives to any mental health patients.

Q. Okay. And now ...

A. Just were ...

Q. ... as a rule, why would that be the case?

A. I guess I just feel like we need to see them and they're presenting for a reason.

Q. And is there a particular need to see them that's more urgent than a five when it comes to mental health, in your opinion?

A. If somebody comes in and tells me that they're suicidal and they have a plan, they're triaged to two and we bring them into our department, into our interview or ... if our interview room is being used, we bring them into one of our exam rooms.

Q. Okay. So if we can look at Exhibit 109, if ... can you see that in front of you?

A. I can.

EXHIBIT P-000109 - NOVA SCOTIA HEALTH AUTHORITY - TRIAGE CODES

Q. So over on the right side of ... I guess what is this, in general, that we're looking at?

A. So this is ... these are CEDIS codes. So it's

Canadian Emergency Department Information System. So after I triage a patient, I find him or her one of these codes as to their presenting complaint.

Q. Are you able to ... so these are pretty sort of scripted codes that are ... you select one from the drop-down menu?

A. We have a laminated paper with it on it. Yes.

Q. And the goal, I guess, is to use the code that best describes the symptoms that are being disclosed to you from the patient?

A. That's right.

Q. Are you able to select more than one code at a time?

A. No.

Q. Are you able to alter the description or alter ... the description that comes along with the code, are you able to alter that at all?

A. No.

Q. So if we go through ... if you look at the right side of the page, I believe there are eight codes under "Mental Health".

A. Yes.

Q. So the first is "Depression/Suicide". What are the

sort of things that you would be ... need to be told to sort of indicate that someone is in for the purposes of depression and suicide?

A. If a patient came in and told me that he was feeling depressed, was having thoughts of self-harm, then that would be the code I'd select for him.

Q. And there's another one there that has "Hallucinations". I guess so again I ... it's fair to say if they reported they were having hallucinations, showed signs of that, you would code them as that's the reason?

A. Right.

Q. Do sometimes these symptoms, I guess, and prescriptions overlap with each other? So someone could actually have anxiety, violent behaviour, and hallucinations?

A. They could. Yes.

Q. So how do you go about conveying that when you do your triage report, if they have a multiple cluster of these pretyped codes?

A. I would include those symptoms in the typewritten history that I write.

(11:13:03)

Q. Okay.

A. Yeah.

Q. One in particular that I'm interested in is the code that has "Anxiety/Situational" and it has a "C". I'm assuming that's "crisis"?

A. That's right.

Q. So what is that, to your understanding? When you enter that in for a patient in the ER and you code them as situational crisis/anxiety, what sort of patient is that? How are they presenting and why?

A. I guess something has happened in their life or in their recent hours/recent days that has affected them and that they're not coping.

Q. So it has an element of recency to it?

A. I guess if they're presenting to the Emerg and they tell me that, yes.

Q. If we could look at Exhibit 67, page 24. I'm wondering if we could just zoom in a little bit at the top portion? So do you recognize what this chart is?

A. Yes.

Q. What is it?

A. So that's my eTriage form.

Q. From when?

A. From December the 1st, 2016.

Q. And it's in relation to which patient?

A. Lionel Desmond.

Q. So December 1st, 2016, you were obviously the triage nurse that would have triaged Lionel Desmond?

A. Yes.

Q. So earlier you talked about swiping a card and you'd get some information?

A. Yes.

Q. When you see the name "Lionel Desmond" and address, it looked like a healthcare number; family doctor, Anita Foley, is that sort of information automatic after you swipe the card?

A. It is. Yes.

Q. So on this particular date, we have two times listed. If you can see, there's R-E-G time, 11:28 and then there's another time 11:40. What is R-E-G time?

A. So that would be the registration time. That would be the time that would come up when I would swipe the patient's Nova Scotia Health Card.

Q. And what is the other time that has 11:40?

A. 11:40 would be when I would send the patient to talk to our secretary or our ward clerk to finish up the

registration. At that time, they confirm address, family doctor, all that other stuff.

Q. So is it fair to say that you would have spent approximately 12 minutes with Lionel Desmond on December 1st, doing the triage?

A. Yes.

Q. And below that we see ... you had indicated that you take vitals. We have temperature, pulse, R-E-S-P. Is that respiration?

A. Yes.

Q. Blood pressure. Was there anything about Lionel Desmond's vitals that caused you concern or anything notable?

A. No.

Q. And then we go down ... if we can just scroll down a little bit. You talked about you would put it in your report, I believe it was you said. So below here we have, "Looking to speak ..." Is that the start of a report that you enter?

A. Yes.

Q. I'm wondering if you could just read that into the record what your report was?

A. So: "Looking to speak to 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."

Q. I appreciate that's the note that you made going back on December 1st, 2016. That was some time ago. I'm just going to ask you a few questions about different parts of that note to see if you recall a little bit more in your interactions with Lionel Desmond. So, overall, do you recall Lionel Desmond sort of presenting in the ER that day?

A. I do.

Q. And were you able to sort of make any general ... was he by himself or was he with anyone, that you are able to recall?

A. As far as I know, he was alone.

Q. Were you able to get a sense of his overall demeanour as he interacted with you that morning or that, I guess, morning. Yes.

A. He was pleasant with me, cooperative. He didn't seem anxious.

Q. So if he had sort of appeared manic, angry, or aggressive, those type of terms, would you have noted that, as a rule, in your report?

A. I would.

Q. How was he in terms of being able to sort of interact with you when you're asking sort of questions along the lines of asking him why he was there? Was he able to articulate to you clearly why he was there?

A. Yes, he was.

Q. So one of the ... a few things you indicate, you said, "Problems with home life." Do you recall what he was referring to there?

A. That he and his wife were having interpersonal relationship issues.

Q. Do you recall if he expanded on that?

A. I don't recall.

Q. Did you get a sense of how long those interpersonal relationship issues were occurring? Was it something that was recent, a one-off, or something that had been longstanding for a while? Did you get a sense?

A. I did not.

Q. You indicated, as well, anger issues. Did he give examples or expand upon anger issues?

A. He told me he was having frequent outbursts at home, frequent outbursts.

Q. And I note that you had noted ... you didn't just say "outbursts at home". You had entered, "frequent outbursts at home". Was that sort of deliberate on your part to give a description as to the level of recurrence of outbursts?

A. The patient would have told me that.

Q. He would have used the word "frequent"?

A. He would have used ... yes.

Q. And you understood that to be more than just once or twice. Frequent is "frequent"?

A. Frequent is "frequent".

Q. Did he give examples of these frequent outbursts at home?

A. He did not.

Q. You also noted "temporary separation". You understood that to be temporary separation from who?

A. From his wife.

Q. Did he give a sense of how long they had been separated or any circumstances around that?

A. No.

Q. And he also spoke about seeing Dr. Slayter?

A. So I would ask him ...

Q. Yes.

A. ... if he's followed by ... or he had ... if he had seen anybody in our Mental Health Department. And he would have provided that information to me, that he had seen Dr. Slayter. And I would ask when he saw him last.

Q. And you understood ... you knew who Dr. Slayter was, I guess.

A. Yes.

Q. And then at the end, it says, "Wants to see someone in Mental Health."

A. Yes.

Q. Is that a request that he had?

A. Yes.

Q. Did he specify who he wanted to see in Mental Health?

A. He did not.

Q. Did you get a sense of was there any sort of urgency on ... he did obviously attend ER, but did you get a sense whether there was any urgency on his part, that he was very driven, I guess, to see someone in Mental Health?

A. I did not.

Q. Overall, in your interaction with him and your note that you made, did you get an impression one way or the other whether Lionel Desmond had ... that the problems he had

described and the concerns he had, did you get a sense of whether this was sort of a one-off bad day or something that had been sort of fairly frequent and sort of lingering around for a while?

A. I did not.

Q. One way or the other, you didn't?

A. No.

Q. Did you make any notable sort of physical observations about Lionel Desmond that morning, anything about the way he was dressed or how he appeared?

(11:23:00)

A. I did not.

Q. How would you ... if you were asked to sort of, in your recall, describe his mood, how would you describe his mood that morning as he interacted with you?

A. He was pleasant with me. He wasn't angry. He seemed calm.

Q. How was his sort of affect?

A. Well, I don't think he was smiling at me, but ... I don't recall.

Q. So you ultimately scored him as a level three, according to just above your notes. It says, "Triage level

three".

A. Right.

Q. Why did you score him, I guess, a level three and what was the significance?

A. I think most of us that work in Emerg give mental health patients a three. Just with his presenting complaints, we wanted to have him see somebody.

Q. There's a spot that is ... that's there where we have the times. We notice the times 11:28/11:40. To the right it has, "Chief Complaint". Do you see that?

A. Yes.

Q. And it says, "Anxiety/Situational CRI" for crisis. Below that, it says, "Old chart obtained", and there's a box. What's the purpose of that? What is that?

A. We used to have a system where ... or we ... yeah. I guess now we ... all of our charts are scanned, so charts are available on our MEDITECH. But there was a system where, if required, we could get the old charts from Medical Records.

Q. And so at this time in 2016, I take it the charts weren't scanned or were they?

A. I don't believe they were scanned then.

Q. So when it says, "Old chart obtained", what sort of

charts would that be? What sort of records would that have been that you would have had maybe access to to obtain?

A. So it would have been the patient's previous medical history.

Q. And "previous medical history", did it apply to sources outside of the hospital setting or the ER setting?

A. No. The Emerg at St. Martha's ... or the St. Martha's Hospital.

Q. So "old chart obtained" would have applied to any old charts that had been present for St. Martha's.

A. Right.

Q. And limited to that only.

A. Right.

Q. So after you had triaged Lionel Desmond on that date, do you recall seeing where he went?

A. I would send him, as I said, to finish his registration with our ward clerk and he would have a seat in the waiting room.

Q. And do you recall when your shift might have ended that day?

A. It would be at 7 that night, but I finish Triage at 1 o'clock.

Q. Okay. So after Triage, where did you go?

A. I went to nursing on the floor.

Q. All right.

A. In Emerg.

Q. So did you see Lionel Desmond after you had triaged him?

A. I did not.

Q. And that was on this date, December 1st.

A. Yes.

Q. My ... a question here is, so December 1st at 11:28/11:40, this was a weekday, through the week. Lionel Desmond had ... to your knowledge, I guess, at this time, was there a mental health crisis team in place?

A. Yes.

Q. And who was the team, I guess, like to your recollection?

A. Well, I think it was Heather Wheaton at the time.

Q. And, normally, someone like Lionel Desmond presenting the way he did on that day, would you normally have called Crisis for a consult?

A. Normally. Or I would ... if I was concerned about him, I would have brought him in right away and pass him on to

one of the nurses working on the floor. I would also make a note that he was looking to speak to someone in Mental Health, so that we would give Crisis a call.

Q. And who would normally do the call to Crisis? Would it be the triage nurse?

A. Not usually because ... unless Triage wasn't busy. And I can't speak to Triage that day. It could be one of the nurses on the floor. Yeah.

Q. After they see the note in the chart.

A. Yes.

Q. So was there a particular reason why perhaps when you were presented with those complaints and symptoms why you didn't call Crisis yourself?

A. My job that day would have been triage, so I'm sure I was probably busy with that.

Q. And generally, I guess, in 2020, is it possible or reasonable to have a scenario where it's put in place that the triage nurse, who is the point of first contact, is presenting with those symptoms, mental health, and suspects maybe Crisis should be involved, that the triage nurse kind of ... is it possible to add that to the triage nurse's responsibilities?

A. I suppose, but I guess it depends on the busyness of

the activity that day.

Q. But as a rule, I guess, in 2020 and going forward, is that something that could be manageable from a Triage nurse's perspective that they're the point of first contact, they see this, We'll make a call into Crisis or notify Crisis.

THE COURT: Just before you answer that, just let me see if I can clarify something. I understood that at the time, from Ms. Wheaton, that there was a time when the Crisis Team, her, she could start an assessment but that since, at some point in time that's changed so that they cannot now do the assessment until the ER doctor says yes. So the question, I guess, that you're asking Ms. MacDonald really would be, yes, she could do it but right now she can't do it until the ER doctor signs off on it.

MR. RUSSELL: You're right, Your Honor. I had lost that aspect.

THE COURT: So we now have the intervention of the, as I understand from Ms. Wheaton, the ER doctor has to kind of sign off before the Crisis Team actually starts its assessment?

A. That's right.

THE COURT: That's how it works now?

A. Yes.

THE COURT: So you could only bring, your notes bring the urgency of the matter to somebody else's attention or you could hand the patient off directly to a nurse, bringing it to their attention so that they could then start that chain reaction, so to speak?

A. Yeah.

THE COURT: Would that be fair?

A. Yeah.

THE COURT: That's how it works. Thank you.

MR. RUSSELL: Thank you, Your Honour.

THE COURT: Thank you.

MR. RUSSELL: I wonder if we could turn to page 22 of that exhibit, if we could zoom in. So here we are, do you recognize this document?

A. Yes.

Q. It's the emergency care record of Lionel Desmond from the same date.

A. Yes.

Q. And if you scroll down just a little bit, please, "Triage Assessment", that is your triage assessment?

A. Yes.

Q. Now I appreciate that you indicated that you didn't

have any further contact with Lionel Desmond or involved in where he went after triage, but I just want to get your perspective on, if we could scroll down a little bit, the procedure surrounding if someone leaves the ER or kind of goes missing from the ER after being triaged. So we see a note here that says, at 15:10, "Not in waiting area" and it's initialed. Now obviously you didn't make that note.

A. Right.

Q. And then there's a stamp here. What is this, have you seen this sort of stamp before?

A. I have.

Q. What is it?

A. So any patient that leaves our department without being seen, we have a file folder, so their chart is put into the folder and on the next day shift the doctor coming on for their Emergency shift, they have a look at the charts to see who's left without being seen and they direct the staff as to whether the patient needs a callback to come back or if they don't.

(11:33:28)

Q. So the ultimate, I guess, responsibility of, look, somebody needs to call that patient back is, rests with the ER

doctor?

A. That's right.

THE COURT: And that's the following day?

A. That's the following day.

MR. RUSSELL: So in this here particular stamp we have a signature up top. Do you recognize the signature?

A. I do.

Q. And whose signature is that?

A. It's Dr. Maureen Allen.

Q. And it is "Phone" ... f/u is follow-up?

A. Yes.

Q. So "Phone f/u required", and it says, "No, file chart is ticked off."

A. Yes.

Q. What does "No, file chart ticked off" mean?

A. So that the patient did not need to be called back and that the chart could be disposed of.

Q. And at the very bottom there's a box ticked off and it says "F/u completed" and "file chart."

A. Right.

Q. What is that saying?

A. So it means follow-up completed, so that doctors felt

that the patient did not need to come back and that the secretaries could file the chart as being completed.

Q. So the chart kind of goes back into the, I guess, the land of hospital charts?

A. To Medical Records, yes.

Q. So to your knowledge, are there ever any circumstances where you're aware that the ER doctor on shift the next day would say, This patient has to be called back? They left or they were missing but they should get a callback?

A. Yes, there are circumstances.

Q. And in the past, in your experience, what sort of circumstances have they been?

A. I guess there can be various complaints. I have called patients back at the request of the doctor. If they've had their child into Emerg the night before, with a fever, and they didn't wait to get seen, the doctor will ask that a nurse, myself, one of my coworkers or our unit coordinator call to make sure that the child has or that the parents are going to bring the child somewhere, family doctor, back to Emerg, for follow-up.

Q. Have you had experiences where this sort of scenario has happened, that the patient has left the ER, the ER doctor

speaks to you about calling the patient back but in a situation where it's been a patient with mental health-related symptoms or presentations?

A. I haven't, not with mental health.

Q. So to your knowledge, I guess, and you've probably already answered this, but do you know if this ... We now know that Lionel Desmond had an appointment with Dr. Slayter the next day, December 2nd of 2016. To your knowledge, did this triage or very brief report get sent to Dr. Slayter's office?

A. I don't know that.

Q. And in your experience, when this happens and it's signed off by the ER doctor the next day, "No follow-up required, file chart", where does the chart go, as a rule?

A. To Medical Records.

Q. So it's not sent anywhere else?

A. No.

Q. I understand that you might have encountered or had a contact with Lionel Desmond on another occasion?

A. I did.

Q. And I believe that was when?

A. I was working the night of January 1st when he stayed in our department.

Q. And that was in St. Martha's?

A. Yes.

Q. So do you recall ... what do you recall of your interaction or the circumstances surrounding Lionel Desmond's stay that particular evening of January 1st?

A. So Dr. Rahman came to see him on consult. Dr. Rahman came and asked me if Mr. Desmond could stay in our Emergency Department, he had had a fight with his wife, he had nowhere to go and he needed a place to sleep. Our Observation unit was quiet at that hour of the night. I think he didn't want to go upstairs because his wife worked there, from what I understand, and he slept in Observation bed 2.

Q. And is it typical for the psychiatrist, I guess, the treating psychiatrist, to consult the nurse that's on shift that particular evening about accommodations?

A. It does happen. I think the fact that Mr. Desmond's wife worked in Mental Health and he didn't want to be up there that night.

Q. And did you have any direct contact with Lionel Desmond on January 1st?

A. I don't recall.

Q. As a result of that conversation with Dr. Rahman, did

you sort of take any sort of action or what did you do from there, do you recall?

A. I think I had a conversation with Lee Anne to say we could put the patient in Obs bed 2, where it was quiet, and hopefully he'd get some sleep.

Q. And Lee Anne at the time was Lee Anne Graham?

A. That's right.

Q. Lee Anne Watts now, right?

A. Right, yeah.

Q. And did you ever go over around Observation bed 2 where Lionel Desmond was?

A. I did not.

MR. RUSSELL: No further questions, Your Honour.

MS. WARD: No questions, Your Honour.

THE COURT: Thank you. Ms. Lunn?

MS. LUNN: I have no questions for this witness.

THE COURT: Thank you. Mr. Macdonald?

MR. MACDONALD: Thank you, Your Honour, I have a few questions.

CROSS-EXAMINATION BY MR. MACDONALD

(11:40:49)

MR. MACDONALD: Good morning, Ms. MacDonald.

A. Good morning.

Q. I'm Tom Macdonald, lawyer for Shanna Desmond's mother and father and brother, Aaliyah's grandparents and uncle. So you were there on January 1st, 2017, when Mr. Desmond came to the hospital?

A. I was.

Q. When did your shift for that day end?

A. In the morning, at 7:15.

Q. Of January 2nd?

A. Right.

Q. Did you Dr. Rahman interact at all on January 2nd with Mr. Desmond?

A. I did not.

Q. Do you have any evidence you can give us today that there was an interaction that you've heard about since that event between Dr. Rahman and Mr. Desmond on January 2nd before he was discharged?

A. I cannot.

Q. Okay. Have you had occasion to discuss the events

that bring us here today with Dr. Rahman since January 2nd, 2017?

A. I have not.

Q. Those are my questions. Thank you very much.

THE COURT: Mr. Rogers, you're going to defer to the end, are you?

MR. ROGERS: If I could, please.

THE COURT: No, that's fine. Ms. Miller?

MS. MILLER: Thank you.

CROSS-EXAMINATION BY MS. MILLER

(11:42:06)

MS. MILLER: Ms. MacDonald, I'm Tara Miller, I represent Brenda Desmond through her personal representative and share representation with Mr. Macdonald of Aaliyah Desmond.

At Exhibit 67, page 24, Mr. Russell took you through this triage record. This is the electronic triage record. I just wanted to get a bit more detail on the box under "Visit". There's a checkoff box that says "Old Chart Obtained", and that box isn't checked off, correct?

A. Correct.

Q. Okay. So I take from that that, as part of building

Corporal Desmond's emergency room chart on December 1st the only material that would have been in it would have been the triage record and the emergency care record that we see at page 22?

A. Yes.

Q. Okay. So there would have been no other information in that physical chart for anyone in the Emergency Room, physician or mental health crisis individual, to look at at that time?

A. If the doctor requested the chart, we could certainly get it.

Q. Okay. So it would have been incumbent upon the doctor to request any prior charts and then that would have triggered Records to produce that material?

A. Yes.

Q. Okay. I have seen other emergency care records for other hospitals in the course of my practice where there is a box in the record that says "Last Emergency Room Visit". I don't see that box in any of the St. Martha's Regional Hospital emergency care records. Is that your experience, that there's no place in any of these forms to capture sort of the last prior Emergency Room visit?

A. That's right.

Q. Yeah. Have you seen ... You indicated you worked in Edmonton, I think, for a while. Have you seen other Emergency Room intake records where there is actually a box where you can note, where the system would gather automatically the individual's last Emergency Room visit?

(11:44:00)

A. I don't know.

Q. You don't know. Okay. Fair enough. And if I understand your evidence, just again to be clear, as the triage nurse on December 1st it wasn't your job to enlist or to call for a consult the mental health crisis team, is that correct?

A. Correct.

Q. It would have been the job of the ER nurse, who would have taken a look at the chart at that time to make the decision to enlist the mental health crisis team?

A. Yes.

Q. Okay. And you have no information to add about whether or not that call was made to enlist the mental health crisis team on December 1st?

A. I don't know if our Crisis worker was in our department at that time with another patient.

Q. Okay.

A. I can't speak to that.

Q. Okay. Thank you, Ms. MacDonald.

THE COURT: Mr. Rodgers?

MR. RODGERS: Thank you, Your Honour. No additional questions.

THE COURT: Thank you. Mr. Hayne?

MR. HAYNE: Thank you, Your Honour.

CROSS-EXAMINATION BY MR. HAYNE

(11:45:21)

MR. HAYNE: Just a few questions, Ms. MacDonald. My name is Stewart Hayne, I'm counsel for the physicians in this matter.

I just wanted to ask you a few questions about the Emergency Department and the triage system, just for background purposes. Is it fair to say that in the Emergency Department the time it takes for any one particular patient to be seen is dependent on, at least in part dependent on how busy the department is as a whole, is that fair?

A. Yes.

Q. Yeah. So for example, if someone comes in with a burn on their hand, something like that, if the department is

busy they may wait maybe an hour, or a cut on the hand or something, they may wait for an hour or two or whatever to be seen by the Emergency Department physician, whereas if the department is not busy, they may be seen quite expeditiously, is that fair?

A. That's right.

Q. Okay. And the triage system, we talked a little bit about it, with a score, triage score of 1, typically that patient is rushed in to be seen by the physician very quickly, is that fair?

A. That's right.

Q. Okay. And then a patient with a lower level, something in the 3 or 4 of 5, for example, again depending on how busy the department is, they may be sent to the waiting room to wait to be seen, is that fair?

A. Yes.

Q. And is the process that once you're in the waiting room, you then are moved into an area with an examination room, and then once you're in an examination room you may still wait a little bit to be seen by the physician?

A. That's right.

Q. Okay. And is it fair that if the examination rooms

are empty, a person may be moved more quickly from the waiting room to the examination room?

A. Right.

Q. Okay. Are there any threshold, for example, or score, triage scores that allows you to ... Let me rephrase that. Depending on the patients who are in the waiting room, does the triage score then determine who gets picked next from the waiting room to go into the area to be seen by the physician?

A. Yes.

Q. Okay.

A. Yeah.

Q. So if you were to assign, for example, a triage level 2 but the department was busy... Let me take that back. If you were to give a triage level of 3, for example, that person may be waiting in the waiting room with other 3s and maybe some 4s or a 5, is that fair?

A. That's fair.

Q. And then when an examination room area becomes available, the 3 would typically be seen before the 4 or the 5, is that right?

A. Yes.

Q. All right. So assigning someone a higher triage score, is that ever used as a mechanism to have the person be able to be taken into an examination room area more quickly?

A. Is it ever used as a mechanism ...

Q. Well, I guess my ... what I'm driving at is, in the situation, for example, where, in the mental health context ... A patient is often seen, as I understand it, in an interview room or a family room as compared to the medical area for examination, correct?

A. Right, yes.

Q. And if you have 3s or 4s or 5s in the waiting room and the family room or the interview room is empty, is it a reasonable process to use a triage score of 2 so that you can then take that person directly into the interview room? Is that something you would do?

A. Yes.

Q. Okay. You also noted that, in addition to the December 1st encounter with Mr. Desmond, you were also working on December 1st and then overnight into December 2nd, is that right?

A. Of January.

Q. Sorry. January 1st over to January 2nd?

A. Yes, I was.

Q. Okay. And would that have been a shift that would have started at 7 p.m. on January 1st and continued to 7 a.m. on January 2nd?

A. Yes.

Q. Okay. And then, typically, you know, although your shift ends at 7 a.m. on January 2nd, you may be in the hospital for a few minutes but, generally, you're out of there soon after your shift concludes, is that fair?

A. Yes.

Q. And that extra time, certainly, is it fair to say that in the ordinary course you would have been at least out of the Emergency Department or the Observation area by 8 a.m.?

A. Yes.

Q. Okay. Thank you. Those are my questions. Thank you.

THE COURT: Mr. Rogers?

MR. ROGERS: No questions, Your Honour.

EXAMINATION BY THE COURT

(11:50:50)

THE COURT: Ms. MacDonald, I have a couple of questions

for you.

A. Okay.

Q. If you could help me out here. I know that on January 1st, 2017, you were working in Emergency that day, that you were ...

A. That night.

Q. That night, rather.

A. I worked the night shift.

Q. Sorry, that night. But you weren't doing the triage?

A. I wasn't.

Q. Was not. So you would, in the normal course of events, you would be tending to patients that were in the ER setting including, as well, perhaps in the Observation beds, as well?

A. So I wouldn't be ... We had a dedicated Observation nurse and that night it was Lee Anne.

Q. That was Ms. Watts.

A. Yes. So I would be tending to the patients in the Emergency Department.

Q. All right. When Mr. Desmond presented at the Emergency Department on January 1st, he would have presented his Health card, there would have been a swipe of his Health card

that would have produced the same kind of form that you talked about earlier from December 1st, correct?

A. Yes.

Q. So if we could go to page 35 of Exhibit 67. This is just for reference, I appreciate that you did not have a hand in creating it, but I just wanted you to have a look at that. So that was from January 1st?

A. Yes.

Q. And so there's a triage level 2. Now this is my question for you, series of questions - You have a clipboard or a file or a form or something that day. Is that the first piece of paper that winds up in it? Is it a clipboard? What's the physical way that documents are kept track of?

A. So we keep them ... we would clip this, as well as the Emergency form that goes with this, after they speak with the secretary, and we paperclip them together. The fact that this patient, I see there he was triaged a level 2.

Q. Mm-hmm.

A. So he would have been brought in right away and he would be placed on the clipboard as to what room that he was put in.

Q. Okay. It's physically on a clipboard now?

A. Yes.

Q. And that clipboard is associated with that room?

A. Right.

Q. When you have ... And I appreciate the documents get added to the clipboard as the night goes on to keep track of medication reconciliation and various other documents, right?

A. Yes.

Q. All right. And one of the things that would be added to that clipboard would be the physician progress notes. And if you could just have a look, start at page 38, please, the same exhibit number. Okay? So those get added to the clipboard as they're made or do they get made at a later stage, or is there any particular practice how they're made?

A. So our clerk would go into the "Visit", or I guess I could go into the "Visit".

(11:54:04)

Q. Yes.

A. So you go according to the patient's HV number that you see on the lower right.

Q. Yes.

A. So that number is associated with that particular visit. So we would print off of our computer physician progress

notes, prescriber's order sheets, we could print a medication reconciliation chart, and whatever other forms the doctor would need or what we felt they might need.

Q. So these physician progress notes, there's two pages, page 38 and 39. If you'd just go over to 39. After Mr. Desmond left, would these two pages have been part of that clipboard ...

A. Yes.

Q. ... in the normal course of events? Yes?

A. Yes.

Q. And when he leaves, Mr. Desmond is discharged and he leaves, the clipboard is there, where does that clipboard physically go?

A. So after the doctor and after the nurses complete their charts ...

Q. Yes?

A. ... we give it to the secretary or we put it in the complete pile. We have a two-tiered thing - the top part is for incomplete charts, the bottom is for complete charts - the charts would go in there. If the patient was in Observation, as I do, I would hand the chart to the ward clerk to say this chart can be disposed of, I've finished with it.

Q. And the ward clerk would then be responsible for

getting it to Medical Records?

A. Yes.

Q. And do they ...

A. They do some procedure and that disposes of the chart. I can't speak to that and I'm ... They take them to Medical Records.

Q. If you'd look at the bottom of page 39 you can see that in the, I'm going to call it in the body of the progress notes, in the form, where the lines are, there's a plan and it's signed off, and then below that there's 02-01-17 and then there's some handwritten notes and it's signed by Dr. Rahman.

A. Yes.

Q. In the normal course of events, do doctors make notes on charts like that and, if they did, would they do that before the chart moved out of the area where it would normally be housed or can you say if there's any kind of standard way they do those things?

A. I guess that each doctor is different. I can't speak to what they do.

Q. Okay. Thank you.

THE COURT: Any questions, Counsel? No? Thank you.

MR. RUSSELL: I just have two, Your Honour.

THE COURT: All right. Sorry.

RE-DIRECT EXAMINATION

(11:57:53)

MR. RUSSELL: Just during your career since... I believe you said 1981?

A. Um-hmm.

Q. There was various opportunities for nurses to have continuing medical education as it relates to different areas. To your knowledge, have you ever been offered or aware of any continuing education as it relates to mental health in terms of patients with mental health crisis?

A. We have education days that are offered annually, and sometimes there are speakers at those, at those things. We did have an education day for mental health that was held in the fall. I haven't gotten to that, I had prior commitments. I believe it's going to be offered again.

Q. In terms of domestic violence or risk factors for domestic violence, do you recall any sort of opportunities for training or education in that regard?

A. I don't.

MR. RUSSELL: No further questions, Your Honour.

THE COURT: Thank you. Thank you, Ms. MacDonald, you're free to go. Thank you for your time.

A. Thank you.

WITNESS WITHDREW (11:59 HRS.)

MR. RUSSELL: The next witness, Your Honour, would be Nurse Amy Collins.

THE COURT: Ms. Collins?

AMY COLLINS, affirmed, testified:

THE COURT: Good morning, Ms. Collins.

Ms. Collins, you're going to be referred to some documentation that will appear on the monitor in front of you but there's hard copies in both the exhibit books. You'll be referred to an exhibit number. If it's easier for you to have a look at the paper copy, just open the exhibit book and help yourself. Thank you.

Mr. Russell?

DIRECT EXAMINATION

(11:59:49)

MR. RUSSELL: Good morning, Ms. Collins.

A. Good morning.

Q. I'm just going to ask you, as best you can, perhaps, to speak up. I know sometimes we all have a tendency to talk low.

A. Okay.

Q. So could you state your full name?

A. Amy Mary Collins.

Q. And what is your occupation?

A. Registered Nurse.

Q. How long have you been a Registered Nurse?

A. Since 1982. 38 years.

Q. 38 years. What sort of departments have you worked in the 38 years as a nurse?

A. I have worked in labour and delivery units, intensive care units, the emergency room. I also did med/surg in my early years. A very small amount of casual work, and adolescent and adult behavioural medicine, and a very brief period in crisis intervention.

Q. Are you able to say how many of those years were spent sort of in the emergency room?

A. Approximately 17. 17.

Q. And you said, A period of time in crisis intervention. Do you recall when that was?

A. That would have been probably in the early 1990s and it was very brief. I'm talking weeks. Maybe a couple of months.

Q. All right. I'm just going to pull up an exhibit, Exhibit 67, page 35. If you could just zoom in. So in your course of career as a nurse, you've obviously had an opportunity to work as a triage.

A. Yes.

Q. And do you recognize what this document is?

A. Yes.

Q. And is it fair to say that is the triage record relating to Lionel Desmond from January 1st, 2017?

A. Yes.

Q. And were you the triage nurse at that time?

A. Yes.

Q. So you would've completed this particular document?

A. Yes.

Q. I'm going to ask you a similar set of questions. It says, "Register time - 18:51." Or "reg. time". Is that the registered time?

A. Yes.

Q. And 18:51, how does that get coded, I guess?

A. One of them is as I swipe the Health card. The other, I think, is generated when the clerk verifies their demographics. In this case, the times are the same. If I remember correctly, we bypassed the registration desk because I took him to the family room. So I would routinely ask them if any of their demographic information has changed and, if not, we would bypass the clerk and I would just ask her to print the

chart.

Q. And demographic information is name, address ...

A. Address, phone number, family doctor.

Q. All right. So we see a third time, I guess, over to the right of 18:51, just below "printed date", and we have a time oh 19:00 hrs, so 7 p.m. What's the significance of that time?

A. I would assume that's when the chart was actually printed. We put our information in on a computer screen and when we're through, the chart's printed.

Q. And the difference between 19:00 and 18:51 is nine minutes. Is that a fair, rough estimate to say that's approximately how much time you spent with Lionel Desmond while in Triage?

A. Yes.

Q. So if we scroll down, we see his vitals. Was there anything notable or concerning to you regarding his vitals?

A. No.

Q. And we scroll below and we see, I guess, a four-line brief report. Do you see that there?

A. Yes.

Q. Who completed that report?

A. That would be my notes.

(12:04:01)

Q. I'm wondering if you could read into the record what your note was.

A. "Patient dealing with PTSD since 2011. Patient had a bad day today. Argued with partner. Walked a lot to try to calm down. Feels is not coping well and is looking for admission. Calm and speaking quietly."

Q. So this particular note, this information, was obtained from Lionel Desmond?

A. Yes.

Q. And how do you go about sort of getting that information from a patient?

A. My opening question is usually, How can we help you? And I don't recall asking Mr. Desmond a lot of questions. He was quite forthcoming with the information. They had been out. "They" being he and his wife. There was an incident with the vehicle going into the ditch which led to an argument, which led to them both becoming upset, and then he said he went walking for a long time to calm down and then came to our department.

Q. And it says, "Not coping well. Is looking for admission." So I take from that we had actually asked to be

admitted? Actually ...

A. To stay. He implied short term. He sort of gave me the impression he felt like he had no place to go.

Q. Sorry, sort of gave you the impression he had no place to go?

A. Yeah.

Q. And so is it typical, in your experience in triage, that a patient would come right out and say, Look, can I get admitted to the hospital? Can I stay at the hospital?

A. Yes.

Q. That is common?

A. Yes, it is.

Q. And in a situation where somebody presents for mental health-related symptoms, and exclusively mental health-related symptoms or mental health-related crisis, is it common for them to ask directly for admission?

A. It occurs. I don't know if "common" is the right word but, yes, I've had it happen.

Q. And did you get a sense from Lionel Desmond that he really wanted to stay in the hospital?

A. That night? Yes.

Q. We note that up at the top, it says, "Chief complaint

- anxiety/situational crisis."

A. Yes.

Q. And that's something that you may have coded?

A. Yes.

Q. And what is your understanding of that concept, I guess?

A. That there was a triggering event to this situation which was the accident with the vehicle that led to a disagreement.

Q. If, say, Lionel Desmond had appeared to you to be manic, not making sense, or angry, would those sort of things have made it into your report?

A. I think so, yes.

Q. And to your recollection, was he any of those things?

A. No.

Q. How would you describe his sort of willingness to sort of engage with you and discuss what was happening, what he was experiencing?

A. He freely gave all the information to me. There wasn't a lot of prodding involved.

Q. You had given him a triage score level of 2.

A. Yes, I did.

Q. And I guess we now know 1 being the most urgent, 5 being the least urgent. So what is a level 2?

A. A level 2 is urgent. It's someone that I'm hoping will be able to speak to a doctor in a relatively short period of time.

Q. And given your experience in the ER and, in particular, people presenting with mental health symptoms, why did you use your judgment here to say, Lionel Desmond, as he's presenting, is a level 2, which is, I understand, fairly urgent, but why in this case?

A. Not knowing his history at all, he presented with a very recent situation that had led to an escalated argument, and he had told me it had taken him a very long time to calm down before he came to Emerg, and, in my eyes, although he was very calm at the time, there was a potential for deterioration.

Q. And when you say "potential for deterioration", what do you mean by that concept?

A. That could go in very many different ways but I'm ... I can't be reassured that he is going to remain calm and quiet. This is very recent to the event that triggered his anxiety.

Q. Okay. And I'll ask a similar question as I asked Nurse Ellen MacDonald. This is at 6:51 p.m., almost 7:00 in the

night. Were you familiar in 2016 with a crisis team that was at St. Martha's?

A. Yes.

Q. And who comprised that crisis team?

A. I don't know all the nurses on the team but it was a group of mental health-trained nurses.

Q. And normally, as a triage nurse, would you have reached out to the crisis team?

A. This incident happened outside of their hours. It wasn't an option at that time.

Q. So you were aware that there wasn't a crisis team available when he presented to you in ER.

A. Yes.

Q. And had there been, would you have consulted the crisis team?

A. I think I would have, but I don't recall if the physician prior to the crisis team was in effect at that time or not, because there was a period of time that they did have to be seen by the physician before being seen by the crisis team and I don't recall what was in effect at that time.

Q. So you don't recall if the rule of "has to be seen by ER physician ..."

A. (No audible response.)

Q. Okay. But had it been a scenario, I guess, where the rule wasn't in place, as it is new - you have to be seen by an ER physician who then makes the call to Crisis. Had that not been the case, I guess, in 2016, would this have risen to a level where you would've said, I'm going to put in a call to Crisis if they're available?

A. Yes.

Q. I note as well, there's a spot where you see "old chart obtained".

A. Yes.

Q. And there's no check mark there.

A. I did not obtain the old chart.

Q. Okay. I understand that after your time spent with Lionel Desmond in Triage, you might've had some further contact with him at some point maybe into January 2nd?

A. Very briefly. The following morning when I came on duty, I was simply assisting delivering food trays for the Observation nurse and I delivered his food tray to him.

Q. Are you able to recall how long of an interaction that might've been?

A. Probably less than minute, and I don't remember the

exact words, but it was in the context of how he was doing that morning, and he responded positively in the sense that he was feeling better.

Q. Was there anything sort of brought to your attention in that brief interaction that would've gave you cause for concern about his mental health?

A. No.

Q. Any sort of physical cause for concern?

A. No.

Q. If we could look at Exhibit 67 again, page 22. I guess a product of being a busy nurse, you work a lot of shifts.

A. Yes.

Q. So do you recognize this emergency care record?

A. I do.

Q. And it indicates "December 1, 2016. Lionel Desmond. St. Martha's Hospital."

A. Mm-hmm.

Q. Had you been working that day?

A. Yes.

Q. What area in the hospital had you been working on December 1st, '16, at that time?

A. In the Emergency Department.

Q. And the time appears to be ... obviously, we know It you worked triage on December 1st. It looks like a triage time of 11:28, but if you can scroll down, we see a triage description.

A. Mm-hmm.

Q. "Looking to speak to someone in Mental Health." And it continues. Are you familiar with that chart?

A. Yes.

Q. And then if we look down at "15:10", there's a note. What does that note say by "15:10"?

A. "Not in waiting area." And those are my initials.

Q. Those are your initials.

A. Yes.

Q. So you were working in ER.

A. Mm-hmm.

Q. What do you recall about making that sort of note?

A. I don't actually recall this but what would've happened is there would've been a room free and I would've gone to the slot of three charts, or triage three charts, and picked up the next chart, which would've been this one, and gone to the waiting room to get him but he was not there.

(12:14:12)

Q. So when you noted that he was not there you made the note "not in waiting area", that is the next step that you took?

A. I give the chart to the clerk, tell them that the patient was not there. They stamp it and it goes into a folder for follow-up.

Q. And if we look down below just a little bit more, we see what appears to be a stamp here "screened by" and signature.

A. Yes.

Q. Is this the stamp you're referring to?

A. Yes.

Q. And the signature, do you recognize the signature?

A. Yes.

Q. And who is that?

A. Dr. Maureen Allen.

Q. So this stamp, was it present when you entered your note "Not in waiting area"?

A. No.

Q. Okay, so do you have sort of any responsibilities at that time, aside from noting "not in the area", when you bring the chart to a specific spot where it goes for people that didn't show up? Do you have any further responsibilities or obligations to notify anyone else that the patient is no longer

there?

A. No.

Q. To your understanding who assesses that, I guess, chart that has the missing patient?

A. It's reassessed the following day by the Emergency Room physician.

Sorry.

Q. I'll just get you to repeat that, sorry.

A. It's reviewed the following day by the Emergency Room physician.

Q. Okay. So during this period of time on December 1st of 2016 we know Lionel Desmond was triaged, we know that you were the ER nurse, and then we know that he left at some point. To your knowledge, was the crisis team that was in place called in on that date?

A. I don't recall.

Q. And to your understanding in 2016, who had the duty and obligation, I guess - or was it shared – to call a crisis team in to speak to Lionel Desmond?

A. I guess you could say it was a shared responsibility.

Q. But to your knowledge, was there any particular person assigned that duty, whether it's triage nurse, ER nurse?

A. No.

Q. No. Okay. No further questions. Thank you.

A. Okay.

THE COURT: Ms. Ward?

MS. WARD: Oh, sorry. No questions, Your Honour.

THE COURT: Ms. Lunn?

MS. LUNN: I have no questions for this witness, Your Honour.

THE COURT: Okay. Mr. Macdonald?

MR. MACDONALD: Thank you, Your Honour.

CROSS-EXAMINATION BY MR. MACDONALD

(12:17:59)

MR. MACDONALD: Good morning, Ms. Collins. I'm Tom Macdonald, lawyer for Shanna Desmond's mother and father, Ricky and Thelma Borden, her brother Sheldon, and share joint representation of Aaliyah Desmond with Tara Miller.

Did you ever have occasion to discuss the events that bring us here today with Dr. Rahman?

A. No.

Q. Thank you. Those are my questions.

THE COURT: Ms. Miller?

MS. MILLER: Thank you.

CROSS-EXAMINATION BY MS. MILLER

(12:18:32)

MS. MILLER: Good morning, Ms. Collins. As you've heard, I represent Brenda Desmond through her personal representative and share Aaliyah Desmond's representation with my friend Mr. Macdonald. Just a couple of quick questions.

You, on January 1st, had triaged Cpl. Desmond as a level 2. You indicated that you had concerns about the recency of his outburst and potential for deterioration?

A. Yes.

Q. Is there anything in your triage policy or training that you received that requires you in a situation like that where you know there's a spouse involved to ask about if there had been any involvement with children?

A. I don't think so.

Q. Okay. My next question is with respect to the electronic system, the triage system, that would have been in place in 2016/2017, and I'm going to look at two documents, both at Exhibit 67. The first is at page 24 and the second is at page 35. So they'll come up on the screen. Actually, if we

could start with the one on page 35.

There. Thank you. This is the triage record that my friend Mr. Russell took you through. This is information that I understand that you obtained from speaking with Lionel on the evening of January 1st?

A. Yes.

Q. Okay, and you would have entered this in. In the middle of the page it says … I think it's "Alerts". Is that the heading on the far left-hand side? Is that "Alerts"?

A. Allergies?

Q. Well, there's a column to the far left-hand side that goes down vertically and there's a hole-punch. But what …

A. Okay. Yes.

Q. Do you know what that says?

A. I think it would be "Alerts".

Q. "Alerts", yeah. Okay, and it says, "Critical care. Allergies, none. PMH", which I understand is past medical history.

A. Yes.

Q. And then it's noted, "PTSD and post-concussion disorder"?

A. Yes.

Q. Okay. And is that information that you would have obtained from Cpl. Desmond?

A. Yes.

Q. Okay, and then we see on that very bottom line, "Admitted elsewhere in previous 12 months."

A. Yes.

Q. And the answer is, "No", and then there's a space for "Hospital" with nothing filled in. Is that a question you would have asked Cpl. Desmond?

A. No.

Q. Okay. Where would that information have come from?

A. That, I'm not sure.

Q. Okay. And the reason I ask is because when we look at page 24 ... and this is his triage record, which I appreciate you didn't fill in. That same space from a month prior. It says, "Admitted elsewhere in previous 12 months". It says, "Yes", and the "Hospital" is indicated as, "Treatment centre, three months. PTSD." So that was my question to you. Where does this information come from to complete this section of the form if someone has been admitted in the past previous 12 months? You don't know where that information comes from?

A. I'm afraid I don't know, yeah.

Q. Okay. You don't recall asking Corporal Desmond that.

A. No.

Q. No, and obviously it doesn't pull. The electronic system doesn't pull information forward. We see that someone had captured information on December 1st that he had been admitted yet in the January 1st, 2017 entry it says he hadn't been admitted. But you don't know where that information comes from.

A. I don't. If it was populated in is it possible that it lapsed over the 12 months in that period of time? But I truly do not know ...

Q. Okay.

A. ... where that information comes from.

Q. All right. My last question is in reference to the December 1st visit when you did go to see Corporal Desmond, having pulled his chart out of the level 3 ...

A. Mm-hmm.

Q. ... triage charts. You said there is no defined responsibility. It's a shared responsibility in terms of who would be responsible for triggering a crisis team?

A. Yes.

Q. And you didn't have the opportunity to see Corporal

Desmond at that time. So you weren't in a place to be able to trigger anything. Is that fair to say?

A. Yes.

Q. In terms of the crisis team's involvement, if they were in place.

A. Yes.

Q. Okay. Thank you. Those are my questions.

THE COURT: Mr. Rodgers?

MR. RODGERS: Thank you, Your Honour.

CROSS-EXAMINATION BY MR. RODGERS

(12:22:51)

MR. RODGERS: Ms. Collins, just a couple of questions. When you set a triage level of level 2, I'm wondering if you took this into account. It's not noted in your report. Did Corporal Desmond identify to you that he did have other places he could stay, he could stay with relatives?

A. No.

Q. You don't recall him mentioning that to you?

A. No.

Q. Okay. As a triage nurse, if somebody identified to you that they did, in fact, have another place to stay and yet

still came to the hospital asking for admission would that tend to elevate their triage level in your mind? Or would that be an additional concern to you?

A. I don't think so. He felt the need to be at the hospital for whatever reason. Whether it was, you know, feeling like he had no place to go or feeling like that was the best place for him, I'm not sure, but I don't think why he asked that question would have been critical to me.

Q. Okay. Was it your impression that he was looking just to get a good night's sleep and sleep it off or that he wanted to see somebody and talk about his issues and have a discussion?

(12:24:02)

A. I would say both. I think he felt the need to see someone but he also felt the need to be somewhere. He did make the comment that he didn't know where else to go or have nowhere else to go. I may be confusing the words but ...

Q. That's fine. No, no. I think we heard from other evidence that he may, in fact, have had another place that he could have gone that he sometimes stayed, where he sometimes stayed but, in fact, chose to go to the hospital for some reason. So just trying to ...

A. He had reasons.

Q. ... parse out what that reason might have been ...

A. Yeah.

Q. ... from your perspective. Okay. Okay. Those are the questions I had. Thank you, Ms. Collins.

A. Okay.

THE COURT: Mr. Hayne?

MR. HAYNE: No questions, Your Honour.

THE COURT: Thank you. Mr. Rogers?

MR. ROGERS: Thank you, Your Honour.

CROSS-EXAMINATION BY MR. ROGERS

(12:25:17)

MR. ROGERS: Could we go to Exhibit 67, page 22, please? Ms. Collins, this is the emergency care record from the visit of December 1, 2016. I think you said that was your handwriting at 15:10 that says, "Not in the waiting area."

A. Yes.

EXHIBIT P-000099-H - EXTRACTION REPORT - PAGES 491-495

Q. Now the Inquiry has heard evidence. I don't think we need to go through it but for references. Exhibit 99-H, page 493, that there were some text messages from Mr. Desmond indicating that his daughter had hurt her wrist and around 12:30

he was looking to attend and assist with his daughter. Did you have any knowledge, when you made the note at 15:10 that Mr. Desmond wasn't in the waiting room, as to why he had left the waiting room?

A. No, I do not.

Q. And can you tell the Inquiry as to whether there are varying wait times that people will have in the Emergency Department at St. Martha's? Is it always the same, or is it dependent on the level of demand and the number of patients who are there?

A. It certainly varies.

Q. Okay. Thank you.

THE COURT: Any further questions? No. I have no questions. Ms. Collins, thank you very much for your time.

A. You're welcome.

THE COURT: You're free to leave.

WITNESS WITHDREW (12:16 HRS.)

MR. RUSSELL: I believe, Your Honour, I could conclude the witness Joan Hines before or by 1 o'clock.

THE COURT: Thank you. Ms. Hines, then?

JOAN HINES, affirmed, testified:

THE COURT: Good afternoon, Ms. Hines. Ms. Hines, you're going to see some documents that are going to come up on the monitor in front of you, but also in those two binders in front of you there are paper copies of the same exhibits. So if it's easier for you to refer to a paper copy you can just open the exhibit book and have a look at it yourself. Okay? I've made the observation you have a quiet voice.

A. Mm-hmm.

THE COURT: So I'm just going to ask if you could speak up. Often I say use your outdoor voice indoors. That would be great, and that way no one will ask you to repeat an answer. All right?

A. Okay.

THE COURT: Thank you.

A. Thank you.

THE COURT: Mr. Russell?

DIRECT EXAMINATION

(12:27:33)

MR. RUSSELL: Good morning, Ms. Hines.

Q. Good morning.

Q. So I wonder if you could state your full name.

A. Joan Hines.

I. And what is your occupation?

A. I'm a secretary.

Q. And a medical secretary?

A. Yes.

Q. And how long have you been employed as a medical secretary?

A. About ten years.

Q. And currently where are you employed?

A. Adult outpatient mental health and addictions.

Q. So you work with Dr. Slayter, I believe.

A. Yes.

Q. In 2016 is that where you worked?

A. Yes.

Q. My understanding is that you were involved in 2016 in scheduling and setting up various appointments with patients to see Dr. Slayter.

A. Yes.

Q. Lionel Desmond. Do you know who he is?

A. I do now.

Q. But did you have contact with him in 2016?

A. Yes.

Q. And I understand that you may have been involved in setting appointments in relation to the outpatient clinic in ...

A. Yes.

Q. ... St. Martha's?

A. Yes.

Q. If we can look at Exhibit 110.

EXHIBIT P-000110 - ST. MARTHA'S APPOINTMENT DATABAS-

Q. So Ms. Hines, are you familiar with what this is?

A. Yes, it's our community-wide scheduling system.

Q. A what schedule?

A. The community-wide scheduling system.

Q. Is this something that you use frequently when you're setting various appointments?

A. Yes, it's like an appointment book for us.

Q. So I'm going to have a couple questions about how this system operates, what it means, who's making entries, and getting ...

A. Mm-hmm.

Q. ... to the details at the same time. So well, I guess if we look right at the top we see Desmond, Lionel Ambrose, date

of birth, and if we scroll down and we continue to scroll down we see another box, similar heading. So are these the appointments that were arranged and scheduled as it relates to Lionel Desmond?

A. Yes.

Q. So if we look at the one ... just one moment. Okay. We'll scroll down and that box there. If we could make that ...

So this particular document as we're looking at it on the screen, if we look to the left. If we could, sorry, just scroll up a little bit. We see the name Lionel Desmond.

A. Mm-hmm.

Q. And we see appointment type, MHAA-psych consult. What is that?

A. That would be the initial assessment he was having with Dr. Slayter that day.

Q. And we see a date below it, December 12th, 2016. What's the significance of that date?

A. Where do you see December 12th?

Q. Right below "Appointment Type".

THE COURT: It's the 02-12-16?

MR. RUSSELL: 02-12-16, yes.

A. Okay. Yes, that was the date of the appointment.

Q. There is a time there and it says 09:00 to 10:30. What's the significance of that time? Right across from the date.

A. Oh, at the top. Okay. Yes, that would be the timeframe given for that appointment type.

Q. We see REGCLI. What is that?

A. It's a regular clinic appointment.

Q. And there's an account number and it's a long sort of number.

A. The HV ...

Q. What's the significance of the account number?

A. The HV number is a number that is given for that visit at the hospital on that date. There's a different one generated for each appointment in our department.

Q. And above it there's MEDREC number. What's that?

A. That would be his ST number, 3691. That would be specifically for Lionel Desmond.

Q. So it'd be sort of a code that identifies ...

A. Yeah.

Q. ... patient Lionel Desmond.

A. Mm-hmm.

Q. And his appointments.

A. And that would be everywhere within St. Martha's.

Q. All right. So if we look down. We'll keep it on the same screen. I'm just trying to find this page here. If we look down towards ... there's event dates, event time, event user comment. Do you see that?

A. Yes.

Q. So if we look to the third one from the bottom it's 01-12-16?

A. Mm-hmm.

Q. So that's, I take it, December 1st, 2016?

A. Yes.

Q. And there's a time recorded there, 14:46, and the event says what?

A. I booked an appointment for him. The psych consult for him at that time.

Q. And there's initials here, user is Hines JE. Is that you?

A. Yes.

Q. So the system records who's booking the appointment ...

A. Mm-hmm.

Q. ... and making entry?

A. Yes.

Q. So I take it from that you would have booked an appointment for Lionel Desmond on December 1st, 2016?

A. Yes.

Q. And the significance of the time that's 14:46, is that the time that the entry is made?

A. Yes. I would have spoke to him earlier. Do you see the edits on the line above? I would have spoken to him most likely before 14:41 or about 14:41, and I had to do an edit on the appointment type and change it into the psych consult appointment.

(12:34:00)

Q. So you would have spoken to him more closer, I guess, to 14:41.

A. Yeah.

Q. So at this particular appointment we see below, the second one from the bottom, 02-12-16.

A. Mm-hmm.

Q. Which is December 2nd, 2016. Do you see that?

A. Yes·

Q. What is the event time?

A. 8:53.

Q. And what does the event say?

A. He attended.

Q. And again the initials.

A. Myself.

Q. So you would have recorded an appointment he attended?

A. Yes.

Q. On ...

A. I registered him.

Q. On that date, December ...

A. Yes.

Q. ... 2nd. So where it says event time of 8:53.

A. Mm-hmm.

Q. Was that the time he showed up for the appointment?

A. Yes, the time he registered.

Q. Okay. Do you recall if you had any interactions with Lionel Desmond on December 1st to December 2nd?

A. No. Just coming to register for the appointments.

Q. If we could look to page 2 of that document. If you could just scroll up a little bit. Maybe the easy way to orientate you is there's a block at the bottom. There's two blue boxes.

A. Yes.

Q. And one at the bottom. So this second block, there's a description that says, "Comment - Taken off waitlist." Do you see that?

A. Yes.

Q. What is the significance of that entry and what does it indicate?

A. Taken off waitlist. When the referral came in, I believe, from the family physician they're put on a waitlist. Then they're triaged and then when their name comes up, next available appointment, we then take them off of the waitlist and book the appointment.

Q. So do you have any sense of how long Lionel Desmond was on a waitlist for an appointment with Dr. Slayter?

A. It looks to me like he was on a waitlist. By looking at this, it looks like the referral came in on November the 3rd.

Q. Of 2016?

A. '16. Correct.

Q. And so the referral comes in November 3rd, 2016. Appointment is booked December 1st, 2016.

A. Mm-hmm.

Q. And you have verification that Lionel Desmond attended his appointment with Dr. Slayter ...

A. Yes.

Q. ... December 2nd, 2016.

A. Yes.

Q. If we could scroll down. So we appear to be looking at another sort of charted entry as it relates to Lionel Desmond.

A. Mm-hmm.

Q. Do you know what it is we're looking at here?

A. This is a return visit.

Q. And ...

A. A follow-up with the doctor.

Q. So there's an indication, appointment type and it's quoted as ... what is it?

A. Return visit with the doctor.

Q. And there's a date for that return visit and it's indicated as what?

A. December the 2nd.

Q. Just below appointment type.

A. Oh, it was booked. Yes, December 21st.

Q. So December 21st is the ...

A. Actual appointment.

Q. The actual appointment time.

A. Mm-hmm.

Q. And if we look down below at the very sort of bottom what we see is we have "Event Date", December 2nd, 2016.

A. Mm-hmm.

Q. See that? "Event Time", 10:31.

A. Yes.

Q. "Event", book. So what is that telling us?

A. The appointment was booked. The return visit was booked on December 2nd.

Q. So we now know that Lionel Desmond attended appointment with Dr. Slayter, December 2nd? Is that correct? And we now know ...

A. Yes.

Q. ... that he booked a follow-up appointment on the same day.

A. Yes.

Q. Do you recall when that follow-up appointment was for? You indicated earlier, I believe.

A. The 22nd of December.

Q. Or if we look at the top it says "Appointment Type".

A. Yes, a return visit.

Q. Of December ...

A. 21st. Okay. Because of the no-show. Right.

Q. So December 21st ...

A. Mm-hmm.

Q. ... as the follow-up appointment?

A. No. Yes, the 21st of December was the follow-up. It turns to no-show at midnight if he hasn't attended.

Q. Okay, and we're going to get to that.

A. Okay.

Q. So he has the appointment follow-up scheduled for December 21st, and what time was it for that appointment set?

A. 11 a.m.

Q. And then if we go back to the bottom, in terms of that event date, and we see 22-12-16, which is December 22nd, 2016 ...

A. Mm-hmm.

Q. ... we have an event time and an event. What does it say?

A. The event time is 1:19 a.m. and it says no-show. The system automatically turns it to no-show if we haven't registered it.

Q. Okay, so what does that tell us? Does that tell us whether or not Lionel Desmond attended his December 21st follow-

up appointment with Dr. Slayter?

A. It says he no-showed.

Q. Okay. Had he showed, would you have made an entry?

A. Yes.

Q. Or someone would have made an entry?

A. Yes.

Q. So if we could look to page 3. This is a third document as it relates to appointments by Lionel Desmond. What does this document tell us about an appointment that was set for Lionel Desmond with Dr. Slayter?

A. I booked an appointment on January the 3rd of '17 at 14:02. A follow-up appointment with Dr. Slayter.

Q. And when was the follow-up appointment scheduled for?

A. The 18th of January.

Q. 2017?

A. Yes.

Q. And for what time?

A. 3 p.m.

Q. And obviously we know about the tragic events and ...

A. Mm-hmm.

Q. ... we clearly know that he didn't show up for that appointment. But what I'm particularly interested in is you

indicated that January 3rd, 2017 he attended at 14:02 to book an appointment?

A. Actually, no.

Q. No?

A. Prior to that it was around 1 o'clock. And it's really busy in the department then. I jotted the appointment down and I put it in the system at 14:02.

Q. Okay, so 14:02 ...

A. So it was about 1-ish, a little after 1, when he did show.

Q. Okay, so 14:02 was when you actually got around to entering.

A. Entering, yes.

Q. But in your estimate it was around what time that he appeared at the clinic?

A. Just shortly after 1.

Q. And I know I'm very leading in my questions. But this appointment, was it booked by phone or was it booked in person?

A. He came in person.

Q. And do you recall him coming in on January 3rd of 2017?

A. Yes.

Q. Do you have any sort of conversation with him when he shows up on January 3rd?

A. He stated he wanted to book an appointment with Dr. Slayter. Dr. Rahman had seen him and asked him to come in and re-book his appointment that he had missed.

Q. Did he explain why he missed the December 21st appointment?

A. He told me it was weather-related.

Q. And how long would you say your interaction was with Lionel Desmond on January 3rd around ... I believe you said 1 o'clock when he attended.

A. It's probably five minutes or less.

Q. How did he seem to you overall?

A. He was very polite, thankful to get the appointment.

Q. Anything appear out of the ordinary that you observed with Lionel Desmond?

A. Not that I observed.

Q. And in your history as working in medical clinics you would have had contact with plenty of patients over the years, I'm assuming. If there had been anything sort of notable or concerning to you as Lionel Desmond presented would you have notified anyone?

A. Oh, certainly.

Q. So if Lionel Desmond appeared angry and in distress ...

A. Mm-hmm.

Q. ... manic, would you have reported that to someone?

A. Oh, yes, we would have. We have alarm systems. My manager's office is just nextdoor to our office. There's psychiatrists. Everybody. There's people in and out of our office all of the time, you know?

Q. And you knew that this appointment with Dr. Slayter was mental health related.

A. Yes, and it was the next available appointment that I gave him at that given time.

Q. And how did he appear? Did he react to the appointment being January 18th?

A. No, he just said thank you and took his card and left.

Q. Did he express as to whether or not there was any urgency that he had to see Dr. Slayter on that day?

A. No.

Q. And overall, if you were able to describe his sort of mood and presentation when he came to book that follow-up appointment in person how would you describe it?

A. Very calm.

Q. Anything unusual?

A. Nothing.

(12:44:00)

Q. If we could just finally look back to page 1. I understand you're probably going to be somewhat limited in your involvement in explaining this, but I note again this is a document as it relates to Lionel Desmond about appointments made. And we see seven listed there. Do you see them?

A. Mm-hmm.

Q. And there appears to be three appointments at the top starting November 18th, 2015, a second one, November 18th, 2015, a third one, November 20th, 2015. Recorded times of 10, 13:00 hours, and 15:30 hours. And then there's a type and it has an ST number on it?

A. Mm-hmm.

Q. Do you know what kind of appointments they were?

A. That's a crisis phone visit.

Q. It's a crisis phone visit.

A. Yes.

Q. And it indicates status on all those three as attended.

A. Yes.

Q. What is a crisis phone visit?

A. At that time somebody would call the department where I work, who was in crisis. We had a crisis clinician. Melissa Robertson was her name. She took the call and spoke directly to the patient.

Q. So was this sort of a crisis hotline, I guess, unique to St. Martha's?

A. Well, it was our crisis clinician at that time, she took calls and she also responded to the ER and whatever.

Q. All right, and ...

A. I don't believe we have the provincial crisis line or we used it at that given time.

Q. So by virtue of the fact that it's connected to Lionel Desmond, can we assume that Lionel Desmond would have reached out to telephone crisis on those three days at those three times?

A. Yes.

Q. To your knowledge - and you may not be able to answer, and if you can't that's fine - are there any records kept as it relates to a patient or someone phoning in crisis? Is that documented, the details documented anywhere?

A. I can't answer that.

Q. No further questions, Your Honour.

THE COURT: Sorry. Ms. Ward?

MS. WARD: No questions, Your Honour.

THE COURT: Ms. Lunn?

MS. LUNN: No questions, Your Honour.

THE COURT: Mr. Macdonald?

MR. MACDONALD: Thank you, Your Honour.

CROSS-EXAMINATION BY MR. MACDONALD

(12:47:35)

MR. MACDONALD: Good morning, Ms. Hines. So I'm Tom Macdonald, lawyer for Ricky and Thelma Borden, the parents of Shanna Desmond, the grandparents of Aaliyah, and also Sheldon Borden, who is the brother of Shanna and uncle of Aaliyah, who I share joint representation with Ms. Miller.

Did you ever have occasion to discuss the events that bring us here with Dr. Rahman?

A. Well, when it first happened, you know, like the next day when we realized what happened, you know, I did state that he was there and booked an appointment as per Dr. Rahman requesting when he saw him in the ER.

Q. So did Dr. Rahman come to you on January 3rd...

A. No, no, no, it was ...

Q. No?

A. ... like a group. It was a group. It was the people in our admin area. When I got in to work there were people there discussing it.

Q. Okay, and was Dr. Rahman in that group?

A. Yes.

Q. Okay.

A. Yeah.

Q. Who else was in the group? Do you recall?

A. I can't recall. There were several people.

Q. Okay. Any other doctors?

A. I can't recall that.

Q. Okay. Is that the only time that you would have had discussions about this matter in Dr. Rahman's presence or to him?

A. Yes.

Q. Okay.

A. Yeah.

Q. And that would be January 3rd, 2017? Is that fair or ...

A. Yeah. Was it the ...

Q. Okay.

A. ... 3rd or the 4th? It was the next day after it happened.

Q. Understood.

A. Yes.

Q. Thanks. So it's probably the 4th.

A. Yes.

Q. Thank you very much.

A. Yeah. Thank you.

THE COURT: Ms. Miller?

MS. MILLER: No questions, Your Honour.

THE COURT: Thank you. Mr. Rodgers?

MR. RODGERS: Just a question.

CROSS-EXAMINATION BY MR. RODGERS

(12:49:26)

MR. RODGERS: Thank you, Ms. Hines. I'm Adam Rodgers, counsel to Corporal Desmond through his personal representative.

Question for you on records. In your role, is it part of your duty to send out packages to obtain records from other jurisdictions for patients when that's required?

A. Yes, if I'm asked by a doctor I would do that.

Q. Okay, and ...

A. Limited I do.

Q. Okay, so if a patient has come from another province and you're requested to get those records that's part of your duties?

A. Mm-hmm.

Q. Can you walk us through how that works and how difficult that process is?

A. And I don't do this all the time because we do have health records specialists at the hospital who do this.

Q. Yes.

A. But from out of province, I typically call the hospital where the information is being held or where the patient was seen. They'll tell me what I need, and if it requires a patient's consent or whatever we have a form that's filled out and faxed off with the information that the doctor is looking for.

Q. Okay. Have you had occasion to request records from Veterans Affairs?

A. No.

Q. Okay. So are you aware of how you would do that if

you needed to?

A. No.

Q. Would that be something that is done exclusively, then, through the hospital records?

A. I believe.

Q. And when Dr. Slayter, for example, determines that he wants these kinds of records is it you that coordinates with hospital records to do that or is that done some other way?

A. It could be me or a coworker who would do that.

Q. Okay, but you haven't had occasion ...

A. I haven't had occasion to do that.

Q. ... in your duties to do that. Or a coworker. How many potential people would be thinking about it?

A. There are three of us.

Q. Three that work in ...

A. Mm-hmm. Adult, yes.

Q. Okay. That work in mental health at St. Martha's, you mean, in that ...

A. Mm-hmm.

Q. ... position. Okay. Okay. Those are the questions I had.

A. Thank you.

Q. Thank you.

EXAMINATION BY THE COURT

(12:51:48)

THE COURT: Ms. Hines, if Dr. Slayter says to you, We need to try and get whatever medical records we can obtain from the OSI clinic in Fredericton, New Brunswick ...

A. Mm-hmm.

Q. ... what would you do in response to that request?

A. I would most likely call Health Records to find out what it was I had to follow through to get them.

Q. Mm-hmm.

A. Or I could call the OSI clinic to find out what they needed.

Q. What they might need?

A. Yes.

Q. Okay, and if you went to your own health records specialists that's part of what they do, is it?

A. Yes.

Q. That they give you direction?

A. Forms, yes.

Q. And you complete the necessary paperwork? Or they

complete the necessary work to make the contact to get the records?

A. Yes.

Q. Normal course of events? Okay. All right. I interrupted. Mr. Hayne? Sorry.

MR. HAYNE: I have no questions.

THE COURT: Thank you.

MS. BENNETT-CLAYTON: We have no questions.

THE COURT: Thank you. Okay. Ms. Hines, you're free to go. Thank you for your time.

A. Thank you very much.

THE COURT: Thank you.

WITNESS WITHDREW (12:52 HRS.)

THE COURT: Mr. Russell?

MR. RUSSELL: Nothing in re-direct, Your Honour.

THE COURT: I understand that that's the witnesses for the morning?

MR. RUSSELL: It is, Your Honour, yes.

THE COURT: The next witness is scheduled for 1:30?

MR. RUSSELL: We did request that Ms. Chambers be present at 1 p.m. We haven't gotten any indications otherwise she wouldn't be present.

DISCUSSION

THE COURT: All right. Let's take a break, and counsel content to come back at 1:30? Yes? All right. Thank you. We'll take a break till 1:30.

MR. RUSSELL: Thank you, Your Honour.

THE COURT: Thank you.

COURT RECESSED (12:53 HRS.)

COURT RESUMED (13:41 HRS)

THE COURT: Mr. Murray, I understand the next witness is Catherine Chambers.

MR. MURRAY: That's correct, Your Honour. And as Your Honour may be aware, Ms. Chambers has counsel for this matter, Marjorie Hickey. Ms. Hickey is in the courtroom and at counsel table.

THE COURT: Good afternoon, Ms. Hickey.

MR. MURRAY: I don't know if Ms. Hickey wishes to clarify anything in terms of her participation.

MS. HICKEY: Your Honour, I did want to mention I did not apply for standing in this matter, so I thought it would be worthwhile just to clarify the parameters of my role here today subject to Your Honour's thoughts on this, which, if there were, which I don't anticipate, any questions which I found objectionable I would hope to be able to raise that.

DISCUSSION

And following the completion of Ms. Chambers' testimony if there were any areas of clarification, to have that opportunity to ask that of her. So I don't know if that falls within the parameters of my role here or not.

THE COURT: It does.

MS. HICKEY: Thank you.

THE COURT: Thank you.

MR. MURRAY: Thank you, Your Honour.

THE COURT: Ms. Chambers?

CATHERINE CHAMBERS, sworn, testified:

DIRECT EXAMINATION

(13:43:43)

MR. MURRAY: Good afternoon, Ms. Chambers.

A. Good afternoon.

Q. There's water there if you want to use it as we go along.

A. Thank you.

Q. Can you state your full name for the record, please?

A. Catherine Elizabeth Chambers.

Q. And how do you spell your last name?

A. C-H-A-M-B-E-R-S.

Q. Okay. And how are you employed, Ms. Chambers?

A. I am self-employed. I have a clinic in Antigonish, Nova Scotia.

Q. And what type of a service do you provide at your clinic?

A. I provide specialization in trauma and anxiety.

Q. Okay. You are a therapist, are you?

A. Yes, I am. I'm a registered counselling therapist candidate.

Q. Okay. Ms. Chambers, perhaps we can have reference to your *curriculum vitae* which I believe is marked as Exhibit P73. Do you recognize that document?

EXHIBIT P-000073 - *CURRICULUM VITAE* OF CATHERINE CHAMBERS

A. Yes, I do.

Q. And as we discussed just before we began, if you prefer to look at the documents in paper you can ...

A. Okay.

Q. ... that's Exhibit 73 in Binder 1, whichever you prefer. So this is your *curriculum vitae*, is it?

A. Yes.

Q. And this is ... I appreciate you don't have the whole document on the screen, but does that appear to be a current or relatively current *curriculum vitae*?

A. Yes, it is.

Q. All right. So your *curriculum vitae* indicates that you presently work at or the name of ... the place that you work is identified as the Kamala Institute. Am I ...

A. Yes, Kamala Institute.

Q. Kamala, sorry.

A. Yeah.

Q. And is that your own clinic?

A. Yes, it is.

Q. Is that affiliated with anyone else or is that your own business?

A. No, that's my own business.

Q. And that's located in the Town of Antigonish, is it?

A. That's correct.

Q. Where does the name "Kamala Institute" come from?

A. Kamala ...

Q. Kamala ...

A. ... is the Sanskrit word for "lotus" ...

Q. Yes.

A. And the symbol there is emerging from the depths of darkness and blossoming into light.

Q. Okay, I see. Do you work there alone or do you have other individuals working there with you?

A. Primarily I work alone. In the past, I have had associates who have worked part-time, and I also rent space in the clinic to another mental health professional.

Q. All right. So the description of the type of work you do at your clinic, I believe, is identified there where it says you offer individual and group psychotherapy services to individuals with a number of conditions or who have experienced

a number of forms of trauma. Is that accurate?

A. That's correct.

Q. So perhaps you can just generally describe for us the type of patient you would see and the type of therapy that you would provide in a general sense.

A. Sure. So I do see a wide range of clients, but mostly my area of specialization is trauma, post-traumatic stress disorder, complex trauma, developmental and relational trauma, the kind of trauma that happens in childhood mostly as a result of dysfunctional family abuse, alcoholism, neglect, inter-generational trauma, so I also work with Indigenous peoples around this issue.

Anxiety, workplace injuries, workplace burnout, compassion fatigue, vicarious trauma, single-incident traumas, including accidents, motor vehicle accidents or other workplace accidents. I work with veterans, first responders. I also have a long history of working with survivors of sexualized violence and complex trauma.

I have worked with cancer survivors who have gotten PTSD as a result of their experience, people who are currently navigating cancer or other life-threatening injuries or illnesses. That's the general area/scope.

Q. So a wide range of types of patients, I guess, or patients with a wide variety of experiences, but the consistent theme is that they've all experienced some form of trauma, is that ...

A. That's correct.

Q. And you had your own clinic then from March of 2016 to the ...

A. Yes. Yes.

Q. And maybe we'll just kind of work backwards a little bit through your *curriculum vitae*. You were for a little less than two years I guess or about two years, you worked at the Antigonish Women's Resource Centre?

A. Yes, that's correct, and also I've had my own private practice since 2007 in various places that I've lived. So in addition to working at various agencies I have maintained a small private practice, as well, since 2007.

Q. Okay. So even when you were working at other places you've ... did you continue to see clients ...

A. That's correct.

Q. ... throughout that period of time?

A. Yes.

Q. Okay. What was the nature of the work you did at the

Antigonish Women's Resource Centre?

A. So I was employed there as a feminist trauma therapist and also the clinical therapy lead. So there were two therapists in the program. It's not a formal supervision role but more of a lead, a coach, a guide, for newer therapists that might be coming to the centre.

So the Women's Centre has a sexualized violence psychotherapy program where survivors of single incident sexual assault, sexual harassment, and childhood sexual abuse can come and receive psychotherapy free of charge and so that's ... I was in that role from 2014 to 2016.

Q. And that focused primarily then on sexualized violence?

A. Yes, that's correct.

Q. All right. Prior to that, for a period of five years you were at the University of Ottawa and you were working on your PhD?

A. Yes, that's correct.

Q. What was the area of study when you were working on your PhD?

A. The area of study was violence against women, specifically racialized and marginalized women, Indigenous

women. I was exploring how Indigenous women engage in trauma therapy with Indigenous women who have experienced sexualized violence. That was my area of research.

Q. And while you were working on your PhD, did you continue to maintain something of a practice during that period of time?

A. Yes, I did. Yes.

Q. Can you give us a sense of how many clients you would have seen while you were also working on your studies?

A. Sure. Approximately five clients per week.

Q. Okay, like five appointments or five new clients every week or ...

A. No, I probably had a caseload of approximately ten clients and would see approximately five clients a week.

Q. Okay.

A. Yeah.

Q. For a period of four years from 2008 to 2012 you were in Prince Edward Island and you worked at the PEI Rape and Sexual Assault Centre, is that correct?

A. Yes, that's correct.

Q. And the nature of the work you did there was what?

A. So it was an individual and group clinical therapist,

so that was a sexualized violence psychotherapy program. We also did outreach education, that was also part of my work at the Antigonish Women's Resource Centre as well. So conducted some groups, as well, for survivors of sexualized violence, violence prevention groups with youth, groups for survivors of childhood sexual abuse where we would offer psycho-education as well as counselling and support.

(13:51:23)

And I would also deliver workshops, community-based public education around the issue of violence prevention and how we can work together as a community to reduce violence against particularly marginalized and racialized women.

Q. Okay. And prior to that, you were in Halifax with Metro Community Living Support Services ...

A. Yes.

Q. ... Limited as a program supervisor. The work there was slightly different, was it?

A. Yes.

Q. That was providing psychosocial rehabilitation services to adults and youth with persistent mental illness, developmental disabilities and dual diagnoses in community-based group homes?

A. That's correct.

Q. Okay. Now if we might just talk about your education. You have a Masters in Education and Counselling which you received from Acadia University in 2007?

A. Correct.

Q. Can you tell us what that degree is and what trains you to do or ...

A. Sure. So the Masters of Education and Counselling from Acadia University is ... I did it part-time over the course of two and a half years. It can also be completed full time over the course of 14 months. And it's a clinical counselling program so it really trains you. The courses, for example, are counselling skills, counselling theories, group counselling, addictions counselling. What other courses did we do? Feminist counselling. We had a practicum, as well, of 500 hours which was supervised. We focused a lot on interventions and counselling approaches for working with a wide variety of clients.

Q. Okay.

A. Yeah.

Q. So ... and the practicum in that program was ... sorry, you said how ...

A. 500 hours.

Q. 500 hours?

A. Yes.

Q. Okay.

A. Yeah. And I completed that at Family Service Association in Halifax ...

Q. All right.

A. ... and I was hired there following my practicum to be a community-based therapist.

Q. Okay. And that's I guess the ... your *CV* makes reference to your work at Family Service Association ...

A. Correct.

Q. ... '05/'06. That was part of the practicum for your MEd?

A. Yeah, 500 hours of practicum and then I worked there for approximately almost a year afterwards as well.

Q. Okay. And if you could explain as well, you have two designations. One, the CCC designation. What is that?

A. So that's a Certified Canadian Counsellor through the Canadian Counselling and Psychotherapy Association. So that's something ... a certification that's applied for following the completion of a Masters degree, following the completion of a

minimum 500 hour practicum, and certain course requirements have to be met as well and there's also a supervision component.

Q. And there is ... I think we have a document from the Canadian Counselling and Psychotherapy Association which we have marked as an exhibit, it's P 75. Maybe we can just go to that. This is a multi-page document obviously, I think 28 pages, but this is the guide to a person wishing to have that designation, is that correct?

A. That's correct.

EXHIBIT P-000075 - CANADIAN COUNSELLING AND PSYCHOTHERAPY ASSOCIATION CERTIFICATION GUIDE

Q. All right. And there's a certain number of, I believe, correct me if I'm wrong, hours of face-to-face with clients to achieve this designation?

A. Yeah.

Q. And what is ... what are those numbers?

A. I believe it's changed since I went through the program. At the time it was 500 hours, it might have changed since then. Did you want me to share the number of hours that I have ...

Q. Sure, if you could.

A. Okay, sure. So I have been practicing since 2005. I

have approximately 7,500 hours of direct face-to-face, one-on-one client hours, and approximately 250 hours of one-on-one clinical supervision.

Q. Okay, so that's face-to-face with somebody supervising you, is that ...

A. The supervision isn't direct in terms of observation, it's meeting with a clinical supervisor once per month to go over any cases that I might need additional support or guidance with.

Q. Okay, all right. And your other designation: RCTC ...

A. Yes.

Q. ... and that stands for Registered ...

A. Registered ... yes.

Q. ... Counselling Therapist Candidate?

A. That's correct.

EXHIBIT P-000074 - REGISTERED COUNSELLING THERAPIST CANDIDATE APPLICATION FORM DATED MAY 11, 2019

Q. All right. And I believe we have a document, P74, which is ... I think we were provided with the application for that designation.

A. Yes.

Q. And what does that ... what is that designation and

what does that allow you to do?

A. So this is part of our College, so we're now a regulated profession in the Province in the Nova Scotia. So becoming a registered counselling therapist candidate allows a person to get a licence to practice in a variety of settings. It could be a public setting, non-governmental organization setting or in private practice.

The candidate designation is basically to allow the person to achieve, I believe, it's 2,000 face-to-face hours and 50 hours of clinical supervision. The reason why my standing is still as a candidate is that my hours from outside the province are not included in my registration.

Q. Right. So you had said you had 7,500 I think you estimated ...

A. That's correct, yeah.

Q. But you need 2,000 in this province?

A. That's right ...

Q. Okay.

A. ... yes. And 50 hours of supervision, I have more than 2,000 in the province but I have approximately 47 of the 50 hours of supervision since 2016 when I applied for the license.

Q. And the designation comes from the Nova Scotia College

of Counselling Therapists ...

A. That's correct.

Q. ... is that correct? And that's your governing body is it?

A. Governing body.

Q. Okay. So you're in a room full of lawyers, so we have Nova Scotia Bar Society that regulates and licences us, this would be something similar for you, I take it?

A. That's right.

Q. Okay. So you have a provincial licence in Nova Scotia to practice?

A. Correct.

Q. It allows you to see clients and, I guess, to bill as well, is that correct?

A. That's right.

Q. All right. And you were registered in 2016?

A. Yes.

Q. So you said that you've been seeing clients and doing counselling since 2007.

A. 2005.

Q. 2005?

A. Yeah.

Q. Okay. You've maintained a regular ...

A. A private practice since ...

Q. ... private practice since ...

A. ... 2007, yeah.

Q. ... 2007? Thank you.

A. Okay.

Q. And has that been primarily with patients who have experienced trauma?

A. No, my private practice in the beginning was more generalized and more broad. I started to focus quite specifically in the area of trauma when I began working at the PEI Rape and Sexual Assault Centre in 2008.

Q. Okay. Do you have specialized training in or have you taken any additional training in the area of counselling trauma specifically?

A. Yes.

Q. And what would that be?

A. So under the specialized training courses, I have attended several post-graduate training courses ranging ... most are focused on trauma, complex trauma, dissociation which is one of the impacts of complex trauma, looking at how trauma ripples through someone's life, what happens neurobiologically when

someone has experienced trauma, these sort of co-morbid conditions that can happen when a person has experienced trauma, particularly complex trauma. So yes, I've sought out extensive training in that area since 2008.

Q. And I just note a couple of the entries under the specialized training courses, one was the neurobiology of complex PTSD ...

A. Yes.

Q. ... at the Institute for Integrative Healing, and that was a year long course?

A. Yes, that's correct.

Q. All right. And further down, Understanding Complex PTSD, Complex Reactions and Treatment Approaches, another course that deals particularly, I guess, with something we're interested in here with post-traumatic stress disorder?

A. Yes. And a lot of these courses are not just specific to sexualized violence but cover a wide range of populations that experience PTSD and complex PTSD, and amongst several of the courses were also training specific to military populations.

Q. All right. So I think when you talk about the nature of the clients that you see it's clear that they come from a number of different experiences before they come to you. Are

there particular types of patients that you would typically work with who have experienced trauma?

A. Yes, first responders. I see quite a few first responders, healthcare professionals, front-line workers, nurses, doctors. I work with, you know, fire, police, ambulance, veterans, survivors of sexualized violence as well, and again, people who are off work through the Workers' Compensation Board and may be in need of support for PTSD diagnosis.

(14:01:13)

Q. All right. So perhaps we can just talk about that. So some of your clients, or many of your clients perhaps, have a diagnosis of post-traumatic stress disorder?

A. Yes.

Q. Okay. Not all victims of trauma necessarily have that diagnosis, is that correct?

A. That's right, yes.

Q. Okay. Can you give us a sense of how many of your clients might have that diagnosis?

A. Approximately 80 percent.

Q. All right. And you had talked about both trauma and complex trauma ....

A. Yes.

Q. ... and I don't know if that phrase applies to post-traumatic stress disorder as well, PTSD and complex PTSD.

A. Yeah.

Q. Perhaps you can help us a little bit just to understand, first of all, what is post-traumatic stress disorder?

A. So post-traumatic stress disorder is a cluster ... it's a diagnosis that's reflective of a cluster of symptoms that a person may experience after having gone through either a life-threatening event or having directly witnessed or observed a life-threatening event. And that includes re-experiencing symptoms such as nightmares, flashbacks, intrusive memories, sleep disturbance, hypervigilance, emotional dysregulation, so sometimes would be described as mood swings. Changes in cognition, so thoughts about themselves or the world that might reflect a feeling of hopelessness or helplessness. Negative affect, negative cognition, so feeling overwhelmed, distressed, upset. And there's a cluster of symptoms also around avoidance, so avoidance of traumatic stimuli or reminders.

There's also a somatic component, so the way in which the body responds after someone has been through a trauma. So

there's a dysregulation of the autonomic nervous system that can result in a kind of fight/flight/freeze reaction which happens at the time of the trauma but then following the trauma can sort of become chronic. So there can be, you know, racing thoughts, feeling unsafe, substance abuse, you know, those kind of things.

Q. Okay. And you said that was a somatic response?

A. Yeah, so that ... so the way the nervous system responds following a trauma, you know, could be manifested in something like sleep disturbance where the nervous system is so activated that the person isn't able to sleep, or if they can sleep they're unable to stay asleep or they have difficulty falling asleep. So that's a reflection that the nervous system is activated and dysregulated.

Hypervigilance, so expecting the next bad thing to happen is also something that's correlated or connected to a nervous system dysregulation. And the body ... so a person can feel and experience the anxiety in a very physical way. So there's a sense of a heaviness in the chest, difficulty breathing, the heart can be racing, there can be perspiration, those kinds of things. It can be a very physical experience.

Q. The traumatic event that leads to the PTSD condition, can that be one event or a number of events?

A. Yeah. So the post-traumatic stress disorder diagnosis typically reflects a single incident trauma. It ... typically, if there's an ongoing trauma, something that persists over a long period of time or escalates over a period of time or happens earlier in life where people/children don't have, you know, the ability to cope with, that can lead to more complex manifestation of trauma.

So military trauma is now, from my understanding and the research being sort of re-classified as a complex kind of trauma because it's interpersonal in nature, it's not like, you know, a natural disaster which we don't have control over. If the trauma happens at the hands of, you know, let's say someone who's supposed to protect us or an institution that's supposed to protect us or at the hands of a caregiver, there's a kind of betrayal trauma that can go along with the actual traumatic event. And that also contributes to the trauma becoming more complex, meaning more symptoms, more complexity, we need more time in treatment to address that and that typically the complex trauma will ripple through the person's life, you know, their relationships, their work, their social, their sense of self, their sense of purpose and meaning in the world. Those kind of things are all impacted by complex trauma.

Q. So to designate a condition as a complex trauma as opposed to trauma ...

A. Yeah.

Q. ... it's the inner relation ... the number of domains perhaps that are affected and the symptomology and the affect ... overall affect in a person's life, is that ...

A. Yes, that's right, and also that the trauma was not just a one time but continued over a period of time. There's also a greater risk of complex trauma if the ... what the person is experiencing escalates over time. So, for example, if there's abuse and it gets worse over time, if there's combat and it gets worse over time there's an escalation to contributes to complex trauma.

If there's a sense of betrayal trauma that goes along with what a person is experiencing, so an expectation of being protected or an expectation of being safe and then having that expectation not met, that's also a contributor to complex trauma, as well as the age at which the trauma happens. The younger the age the more complex the trauma typically.

Q. All right. And there are, I guess, or I understand, neurobiological changes that go along with traumatic experiences ...

A. Yes.

Q. ... potentially?

A. Yes, that's right. So the fight/flight/freeze reaction, so that's from an evolutionary biology perspective. These are survival responses that are outside of our control; they happen automatically at the level of brain.

The limbic system, which includes hippocampus and the amygdala is sort of the smoke detector part of the brain, and that's the part of the brain when we're in a situation where our life is in danger, that part of the brain kicks in. And so the fight/flight response is the body preparing or the brain and nervous system preparing the body to either fight the threat, run from the threat, or to freeze and immobilize.

And so those responses when they happen at the time of the trauma, sometimes can be resolved. However, if the trauma is ongoing can kind of become where there's no expectation that the trauma will end or that it will be over, so the brain and the nervous system prepares the body to be in a constant state of fight/flight.

And that's what happens typically when someone has seen combat or has been in a combat situation. There's a kind of hypervigilance where the person sort of can't relax. You know,

there's muscle tension, the heart rate is going constantly, there's perspiration, the breathing is rapid and shallow. And the reason for that is that the body is pumping blood out from the core of the body out to the extremities, the hands and the feet, to prepare a person to be able to fight or to run if they had to.

And that's good for, you know, if let's say we come across a bear and we have to fight the bear or we have to, you know, run or maybe freeze, immobilize, play dead, quote/unquote, and this is all involuntary.

That's helpful at the time of the trauma, however, if that's the sort of mode that person has been in over time it's very difficult to turn that off once the person is out of the traumatic situation. And so the brain and nervous system continue to be ready for the next, you know, trauma to happen. And so when a person finds themselves, you know, away from the abuse or not in the combat situation anymore, the brain and the nervous system, it takes some time to rewire out of the trauma mode back into the present moment because there's an anticipation that the threat will continue.

Q. That then rewiring I guess ...

A. Yeah.

Q. ... or change, that can ultimately be achieved, can it?

A. Yes. Yes, we know now, through more recent research over the past 10 to 20 years around neuroplasticity, this idea that what fires together wires together, so in a situation where a person is in fight/flight - and freeze is not an option in the military, of course, and neither is flight; you have to fight, that's your only option - once that's over there's just a continuation of that that goes on even though the person might be out of that situation.

Q. But you said that the research in neuroplasticity suggests that that can be changed over time?

A. Yes, that's right.

Q. With therapy?

A. Yes, that's correct. Yes, with a trauma-specific therapy that works to re-regulate the nervous system and help the amygdala to ... There's various ways of doing that, but the ultimate goal is, for the amygdala, which is the smoke detector part of the brain that signals danger, after the person comes out of the traumatic situation, that part of the brain is still signaling danger even though the danger might, for the most part, be over. So a good analogy would be we need a smoke

detector when there's a real fire but we don't need it every time we burn the toast and so there's, you know, there can be a kind of intense reaction to mundane events. So part of the goal of therapy is to help the brain and nervous system sort of rewire out of a kind of chronic activation to be in the present moment, which is, typically, much safer than the imagined places that the traumatized brain goes, you know, during flashbacks or nightmares, for example.

(14:11:41)

Q. To learn to resolve those, I guess, intense reactions to what are otherwise benign or mundane events?

A. That's right, yeah. That's, the first goal of therapy is to work with reactivity and try to differentiate real danger from perceived danger.

Q. Okay. And patients who come to you who have a diagnosis of post-traumatic stress disorder, whether they were soldiers or victims of some other trauma, I assume they also have some or often have some co-morbid conditions or other things that are going on?

A. Yes. Oftentimes there's depression, anxiety, substance use sometimes, dissociation, loss of a sense of self, feelings of hopelessness or helplessness, loss of a sense of

future purpose in life, occupational and social functioning impairment. Because of the way that trauma manifests in the brain and nervous system, anything in the moment of the trauma, anything that's not essential to survival shuts down, so that includes the digestive system. It also includes the whole frontal part of the brain, and that part of the brain is responsible for memory, judgment, focus, decision-making, planning.

And so after someone has been through a traumatic experience or ongoing trauma, part of our work is to help sort of turn on the frontal lobe because what's not essential to survival is not active at the time. And so if that goes on over time, let's say the trauma lasts several months, there can be a kind of chronic rewiring of the brain to just be in fight/flight and the person sort of might lose temporarily their ability to, you know, use their executive functioning.

Q. So those frontal lobe functions, like memory, judgment, planning, focus that you mentioned, those are all affected particularly with PTSD patients or can be?

A. Can be to varying degrees, yeah. It depends on the person. That's part of what we're looking at in the beginning.

Q. And you said their appetite actually is ..

A. Yes, that's right.

Q. ... affected, as well?

A. That's right. So it could be a decrease in appetite, also could be issues, you know, with various gastrointestinal manifestations, so constipation, diarrhea, heartburn, those kinds of things.

Q. So, typically, soldiers and veterans who have a diagnosis of PTSD, are those conditions more typically what you would classify as complex PTSD?

A. Yes, I would.

Q. Exclusively or usually or ...

A. Yes, I would say most, the majority of the time it's complex trauma, because of the interpersonal nature of combat. It's not sort of ... You know, we sort of contrast it with a natural disaster, where it's something that we don't have any control over. There's a sense in combat that someone else has caused, there's another person on the other side there, and that tends to amplify the complexity of the traumatic presentation.

Q. So you said you've treated a number of patients with post-traumatic stress disorder. Can you give a sense of... Well, first of all, have you treated soldiers or veterans with post-traumatic stress disorder?

A. Yes, I have.

Q. And during your practice can you give us an estimate of how many you may have treated.

A. Approximately 50, up to the present day.

Q. Okay. Would those individuals typically be referred to you through Veterans Affairs Canada or would they come to you through a variety of routes?

A. A variety of routes. More recently through Veterans Affairs; however, in the past, when working in the community, not necessarily through Veterans Affairs but in the context of couples counselling or coming in for another, you know, possibly unrelated issue that may end up being related once you start to explore the person's history.

Q. Do you make that diagnosis yourself or do patients typically come already having had that diagnosis made?

A. No, I don't do diagnosis myself.

Q. Okay.

A. Typically, someone would come with a diagnosis. If they don't have a diagnosis, we might explore the history, and if the person feels that the diagnosis is something that's important to them to know, then I might refer them to a psychologist or a psychiatrist to get a confirmation of

diagnosis.

Q. Okay. Even without the diagnosis, if you see a person with this presentation you can approach treatment?

A. That's right, yes.

Q. With or without the formal diagnosis?

A. Correct.

Q. All right. So I think we had spoken and you had indicated if you're dealing with a patient with post-traumatic stress disorder, a diagnosis of with that presentation, and you were about to begin working with them, there's, I guess, a step-by-step process, is there, for dealing with a patient in that circumstance?

A. Yes. So there's an assessment period, which can be, typically, anywhere from three to six sessions, and that's a really exploratory approach where, during that time, I'm looking to hear from the person about a wide variety of domains in their life. I am talking to them about what they experience on the inside - do they experience anxiety, panic attacks, depression, what does the depression look like, what kinds of thoughts come. You know, typically, there are sort of what we call cognitive distortions, a person might see things in black and white, all or nothing, they might, you know, discount the positive and only

focus on the negative. That's quite typical for depression, so I'm looking for things like that. I'm looking to see what kinds of symptoms they're experiencing, what's happening with their sleep, what's happening in their workplace, what's happening in their relationships, what kinds of relationships do they have, are they relations that feel safe, is there conflict in those relationships, how does the person deal with that kind of conflict. I'm looking at their kind of external environment, what kinds of supports they have in place. I'm not talking too much in the very beginning about specific details related to the trauma because, again, we're really working in the beginning to try to regulate the nervous system and help the person be able to access feelings of calm and safety in the body and also in the external environment. Recounting, you know, details of the trauma, the research is pretty clear on that now that that just re-traumatizes people. So I'll get a broad sense of, you know, what they're struggling with, but we don't really look at addressing specific traumatic memories until later in treatment.

Q. So that first stage, we refer to that as, basically, an assessment phase?

A. Yes.

Q. Okay. And if a person comes to you having suffered

trauma, then, as you've said, you don't want to just begin to ask them immediately all of the details of the trauma.

A. Yes.

Q. That would have a negative impact on them?

A. That's right, yeah.

Q. All right. The term stabilization, what is that and how does that come into play?

A. Sure. So, generally speaking, there are three phases of trauma specific treatment. The first phase is safety and stabilization.

Q. Yes.

A. The second is trauma processing or memory processing work, and the third phase is integration. So in the beginning, what we're looking at with safety, and this is once the treatment starts, following the assessment period.

Q. Gotcha. So the assessment phase, you said, was typically three to six sessions?

A. Yes, that's right.

Q. So that's really just gathering, you gathering information?

A. Yes.

Q. Okay. And in that assessment phase I assume you are

developing or attempting to develop a therapeutic rapport with the client?

A. Yes, that's the other goal of the assessment phase, is to not only gather information but help the person feel that they're in a safe place so that they can begin to disclose painful aspects of their experience, so trying to create safety in the context of the therapeutic rapport, so a non-judgmental approach, what we call sort of unconditional positive regard, meaning that even though a person might share something that I might not agree with or, you know, that that doesn't actually affect the therapeutic relationship itself, so it's kind of communicating this sort of unconditional positive regard for the person.

Q. Okay.

A. And we're building a sense of trust and safety in those first few sessions, as well, and that actually extends beyond the six sessions - that's kind of an ongoing, you know, endeavor.

Q. Right.

A. And you know, the research is also pretty clear that it's the relationship that actually stands to have the most positive benefit. So there are treatments, of course, and

those are, you know, evidence-based and appropriate, but none of that is possible if you don't have a safe and trusting therapeutic rapport.

Q. Okay. So that assessment phase and the building therapeutic rapport, something that's ongoing throughout, but, in particular, in the three to six sessions, and then you said you move into the safety and stabilization?

(14:21:07)

A. Yeah, yes.

Q. So what's involved in safety and stabilization?

A. This is also information that I would share with the person in the assessment phase, as well. So once we sort of start to gather this information, we're also talking about, you know, informed consent, as well. Like, if we were to work together, this is what it might look like, et cetera.

Q. Right.

A. So I would explain to the person that the initial phase of treatment is about making sure that we can establish a sense of internal safety in the body and external safety in the environment. Stabilization also refers to being able to work with a dysregulated nervous system, so that's where the nervous system fluctuates between hyperarousal and hypoarousal. So

hyperarousal being fight/flight and hypoarousal being freeze/immobilization/collapse and shutdown. And oftentimes following traumatic events the nervous system becomes dysregulated because it's now waiting for that next, you know, traumatic event to happen. So the safety and stabilization is about building skills and tools to deal with activation that happens, physiological reactivity and activation that happens at the level of the nervous system, so panic attacks, anxiety, those kinds of things.

Q. So learning to deal with those things?

A. That's correct.

Q. Okay.

A. Also ...

Q. And those things are typically brought on, are they, by triggers?

A. Yes. So we're looking at identifying what are the triggers for that person, what are the things ... And triggers are typically reminders of the traumatic event.

Q. Right.

A. They may be sort of at the level of conscious awareness, they may also be under the level of conscious awareness, for example, smells, anniversary dates, and things

like that. The person might not be aware in the moment that it's a trigger, but by exploring what's happening in the body in the therapy room, we can start to understand, Ah, okay, when you talk about this or when you encounter this in the world, what happens on the inside? Well, I get really tense, I can't breathe, my heart starts racing. Okay, that's a trigger.

Q. Okay.

A. And then once we know what the trigger is, then we can start to build a toolbox of resources and skills that the person can use in those difficult moments.

Q. And what would be some of the tools in that toolbox for dealing with those types of triggers?

A. Sure. So there's a wide variety of tools. There's some sort of grounding tools, which are things just as simple as feeling your feet flat on the floor, feeling your back against the chair, a body scan, which is sort of scanning various, starting at the toes and going up to the head, with your awareness and that brings your awareness back to the present moment and away from the traumatic past or worries about the future. And that's a mindfulness intervention. Various kinds of breath work. There's also postures, postural changes that can be made that can feel, sort of give a sense of relief or a

sense of calm. So, for example, if a person is experiencing sort of hyperventilation, there's a particular breathing tool which involves a long slow controlled exhale that tends to activate the parasympathetic nervous system and disengage the sympathetic nervous system, which is fight/flight, and that's what we're looking for. That will calm the amygdala, which is the smoke detector part of the brain, and wake up the frontal lobe. And that's really the goal of what those interventions are. So one example could be a posture of putting the hand over the heart and noticing what happens, pushing the feet into the floor while you push the head up towards the sky, noticing what that feels like. So it's really a combination of dealing with what we call sort of top-down and bottom-up. So bottom-up is what happens in the body, and top-down is what happens cognitively. So we're really combining both resources in terms of our tools.

Q. So identifying triggers for patients and giving them the tools to help them deal with those triggers or the reactions to those triggers, that's all part of the internal stabilization and safety process?

A. Yes, that's right.

Q. Okay. And you said, I think, safety and stabilization is both internal and external?

A. Yes.

Q. So what do you work on when you focus on external safety and stabilization?

A. Sure. So external safety and stabilization is about a safe living environment. It's about trying to make sure that any relationships where there's conflict, that we have a way to look at that and address that, because in the absence of safety in the external environment, the external environment will continue to trigger the internal environment. So it's important to make sure that the person, you know, has safe and stable housing, that there's no, you know, conflict, violence in any of their relationships. If they have a work or an occupational environment, that maybe there might be elements there that might not be particularly safe or supportive, we would look at that. So we're doing that concurrently as we're working on the internal.

Q. So when you, I guess, you pass through that or perhaps you continue with safety and stabilization throughout ...

A. Yeah.

Q. But you said the second stage that you work on with patients is trauma processing?

A. Yes.

Q. So what is that?

A. So, again, just when we were talking about the phases, I think it's important just to, as you said, just to note that it's not necessarily linear. We may need to circle back to safety and stabilization at various times within a particular session or also between sessions, because trauma processing work involves revisiting specific traumatic memories.

Q. And that's what you didn't want to do right at the very beginning?

A. That's correct, yes. So we do that in a very particular way, in a very titrated way, so we're titrating exposure to those traumatic memories, meaning I might ask the person to tell me a little bit about what happened and, as soon as I notice the signs of nervous system activation, then I would pause, we would return to do some grounding, do some safety and stabilization work, and then go back to the trauma processing. So that happens sort of in a medisense in between sessions, and it also can happen within a single session, where we do some trauma processing work. If I notice, for example, the striated muscles in the face begin to tighten, the brow furrows, the breath becomes shallow, shoulders get tense ... I'm also asking

people to check in with their own bodies about what's happening. That can give us a sense that we've sort of exceeded our window, meaning the nervous system is now back in fight/flight. That's not where healing happens.

Q. Right.

A. So then we need to return to what we call the window of tolerance, where the frontal lobe is online, the amygdala is calm, and the person is fully in the present moment.

Q. Which requires some work with stabilization?

A. In the beginning, that's why we do that in the beginning, yeah.

Q. Okay. And then, finally, you move into integration?

A. Yes.

Q. And what is integration?

A. So integration is a sort of meaning making phase of the work where we look at what's been learned. There can be some grief work that's done at the time in terms of making peace with what's been lost as a result of traumatic experience and also, you know, what learnings have come and how the person wants to move forward with those learnings - you know, who are they now that the trauma isn't a focus of their daily lives, so what personal goals might they have, what professional goals

might they have, how might they, you know, start to engage in their relationships differently. So we're really looking now at, once the trauma has been somewhat resolved, what now, where is the person going to go in their life now.

Q. Future looking?

A. Future, purpose, sense of purpose and meaning and what would be meaningful going forward.

Q. And so those stages you would use for any, any patient with post-traumatic stress disorder?

A. Yes.

Q. In particular, with veterans and soldiers, that process takes some time, I assume?

A. Yes, it would be several years.

Q. Okay. Are there particular challenges dealing with military personnel who are dealing with this?

A. Yes, I'd say the biggest challenge is hypervigilance, and this is ... You know, if we think about sort of our evolutionary biology, we evolved to have a very sensitive threat detection system, and this is to help us stay alive. You know, for example, if we even think about just the, you know, experience of maybe living in a cave and having predators all around - it's hard to relate to now in modern life, but we still

have a brain that functions that way - and so when we end up being in a state of chronic fight/flight, again what wires together, what fires together wires together, and so the sense of hypervigilance, meaning I need to check and make sure that my house is secure, I need to check and make sure that, you know, that there's not something behind me. It's like that kind of sense of always having to look behind you - what's going to happen next, when's the next shoe going to drop. And that's, I think, a result of being in that prolonged, you know, combat situation where, if you weren't vigilant, you could die. So that hypervigilance is necessary in the theater of war but can cause problems in civilian life.

Q. Okay. And have you found anything about the culture in the military patients that perhaps poses a challenge?

(14:31:06)

A. Yes, absolutely. I think the culture of silence, this is where, if you were to admit that you were struggling with something, you would be weak, I think that's quite a large challenge, because it means that if you are struggling, you keep it to yourself and you try to push through, and if you do disclose you might not disclose everything, because you're trying to protect your job or you're trying to make sure that

people don't see you differently or treat you differently. So I think the culture of silence and trying to be strong and tough and push through is a huge barrier to disclosing and also to seeking help.

Q. Soldiers also can suffer from secondary or vicarious trauma, as well, can they?

A. Yes. The trauma, the most recent diagnostic criteria for post-traumatic stress disorder includes witnessing violence. So vicarious trauma, we think of as sort of when someone else close to you is going through something traumatic, that that resonates also in your nervous system. And that has to do with the mirror neurons and the social learning system that we're sort of designed to sync up with one another through these mirror neurons in the brain. So, for example, a good example would be, you know, with a toddler, if you, you know, clap your hands and beat on a drum, then the toddler does the same thing. So we're designed to mirror one another, we're designed to sync up with one another on a neurobiological level. So the vicarious trauma speaks to the fact that whether you're witnessing it or going through it, it has the same effect on your nervous system.

Q. Okay. So your client base is patients or consists of patients who suffer from trauma. The trauma, though, obviously

can come from other places. We've talked about, you know, abuse and that type of thing. Do you deal with domestic violence in your work at all?

A. Yes.

Q. In what context?

A. So typically my work with sexualized violence, it often involves not only incidents of sexualized violence but also domestic violence, what we refer to now as intimate partner violence, so that could be physical abuse, emotional abuse, psychological abuse.

Q. So obviously you're here because you had some contact with Lionel Desmond.

A. Mm-hmm.

Q. So if you could, perhaps you can turn your mind back to 2016 when you became involved with Lionel Desmond's case and you took him on as a patient. Can you tell us how he was referred to you.

A. Just to clarify, I hadn't necessarily taken him on as a patient yet. I was still in the process of conducting the assessment. If the assessment, you know, continued to move forward in a good way, then I would have taken him on as a patient, but I don't necessarily take on everyone that I do an

assessment for.

Q. Okay. So you might do the three to six sessions with someone in the assessment phase and then decide that you weren't able to really give them much assistance?

A. That's right.

Q. Or they might benefit from a different type of counselling?

A. That's correct. If it wasn't a good fit for whatever reason, relationally, if there was something that was outside my scope of practice, if there were areas that I felt there were other professionals who had a better area of expertise, then I might offer a referral.

Q. Okay. All right. But you did see him at the beginning of the assessment phase, is that fair?

A. Yes, yeah.

Q. Okay. Can you tell us how and when that came about?

A. Yes. I was contacted by Veterans Affairs Case Manager Marie Paule Doucet, in the fall of 2016. She said that she had a veteran who needed some psychotherapy, community-based psychotherapy for a PTSD diagnosis, and she was waiting, I believe, to get a consent form signed so that she could give me the details of the case.

Q. So that was the extent of the information in the initial contact from the Veterans Affairs case worker?

A. Yeah.

Q. Had you dealt with this particular Veterans Affairs case worker before?

A. No, I had not.

Q. Had you dealt with ... I think you said you had other patients who were referred by Veterans Affairs. You had worked with other Veterans Affairs case workers?

A. Yes, yeah.

Q. Okay. So this didn't necessarily come as a surprise to you that a Veterans Affairs case worker might be calling you?

A. Not surprising, no.

Q. All right. So the information you had initially was that this patient who was being referred for community-based therapy ...

A. Psychotherapy, yes.

Q. Psychotherapy, all right. You didn't know really anything else, though, at that point?

A. No. I believe after she got the release from Mr. Desmond that she was able to tell me that he had been in an inpatient treatment program in Quebec, and the information that

was shared with me at the time was that it wasn't particularly helpful, that he had just recently moved to Nova Scotia and needed treatment for PTSD.

Q. Did you have a name at that point?

A. Yeah, after she ... after the release was signed she did share his name and contact information with me.

Q. Okay. So the first call, you didn't even get a name, just would you be interested, potentially, in seeing this person?

A. Yes, that's my recollection.

Q. Okay. And then the second call, once she had the release, she gave you his name and contact information and a little bit more of that history?

A. Yes, yeah, briefly, about what his experience in his past inpatient treatment.

Q. Did she give you any more details on the inpatient treatment facility that he had attended prior to coming back to Nova Scotia?

A. No.

Q. Did you know what province it was in?

A. Quebec.

Q. Are you familiar ... subsequently do you know what it

is and are you familiar with that?

A. I wasn't familiar, no, at the time with what that program was. I'm not too familiar with it.

Q. Okay. So Ste. Anne's in Montreal, Quebec, have you had other patients who have attended at that facility?

A. No, I don't believe so.

Q. Okay. Did she give you any information, initially, about his attendance at OSI or Occupational Stress Injury clinics?

A. I believe she shared with me that he had been to an Occupational Stress Injury clinic, and then he did share that with me during our initial visits.

Q. Okay. And had you had other patients who had been to OSI clinics?

A. Yes, I did.

Q. Okay. Are you familiar with OSI clinics and what they do?

A. Yes, I am, yeah.

Q. Okay. The diagnosis of post-traumatic stress disorder, she disclosed that to you?

A. Yes.

Q. Anything else about his diagnoses, conditions,

anything like that?

A. No, nothing else.

Q. Is that information in the initial phone call or referral that would be beneficial to you?

A. Certainly, information ... Ultimately, it would be helpful to get a full history of a person's involvement with any kind of mental health treatment. In the past it's been helpful, other case managers have shared assessments from the Occupational Stress Injury clinic that have, you know, the confirmation of diagnosis, as well as information that was gathered during those interviews. I have received that at different times, not in this instance, so that is very helpful information to get a sense of what the diagnoses were, first, and it also goes through a sort of psychosocial history and there's a lot of information that can be really, you know, valuable for any clinician who's, you know, going forward with treatment to have that.

Q. And that would assist, I assume, in the assessment phase, would it?

A. Yes, that's correct.

Q. All right. In this case, though, that information wasn't available to you?

A. No, it was not.

Q. Okay. From the information that you did have, did you have a sense, and I appreciate that you were going to go through the assessment phase, but did you have a sense that this might be somebody that you would be able to help and that it would be worthwhile going through the assessment phase with him?

A. Yes, based on the information that he shared with me and that the case manager shared with me, yes, I thought that he would be a good candidate for treatment with me.

Q. Okay. And in conversation with the VAC casework, she gave you some information or contact information for him?

A. Yes.

Q. Was it the anticipation that you would contact him or that he would contact you?

A. I believe what happened is that I called and left him a message. I did not hear back from him for a period of time which, I believe, was approximately four weeks. At that time I did reach out to the case manager again, just to let her know that I hadn't heard from Mr. Desmond. She said that she was going to contact him and have him give me a call and that did happen a couple of days later.

Q. Okay. So after the first referral, I guess, from

VAC, you reached out to Lionel Desmond and left a voice mail message, is that correct?

A. Yes, yes.

Q. Okay. And that would be typically your practice, would it?

A. Yes. Sometimes people would give me contact information and I'll reach out. Other people prefer to make the call themselves. So it can go either way.

Q. Right. Okay. So after about four weeks, you reached out to Ms. Doucet again at Veterans Affairs?

A. Yes, just to let her know that I hadn't heard anything back.

Q. Okay. And after that call, how long was it before Lionel Desmond reached out to you?

(14:41:00)

A. It was only a couple of days, I believe, after she said she was going to get in touch with him he contacted me. And then we set up our first appointment.

Q. Okay. And do you have a sense ... you said it was in the fall of 2016.

A. Yes.

Q. Do you have a sense when it was in the fall of 2016?

A. I believe it was in November where we had spoken and set up our first appointment.

Q. The "we" being you and Lionel Desmond?

A. Yes.

Q. Okay. And the earlier calls from Ms. Doucet, those were earlier ...

A. My recollection, it was September ... September - October, but I'm not sure exactly.

Q. Okay. Would you typically ... if, say, that was the first contacts you ... would you open a file at that point or make a note of it or would you just wait to hear from the patient?

A. I would wait to hear and get that information and then open the file once we had our initial visit.

Q. Okay. So when Lionel Desmond called you in November of 2016, what was the nature of your phone call there initially?

A. That's logically just to introduce myself and to set up an appointment time.

Q. Okay. And the appointment would be at your office in Antigonish?

A. Yes.

Q. And that's the only place now you see patients ...

A. That's right.

Q. ... or clients or potential clients? I don't know how to refer to them at that stage but ...

A. Yeah.

Q. All right. And were you aware of any other problems or any issues with Veterans Affairs in terms of them referring him to you?

A. No.

Q. All right. So you said you met him first ... or, sorry. You spoke to him November of 2016.

A. Yes.

Q. And you made an appointment.

A. Yes.

Q. And do you recall when that appointment was?

A. Yes. We scheduled the appointment for December 2nd of 2016.

Q. Okay. And that was just your next available appointment, was it?

A. Yes, most likely.

Q. Was there some urgency to see him? Was it ... did you get any sense of that from Veterans Affairs?

A. No, nothing of that nature was communicated to me.

Q. Okay. And have they communicated a sense of urgency with respect to clients in other cases?

A. Yes. I can think of a couple of examples where working with ... I also work with spouses and family members of veterans and I can think of a couple of examples where there was a history of, let's say, police were called out to the home and there was a history of some, you know, potential aggression possibly bordering on intimate partner violence. And that was communicated with me by the case manager.

Q. And in those cases, you might reach out to the client more quickly or try to give them a quicker appointment perhaps?

A. Yes, at my earliest convenience I would. Yes.

EXHIBIT P-000076 - INDIVIDUAL PSYCHOTHERAPY ASSESSMENT FORM

Q. Okay. So maybe as we go forward in the questions, we'll refer you to another document which has been marked as an exhibit. And this is your individual psychotherapy assessment form which is P76. And, again, if you want to refer to it by paper, you can. If we could go to page five of that document? So this is the end of ... or near the end of that document. After your signature, there's an entry. It says, "Appointments, dates, information gathered", and you have a number of dates listed there.

A. Uh-huh.

Q. Okay? And the first of that ... the first of those is December 2nd, 2016 and you say, "Attended appointment".

A. Uh-huh.

Q. And so that would refer to the first appointment that you made with him?

A. Yes. That's correct.

Q. Okay. And, sorry, if we could just go back to the first page there. So this document, the individual psychotherapy assessment form; first of all, perhaps you can explain to us what is this form?

A. Sure. This is a form that I adapted from my work in various agencies in the past. So the first several sessions again are about gathering information. And so this is a form that I would be completing during the first six sessions. And basically goes over, you know, what are the present living and working, you know, situations? What is the current support network? We're looking at who else might be involved in terms of supports, if the person has experienced any past counselling or psychotherapy; if so, how that was.

Also looking at various risk factors, looking at any other chronic medical conditions either physical or mental health

related. Looking at any hospitalizations, any other issues like substance abuse, disordered eating, self-harm, other, you know, things that can go along with having experienced trauma. Also looking at the reasons why the person decided to seek therapy at this time, what they're hoping for, how they currently cope, as well as the nature of the trauma and some of the specifics of the trauma.

Q. All right. And so you say it's a form that you developed from ...

A. No. It's a form that I used in the past at my work, for example, in PEI and also in Antigonish.

Q. Right.

A. And I just took that form and continued to use it in my private practice.

Q. Okay. So the subheadings in this form are kind of ... touch on all of the various issues that you might want to deal with a patient in the assessment phase?

A. Yes.

Q. Okay. So this document is focused on the assessment phase then, is it?

A. Yes.

Q. Okay. And you said that your assessment phase is

often three to six sessions.

A. Yeah.

Q. So is this a document that is, I guess, a dynamic document that you continue to add to ...

A. Yeah.

Q. ... or is it something that you create at the end of the assessment phase?

A. Typically, my practice has been to ... that it's a dynamic document, but I'm continuing to add to over time as the assessment process unfolds.

Q. Okay. This particular document that relates to Lionel Desmond, when was this created?

A. So this was created on January 4th of 2017. So at the time, I also had a phone call with Mr. Desmond on January 3rd and ... when we discussed some things. And as soon as I learned about the events that happened, I prepared quite a detailed timeline with my recollections of what we had talked about in our session and prepared this assessment document after the fact.

Q. On January 4th?

A. That's correct.

Q. Okay. As we go through this document, some of the

entries appear to be, I guess if I'm using the right phrase, backward-looking and some are more forward-looking. Some of the entries suggest things that would be for follow-up, but you had obviously written it after Lionel Desmond's death.

A. Yes.

Q. Why was it phrased that way or why was it written that way?

A. I think probably my ... because my practice was to fill this out as I go along. That's typically how I did it. In this case, that wasn't the case. So probably a combination of just rote memory, having done it a certain way for many, many years. Also, I was quite distressed after the events unfolded and so might not have been as clear with tenses. But it is my best recollection of events.

Q. Okay. And it was created at the request of someone?

A. Yes. Request of the funder, Veterans Affairs.

Q. Okay. And who, in particular, at Veterans Affairs requested this document?

A. Marie Paule Doucet.

Q. And what was the request from Ms. Doucet? What instructions did she give you or what did she ask you for?

A. She asked me to send along the assessment as far along

as I got.

Q. That was the way she phrased it?

A. I believe it was like, Can you send me what you have so far on the assessment?

Q. Okay. And so on the 4th of January, you created this document which is marked as Exhibit P76.

A. Yeah.

Q. Okay. And forwarded that to Ms. Doucet?

A. Yes, I did.

Q. The same day?

A. Yes.

Q. Okay.

A. I believe so.

Q. Or thereabouts?

A. No. It looks ... I'm just looking at it. It looks like it was faxed on the 10th of January.

Q. Ah! Right. Okay. So the fax line at the top of the copy we've used is actually when you would have forwarded it to Ms. Doucet?

A. Yes.

Q. Okay. After this was created and sent to Ms. Doucet, did you add to it or change it?

A. No.

Q. Okay. So the ... if you could just go back to page five, at the bottom, again back to the "appointments, date, information gathered". So you saw Lionel Desmond on the 2nd of December 2016. And I'd like to go through with you kind of what you learned in each of the times that you spoke to him. But perhaps just before we do that, we can clarify. So you saw him on the 2nd of December 2016 for an appointment at your office?

(14:51:21)

A. Yes.

Q. Okay. And that was the first time that you sat down face-to-face with Lionel Desmond?

A. That's right.

Q. And how long is that appointment, roughly?

A. That's a 50-minute hour.

Q. Fifty minutes to ... 50 to 60 minutes?

A. Approximately. They're usually approximately 50 to 60 minutes.

Q. Okay.

A. Typically, it's a 50-minute counselling therapy hour which allows ten minutes to do any documentation after the fact.

Q. Okay.

A. So it would be anywhere between 50 and 60 minutes.

Q. Okay. And after that first appointment on December 2nd 2016, did you give Lionel Desmond another appointment?

A. Yes. We booked an appointment for December 9th.

Q. After having met him the first time and talked to him for an hour, did you have a sense of how many appointments might be necessary in the assessment phase and with what regularity you would have to see him?

A. My hope was to be able to meet with him weekly in order to complete the assessment and my sense was that we would need at minimum six sessions ...

Q. Okay.

A. ... to complete the assessment.

Q. All right. So you'd given him an appointment then for December 9th, which was just one week after your ...

A. Yes.

Q. ... first meeting. And on your assessment form, you say, "Appointment missed".

A. Yes.

Q. So he did not attend at that appointment?

A. No, he did not.

Q. Do you recall if you had any contact with him as a

result of him missing that appointment? Did he call you in advance or afterwards?

A. No. But my practice is to contact a person if they've missed an appointment and then to set up another appointment. So that's what I did. I contacted him after the missed appointment and then we booked for the following week.

Q. Okay. And do you recall the conversation when you called to set up the new appointment?

A. I don't really discuss any kind of information other than logistics and setting up appointments with people typically on the phone. That can open things up. And I'm not there to help a person manage it, so the conversation would have strictly been about scheduling.

Q. Okay. So if you start asking a client why they missed, you might get into something more than you really should do ...

A. That's right.

Q. ... on the phone.

A. That's right.

Q. Okay. So you were able to reach him, though.

A. Yes.

Q. Okay. And if somebody misses an appointment, you said

it's your practice to follow up with them.

A. Yes.

Q. Is that ... is there a particular reason why?

A. Good question. I guess, first of all, I want to make sure that the person is okay, that nothing happened to them and also to rebook and see if we can keep moving forward.

Q. Okay. So if ...

A. Yeah.

Q. ... a person has one appointment with you in the assessment phase and they walk away and maybe ...

A. Yeah.

Q. ... they make another appointment, decide it's not for them ...

A. Yeah.

Q. ... that ... I suppose that could happen.

A. Yeah.

Q. You still want to follow up to make sure they're okay and to rebook if they wish? Is that ...

A. Yes, if they wish. And then if they don't show up again, I would still make the call. And if they're not, you know, willing to set up another appointment where we can sort of talk about that, then I might ask, you know, Is this something

that you want to continue with?

Q. Okay. All right. So you made an appointment for December 15th, 2016. And you say "attended appointment", so that was an appointment that he attended?

A. Yes.

Q. And do you recall how long that appointment was?

A. Same duration, 50 to 60 minutes.

Q. Would all of the appointments during the assessment phase be in that 50- to 60-minute range?

A. Yes.

Q. Okay. You made another appointment then for December 19, so about four days later.

A. Uh-huh.

Q. And he missed that appointment?

A. Yes.

Q. Okay. And, again, did he contact you in advance or afterwards?

A. No. Actually, I believe that Mr. Desmond did text me after the ... or prior to the December 15th appointment. I think there's a record of that.

Q. So you had provided us, I think, with some text messages or screenshots of text messages?

A. Yes.

EXHIBIT P-000077 - SCREENSHOT OF TEXT MESSAGES - DECEMBER 9, 14, 2016, JANUARY 2, 2017

Q. And those are marked as Exhibit P77. So can you tell us what P77 is, first of all?

A. Yes. This is a screenshot of a text message between myself and Mr. Desmond.

Q. These are taken from your phone?

A. That's correct.

Q. All right.

A. So this would have been in response to a message that I would have left him after the missed appointment on ...

Q. So let's start at the top. The first one ... the text message is dated December 9th, 2016?

A. Yes.

Q. At 11:23?

A. Yes.

Q. And it says "voicemail". Perhaps you can just go ...

A. So that would be ...

Q. ... just down to the voicemail.

A. ... like a text ... a voicemail to text conversion of the message.

Q. Okay. So it was a voicemail that he left you?

A. Yes. And I would have left him a voicemail message that morning with the missed ... just letting him know that we had missed the appointment.

Q. Okay. So this is, I guess, the functionality on your phone converting a voicemail to a text message.

A. Yes.

Q. And what does ... appreciate some of the ... some of it is lost in translation, I guess, from voicemail to text but ...

A. Yeah.

Q. ... what was the nature of this and can you indicate what he said to you?

A. Yeah. The nature would be that he had missed the appointment that we had at 9 o'clock that morning, that he had slept in, was feeling drowsy, didn't want to take a chance driving because he was feeling drowsy. Wanted me to call back and reschedule the appointment, preferably in the afternoon rather than the morning.

Q. Okay. And so, to your recollection, did you call him back?

A. Yes.

Q. Okay. And that was when you made the appointment for December 15th?

A. Yes.

Q. Okay. The second entry just down a bit is a text message from you to Lionel Desmond, is it?

A. Yes.

Q. And what ...

A. The day before the appointment. Since he had missed our second session, I wanted to reach out with just a friendly reminder that we were booked to see each other the following day.

Q. And is that your practice, if somebody misses an appointment, to send them a reminder?

A. It depends. Not always. No, not necessarily always.

Q. In this case, you did?

A. Yes.

Q. Okay. Any reason why in this case you did?

A. I think it had to do with the fact that during our first appointment he seemed to have some challenges with memory and some of those frontal lobe impairments that I talked about in terms of the executive functioning. So it was really more of a courtesy to support him in getting to the next appointment.

Q. Okay.

A. And I have done that in the past for other people who seem to struggle with that.

Q. Okay. So you had said just, "Hi, Lionel. Just a reminder that I have us booked in for an appointment tomorrow, Thursday, at 12 o'clock. See you then."

A. Yes.

Q. And his response ... is that his response, the "Okay"?

A. Yes.

Q. All right. And as we said, he did attend on December 15th, 2016 for the appointment. The next appointment was December 19th, 2016 and he did not attend for that appointment?

A. That's correct.

Q. Okay. Did you reach out to him, do you recall, after the missed appointment on the 19th?

A. Yes. I would have called and left him a message about the missed appointment and looking then to book an appointment for the new year, since I was going to be off over the holidays.

Q. Okay. When you say "I would have called him", do you remember if you did or it just would have been your practice?

A. I'm sure, because we ended up booking an appointment for January 5th. And so I didn't have any contact with him

after that until January 3rd. So that's the only time that would have been possible for us to book that session.

Q. And that appointment that you booked for January 5th, 2017, that was done how? Was that by phone or by text or do you recall?

A. Yes. So when he missed the appointment on the 19th, that's when we rebooked and rescheduled for January 5th.

Q. Okay. And then you said you were off over the holidays for a period of time.

A. Yes. Yeah.

Q. Okay. And I know there was a conversation, obviously, prior to the events that we're here to talk about on January 3rd, so we'll get to that in a little bit. But, in total, you had an appointment with him on December 2nd for about an hour, you had an appointment with him on December 15th for about an hour, and you had a conversation on the phone on January 3rd that we're going to talk about.

A. Yes.

Q. Apart from those interactions, your only contact with him was in the context setting up appointments and the like. Is that correct?

A. Yeah. That's correct.

Q. Okay. So apart from the individual psychotherapy assessment form that you completed on January 4th, did you keep other running notes or a file when you met with Lionel Desmond?

A. No.

Q. Okay. Now we've heard from some other clinicians that when they're dealing with mental health patients, they don't necessarily want to be sitting, taking notes while they're talking to the person. But I think some other witnesses have said they'll try to make notes after the fact, after an appointment, you know, or when it's convenient, that type of thing. You didn't take any notes or make any kind of recorded notes about your meetings with Lionel Desmond?

(15:01:01)

A. No. My practice at the time, again, was to use the assessment form as my documentation of those assessment sessions. In this case, I did not have any other notes about those sessions.

Q. Okay. So when you say you would use this kind of as your form of documentation, would you have the headings perhaps or have a blank form to follow?

A. Yeah. Yes. That's right. That's my typical practice.

Q. Okay. All right. And did you use that with Lionel Desmond?

A. No.

Q. Okay. So just so I understand, if you had this individual psychotherapy assessment form in blank but with the headings ...

A. Yes.

Q. ... and you were meeting with a patient, would you make handwritten notes or how would you do that?

A. Yes, I would make handwritten notes after the session just to fill in some aspects of our conversation.

Q. Okay. Would you do that with all patients or ...

A. It depends. Not all patients ... you know, not all patients have a funder associated with their therapy. So the funder usually requests a formal assessment. If someone is coming in for private psychotherapy, the same model applies in terms of assessment, but I would just be taking sort of handwritten informal notes. And, typically, I wouldn't include informal notes in my case file. I've since changed my practice but ...

Q. Okay. All right.

A. ... that was my practice at the time.

Q. So if somebody comes to you and they have a funder, say Veterans Affairs ...

A. Yes.

Q. ... you know that ... from experience, that they're going to want a report. They're going to want something back.

A. Yes.

Q. And in those cases, you would use a form such as the one that's marked as Exhibit P76?

A. That's right.

Q. If somebody didn't have a funder and they were just coming in on their own, you said you might still take handwritten notes?

A. Yes.

Q. And you said you wouldn't include those in the case file?

A. No. Typically, I would look at the handwritten notes and then complete a formal client progress note once ...

Q. Okay.

A. ... I had begun treatment. Now what I do is I do include those informal notes in the file, but that wasn't my practice at the time.

THE COURT: Sorry, Mr. Murray. I'm going to stop you

just for a second so that I follow it. Exhibit P76, which was the individual psychotherapy assessment form that you ultimately prepared, signed, and sent to Ms. Doucet, how much of that form, as we see it as Exhibit 76, was prepared ... was actually written as of midnight January 3rd, 2017?

A. None.

THE COURT: Not a word.

A. No.

THE COURT: Okay. Was there a word written anywhere in any documentation about any of your interactions with Lionel Desmond as of that time and date?

A. No.

THE COURT: All right. Thank you. I understand. I'm sorry, Mr. Murray. I'm just going to say it's 3 o'clock and we would normally, at 3 o'clock, take a little break. So we will take a break for maybe 15 minutes or thereabouts and come back. And we'll likely go through to 4:30 then. All right? Thank you.

COURT RECESSED (15:04 HRS)

COURT RESUMED (15:20 HRS)

THE COURT: Mr. Murray?

MR. MURRAY: Thank you. Ms. Chambers, before we broke I

think we were just talking about your note-taking practices and ...

A. Yeah.

Q. ... how you recorded the information that you got from Lionel Desmond. So we had said the document, your individual psychotherapy assessment form, was completed on January 4th. You said that it was your practice with some clients that were referred by Veterans Affairs to use the form and to make notes on them but you didn't with Lionel Desmond?

A. Mm-hmm.

Q. And was there any particular reason why?

A. Sometimes it's possible that I get behind on my notes by a couple of weeks. If I'm seeing a lot of clients or my schedule is really busy. So I don't really know. I don't have a good explanation for that other than the fact that I may have gotten behind in my notes which does happen from time to time.

That time of year is particularly busy in a psychotherapy practice. I think most clinicians agree. December is a difficult time for people. It's a very busy time with a lot of sort of new calls, new referrals. So that could also be a factor.

Also, I just wanted to say that I did, after the events of

January 3rd, take some time to do a very detailed timeline of my recollection, and the January 3rd phone call also touched on a lot of themes that we had talked about in our sessions and that was very fresh in my mind when I completed the report, as well as the timeline.

So I just wanted to emphasize that, and I know that the optimal practice is to have a clinical note after every contact, but it was completed within a month of my initial contact with Mr. Desmond. So it's not optimal but it is my best recollection of events.

Q. And the phone call on January 3rd, which we'll talk about, you didn't take notes during that phone call either?

A. No.

Q. The material that's in the document P76, that's information that you obtained from Lionel Desmond on December 2nd and 15th and January 3rd?

A. Yes. Yes, that's correct.

Q. Okay, and in the documents you don't differentiate or delineate which pieces of information you might have gotten in which appointment?

A. That's correct.

Q. All right.

A. And, also, what I wanted to communicate also with Marie Paule and Veterans Affairs were what my ideas might have been going forward. So that's why some recommendation sections are filled in that way. I wanted to give a sense of what I would have done going forward, not just what I did. So to your previous question about tenses, you know, that could be also partially what's happening there.

Q. All right, so kind of going through the time you spent with him, the first appointment was on December 2nd and you said your first appointment, and indeed all of your appointments during the assessment phase, are approximately an hour?

A. Yes.

Q. All right. In the very first appointment what are the types of things that you want to cover, what do you want to observe, what do you want to do or achieve?

A. So I'm looking to hear from the person that I'm meeting with, what brings them here at this particular time in their life, what they're hoping for, what life looks like for them, what do their days look like, what kinds of relationships do they have, you know, what are those relationships like, are they supportive, are they not supportive?

I want to get a little bit of history without going into

too much detail about, you know, kind of what the traumatic incidents are without going into too much detail. I'm looking to see what his coping mechanisms are, how he's dealing with the challenges that he has, what his symptoms are as they relate to PTSD and complex PTSD.

I'm looking to do, also, a risk assessment, what's happening in terms of suicidal risk, homicidal risk, self-harm, other possible risks like substance abuse, eating disorders. This would be over the course of the full assessment. I'd be looking at those kinds of things.

Q. Over the course of the three to six sessions?

A. Correct, yeah.

Q. So the first session, then, isn't necessarily different than any of the other sessions in the first ...

A. It's exploratory, yeah. So I'm asking some probing questions, you know, what brings you here, what are you hoping for, what's been going on, how are you suffering, how are you coping, you know, if this was helpful what would be different for you at the end of this? You know, I'm kind of looking to see what their goals might be for the therapy.

I'm also looking to build trust and rapport. So that's, you know, active listening and nonjudgmental, respectful stance,

unconditional positive regard. It's also sort of a narrative approach and a feminist approach which sort of de-centers me as an expert. So I'm not there to tell anybody what they should be doing or how to do that. It's really about hearing from them how they see the world. I'm also looking for what their strengths are and how they're navigating their situation.

Q. You say there are some probing questions.

A. Mm-hmm.

Q. Are the questions also open-ended and ...

A. Mostly open-ended.

Q. Okay.

A. Yeah.

Q. You said in these first sessions in the assessment phase you do some form of risk assessment?

A. Yes.

Q. And if you were, at this stage, sort of determining whether you have something to offer them or whether the relationship is going to work out going forward ...

A. Mm-hmm.

Q. ... you nonetheless do a risk assessment right ...

A. Yes.

Q. ... from the beginning?

A. Yes.

Q. How do you approach assessing risk?

A. So typically I would ask the person if they have any thoughts of hurting themselves or someone else, do they have thoughts about ending their life, killing themselves? I would ask if they ever have thoughts about hurting or killing anyone around them in their circle, in their life, and kind of go from there.

So if the person indicates, you know, I might ask. You know, for example, Mr. Desmond had shared that there was some conflict with his wife. So I'm going to be asking, and did ask, you know, things like, you know, what happens when you argue? What does that look like? You know, what do you do? How do you cope? Does it ever get physical?

So those would be the questions that I would ask, and those were the questions that I did ask Mr. Desmond.

Q. And again, ideally, you like to have some material when you meet with a patient first, if there's other assessments done, that type of thing.

A. Yes. Mm-hmm.

Q. In Lionel Desmond's case, you have none of that.

A. That's right.

Q. All right, and in the assessment phase you develop what might be the treatment plan if you were to go forward?

A. That's correct.

Q. All right. So with respect to Lionel Desmond specifically, do you recall what your first impressions of him were? Can you tell us about when you met him first and what you observed?

A. Sure. Mr. Desmond was very polite and soft-spoken, had a very sort of mild and soft demeanour. He appeared to have a little bit of trouble explaining or talking about things in a linear way, which is not uncommon, again, because of the neurobiology of trauma, where the frontal lobe goes off line, and this can also affect language, word-finding, and things like that.

So it wasn't unusual, but I did note, mentally note, that he, you know, was sort of free-associating, sort of talking about one thing and then kind of going off into a potentially connected area and speaking about that.

Q. I think in different spots in your assessment you referred to him as having, I think, a circuitous approach to answering.

(15:30:01)

A. Yes.

Q. And also, you said his speech and narration, you described it as confused and disorganized?

A. Yes, so he wasn't presenting information or answering my questions in a really linear, straightforward way. So he would sort of answer a little bit and then talk about something possibly related, something possibly, from my perspective, a bit unrelated but might have been related to him. So yes, he seemed to be struggling, you know?

Q. Did you have difficulty drawing information out of him?

A. Yes, I did.

Q. What do you mean by that?

A. Well, as I was asking the questions it was difficult to get a sort of a hundred percent clear answer on the questions that I was asking. So you know, for example, in some ways he was able to answer clearly, like when I would ask him about, you know, tell me about what happens when you have arguments with your wife. And he would say that they would argue, he would yell, and he would sometimes regret things that he said.

And I said, Well, what do you do in those cases? And he was able to clearly say that he would go for a walk or take a

drive or leave the home, go to his aunt's house. So that was clear. When he started to talk about his experience in the military that's when things became more confused and disorganized, which makes sense because he's talking about, really, where he experienced the trauma. So in that sense, it wasn't surprising.

Q. And again, if I understood you earlier you really weren't, I take it, going to be asking a lot of questions about his military experience if that was the source of his trauma?

A. That's right.

Q. When he attended, well, the first session - perhaps any of the sessions - was he with anyone or was he alone?

A. No, he was alone.

Q. Okay, so in that first session you had him complete some necessary documentation, did you?

A. Yeah, so that's ...

Q. Okay.

A. ... a consent to counselling form as well as a statement of confidentiality.

Q. So if you just go down to the next one, I think, on page 6. So this is a statement of confidentiality?

A. Yes.

Q. And you had him complete this on December 2nd, 2016?

A. Yes, and ...

Q. And you did as well.

A. Yes.

Q. What's the purpose of this document?

A. So this document is to provide an informed consent to the client about their rights as a client in psychotherapy, as well as the limits to our confidentiality. So I would have explained at the time, as I would with any client in the first few sessions, that what we talk about in the session is confidential but there are exceptions to the confidentiality. If a person represents a risk to themselves or others, if there's a child that's in harm in any way, or if the records are subpoenaed by a court, that those are limits to confidentiality.

And I explained that I do keep notes based on our interactions and that the client has opportunity to look at those notes at any time if they wish.

Q. And because he was referred by Veterans Affairs, was there a discussion about whether any of the information that you obtained from him, or your discussions, might be shared with Veterans Affairs?

A. Yes, that's right. So Veterans Affairs does require

updates, counselling progress updates, in addition to an initial assessment form. So typically minimal, once every six months or so, they require a progress note, and so that's shared as well, that I'm going to be sharing that information with Veterans Affairs and that what I'm sharing with them is less about specific disclosures and more about what's happening in terms of the therapy and the process, where we're at in the three phases, and how treatment is progressing.

Q. Although there would be overlap between those two.

A. Yes. Yes.

Q. So I take it you couldn't guarantee that some disclosures that he might not wish to be ...

A. Correct.

Q. ... shared with Veterans Affairs might, nonetheless, be shared with them?

A. Particularly when it comes to risk. Then that's all we ...

Q. But even setting aside risk.

A. Yes.

Q. They don't seem to be water- ...

A. They're not mutually exclusive.

Q. They're not watertight compartments, you know?

A. That's right, exactly.

Q. And I guess I misspoke earlier when I referred to him at this stage as your patient, because he was not yet your patient. But you have referred to him as your client? Is that the appropriate terminology for ...

A. I use client instead of patient.

Q. Okay. He would have become your patient had you taken him on for full-fledged treatment, I guess? Is that ...

A. He would have become my client.

Q. He would have continued to have been called your client.

A. Well ...

Q. That's the phrase ... that's the terminology you would use?

A. Sure, that's the terminology I would use rather than patient.

Q. Okay. And so in a case where somebody is funded as, say, through Veterans Affairs, do they have a client relationship with you as well?

A. If someone is referred through Veterans Affairs? Yes.

Q. Yes. So they would also be a client of yours?

A. If someone's referred through Veterans Affairs, and

after the end of the assessment we determine that it's a fit, then that would be a client, yes.

Q. I understand that the person you're treating is your client.

A. Client, yes.

Q. I'm referring to Veterans Affairs. Would you refer to them as your client as well?

A. Oh, no, that would be the funder, yes.

Q. Funder.

A. Yes, they're the funder.

Q. So that's the way you distinguish, the person you're treating is your client.

A. Yes.

Q. The person that pays for it is your funder.

A. Correct.

Q. And the other document, which would be the next page, which is consent to counselling, what's that document?

A. Mm-hmm. So this is an informed consent that we've talked about, you know, if this person was to start treatment; what that would involve. So that would involve sometimes talking about difficult emotions, practicing different tools and strategies and that the person has the right to refuse to

participate in that and that it wouldn't have a negative effect on their therapy. So it's a way of letting the person know what to expect once treatment begins.

Q. And these two documents are completed for your benefit and retained in your file, are they?

A. Yes.

Q. Are they shared with Veterans Affairs?

A. No, but I would say it's also to the benefit of the potential client and/or potential client to understand what their rights are.

Q. Right.

A. And, as well, what the expectations are around participation and confidentiality.

Q. So the releases that Ms. Doucet spoke about earlier, those are different documents that would have been completed on their end, are they?

A. That's right.

Q. Okay. Before she could provide you with more specific information about the potential client.

A. Yes.

Q. Okay. And those presumably were completed but no other information was received from Veterans Affairs?

A. No.

Q. Did you think to ask, or is that something you would say to the caseworker, you know, You said he went to an inpatient residential treatment type facility, do you have any documents? Something like that?

A. Typically that would have been offered by the case manager and I didn't ask for it in this case.

Q. Okay.

A. Yeah, it wasn't offered.

Q. Sorry, you think it was offered?

A. No, it was not offered.

Q. It was not offered.

A. No.

Q. Okay. Typically, you mean ...

A. It's not something I have to ask for typically.

Q. Oh, okay. I see. So it would be offered if it was available.

A. Correct.

Q. It was not offered here.

A. That's right.

Q. Okay. The assessment form has, I guess, what I might characterize as the goals of counselling, and I'm looking

specifically at page 2. And down the page a bit at (e), the questions, What prompted you to come here, and, What are you hoping for, is that where you would include, I guess, the goals of counselling in that section of the form? Am I correct about that?

A. Yeah, that's right.

Q. And these would be developed. I mean you have them here. Were they developed in the first couple of sessions?

A. No, they weren't fully developed goals. It was my best summation of some things that he mentioned in our conversations, but we didn't have a ... treatment planning is something that I usually collaborate with, with the potential client, so that it's not me superimposing my treatment goals but really hearing from them about what they'd like to get. This is just an exploratory question and what I've included are some of what he spoke to. But it's by no means reflective of, you know, treatment goals. We didn't really have a chance to explore that.

Q. So let me ask you. The first paragraph there says:

> Mr. Desmond was referred for individual psychotherapy by his VAC case worker, Marie Doucet, following a lack of success at the

inpatient rehabilitation program in Quebec. Mr. Desmond's main reason for seeking therapy at this time is to minimize his PTSD symptoms, work towards a healthier relationship with his wife, and learn strategies for making the transition from military life to civilian life, which he reports has been extremely difficult.

A. Mm-hmm.

Q. And then separate from that there's a heading "What Are You Hoping For":

Mr. Desmond shared that he wants to have a happy and healthy home life and a healthy relationship with his wife. He would also like to be able to sleep better and find ways of dealing with intrusive memories and flashbacks.

(15:40:10)

When I read that I get the sense - but you can correct me - that the "What Are You Hoping For" section is kind of more what came from Lionel Desmond and the "What Prompted You To Come Here" section seems like it's more the goals or the reasons for

referral from VAC. Is that accurate?

A. No. I would say that both paragraphs are a summation of what Mr. Desmond shared with me. VAC didn't have any particular goals that were communicated to me around Mr. Desmond's therapy. That's something that I really look towards the person to share with me.

Q. Okay.

A. Yeah, and collaborate on, and I include my hunch about what treatment goals might be helpful as well.

Q. Okay, so beyond the diagnosis of PTSD, beyond the reference to the inpatient treatment in Quebec and that this was to be community-based psychotherapy, there was nothing else from VAC?

A. No, nothing else.

Q. Okay. So as you met with him you obtained various forms of information from him, and you have a section, "Present Living Circumstances", work, living arrangements, partner, children. What did you learn of Lionel Desmond's current situation when he had come to see you?

A. So Mr. Desmond shared with me that he had recently moved to Nova Scotia from New Brunswick and that he had a wife and a daughter. And he shared with me that sometimes he did

stay with a family member and sometimes he stayed in the family home, depending on how they were getting along, and that he had been discharged from the military. He shared with me a little bit about that, that he hasn't been able to work, and a little bit about the support he was receiving from Veterans Affairs.

Q. What did he tell you, or what sense did you get, of the status of his relationship with his wife?

A. The impression that I got was that Mr. Desmond loved his wife tremendously and regretted the fact that they often argued and didn't want to have a relationship with conflict; he wanted to have a healthy relationship and he wanted to, I think, rebuild his family and his relationships with his family following his release from the military.

Q. There was information that you had received, and perhaps more in the phone call on January 3rd, about the status of their relationship.

A. Yeah.

Q. That they were ... or that she had asked for a divorce, I believe?

A. Yes, yeah.

Q. In the earlier sessions did you get a sense that the relationship was at that stage?

A. No, I didn't get that sense. Mr. Desmond didn't share anything with me about a possible separation or divorce. That was never brought up. He, you know, did talk about wanting to be the best father and the best husband that he could be and that sometimes he did argue with his wife. I asked him and probed a little bit more about that, but my sense was that they were working on trying to have a healthy relationship.

Q. He told you that they did frequently argue?

A. Yes, he did.

Q. Okay, and did he give you any more details on the nature of the arguments or what triggered those?

A. No. He said when his PTSD symptoms were elevated that would be the time that he would argue more frequently with his wife. Also, he did mention that sometimes when she had, had something to drink, that their arguments would also happen at those times. I did ask Mr. Desmond, you know, what does that look like, and he said that there was sometimes some yelling and that he often regretted things that he had said.

Q. That he would yell?

A. Yes, and so I said, Well, what do you do, you know, what happens when you argue? And he said that he would try to take a break, go for a walk, take a drive, go to a family

member's house to cool off. I remember being struck by that and that that seemed to me at the time to be a real strength and an awareness that he was able to take those actions during an argument. That would be something that I would want to explore in further sessions and just amplify, you know, the wisdom in that.

I did ask him if things got physical and he said that they had not.

Q. Okay, and when you asked if things became physical ...

A. Yeah.

Q. ... is that the way you would phrase ...

A. Yeah.

Q. ... the question? Okay, and the client typically interprets that, you think, to mean some sort of assaultive behaviour between the partners?

A. Yes.

Q. Okay. You did say that their situation was in flux and that at times he stayed with relatives, specifically an aunt?

A. Yes.

Q. And what circumstances would he stay there? Did he say?

A. I don't think he offered too much detail around that but just said that if things were sometimes difficult with his wife, that that's where he would stay, and I interpret that to mean that there was a safe place he could go when conflict would arise.

Q. Did the fact that he talked about arguing and yelling after experiencing intense PTSD emotions ...

A. Mm-hmm.

Q. ... or an increase in intensity in those ...

A. Yes.

Q. ... symptoms, did that trigger any particular concerns for you in terms of safety?

A. Not necessarily. Anger and rage and frustration and marital conflict, that is sometimes, quite often, par for the course, especially very soon after being released from the military. It doesn't necessarily mean that anyone is at imminent risk of harm.

Q. All right. His support network is ... or at least under that heading you reference his VAC case worker, Marie Doucet, and you also mention a clinical case manager, Helen Boone. So the support network that you're referencing is from Veterans Affairs.

A. Yes.

Q. A support network obviously more generally can refer to other people, other individuals.

A. Mm-hmm.

Q. Did he have other supports other than Veterans Affairs?

A. The only support he disclosed to me was that he had a cousin that he was close with and he didn't disclose that he had any other supports.

Q. Family members could be supports, though?

A. Family members could be, yes.

Q. Okay.

A. He only referenced a cousin.

Q. Okay, so would his wife be a support? Or would you characterize her ...

A. I'm not sure how he saw that.

Q. Okay, so it's a question of how the client sees the other individual?

A. Yes, if he sees that person as a support, and often it's not black and white. A family member can be supportive in some instances and could be very difficult in other instances. I know that he spoke about not wanting to burden his family with

his problems. So he may not have always reached out to immediate family when he was struggling.

Q. All right, so at the time that you met him on December 2nd you had had two contacts with Marie Doucet.

A. Yes, first originally to let me know there was someone that she wanted me to meet and then second with the contact information.

Q. And she was not a case worker with whom you had worked before.

A. No, I hadn't worked with her before.

Q. Okay. And during the course of the time that you met with Lionel Desmond in December and very early time in January did you have any contact with Marie Doucet during that period of time?

A. No.

Q. The next time you had contact with her was when?

A. Was January 3rd.

Q. January 3rd?

A. I'm sorry, my apologies. January 4th.

Q. January 4th? And what was that contact?

A. So after I learned about the events that had transpired on January 3rd ... no, my apologies. I contacted her

on January 3rd after my conversation with Mr. Desmond to let her know about the safety plan that we had created and just follow up with her and let her know of the change in his circumstances where he had been in an automobile accident the day before and his wife had also asked for a divorce.

So I followed up with her and had a phone conversation with her - I believe she has documentation of that - and then after the events transpired on the 3rd I spoke with her again on the 4th.

Q. By phone?

A. By phone.

Q. And it was then that she requested this form that we have marked as an exhibit?

A. Yes.

Q. And that was sent to her on the 10th.

A. Yes.

Q. The other person that's referenced is Helen Boone, the clinical case manager. Did you ever have contact with Helen Boone?

A. No, I didn't.

Q. Do you know what a clinical case manager is?

A. Yeah, my understanding is that a clinical case manager

coordinates with the more logistical, sort of on the ground aspects of a person's care. So if a person is in need of some help with housing, you know, getting to appointments, transportation, things like that, my understanding is that a clinical case manager would be a support in helping to implement a care plan.

(15:50:06)

Q. When you say that's your understanding had you ever dealt with a clinical case manager from back in ...

A. No.

Q. ... the past? Okay. So the information that you have with respect to the role of that person is from whom?

A. Would be from Marie Doucet.

Q. Okay. Did you anticipate that you would talk to his clinical case manager going forward?

A. Yes. Yes, I anticipated that we would connect and try to offer sort of wrap-around kind of support for Mr. Desmond where he would have a case manager, clinical case manager, myself as a therapist, and then we would try to build that circle. So I did anticipate having contact with her.

Q. He was unable to identify any other support individuals?

A. He didn't disclose any other supports.

Q. Okay. Are there specific people that you suggest? Because if you say, Who do you have as a support, they may not understand what you're getting at.

A. Mm-hmm. Yeah.

Q. Were there other potential supports that you suggested to him?

A. Like friends, family members, anyone else that you talk to, any other appointments that you go to. That kind of thing.

Q. With professionals?

A. Correct. Yeah, so we call them formal or informal supports.

Q. Okay, and when you asked him if there were other professionals with whom he had had appointments did he disclose anything to you?

A. I believe I asked him, Is there anyone else that you're talking to about what's happened, and he said no.

Q. Okay, and this first appointment on December 2nd, the time of day that you met with him was what?

A. I'm not sure. I could back-check my calendar, but I don't have that information on hand.

Q. Did you understand that he had an appointment with a psychiatrist that same day?

A. No, I didn't know that.

Q. Okay. And did you suggest or ask if he had seen or was seeing anyone or was scheduled to see anyone in mental health and addictions?

A. No, I didn't. I wasn't aware that he was connected and I didn't know. No, I didn't ask him.

Q. Okay. I would assume that many of the clients who see you might also have some interaction with mental health and addictions locally. Is that something that you might typically ask a client, Are you seeing someone?

A. Unfortunately, a lot of the clients that I work with don't have a lot of contact with mental health and addictions because there isn't a lot of ongoing psychiatric support. So if someone's not being following regularly by a psychiatrist typically there would only be one therapist involved in a person's case.

So it's not very typical that there's myself and another therapist working on the same case, and it's very infrequent that someone is being followed regularly by a psychiatrist. That wasn't the case in other provinces where I worked, but here

in Nova Scotia it's very rare that someone has ongoing contact with a psychiatrist. Typically it's a one-time appointment for a medication review and that's the extent of the psychiatric support.

Q. Would that be relevant to you, though?

A. Yes, it would be relevant to know that.

Q. Okay.

A. Yeah.

Q. And did you specifically ask if he had seen any doctors for medication review or ...

A. I think that's something that over the course of the six assessment sessions that we would have covered, but again, we only met twice and that's not specific information that came up over the course of the two sessions. But it is information that I would gather over the course of an assessment more broadly.

Q. Okay. Okay, so for example, when you say, "Other professionals currently involved with physician, unsure, Follow up with M. Doucet for further information." Does that mean you were unsure or he was unsure?

A. I was unsure.

Q. Okay.

A. Yeah.

Q. And do you recall if you asked specifically, Do you have a family doctor?

A. I don't think that came up over the course of our first two conversations, but it is something that as we go through the assessment process, again, would be covered but wasn't covered in the course of our first two conversations.

Q. Okay. All right. so it just wasn't asked in those two sessions.

A. That's right.

Q. Okay. And I know you've addressed this, but this document which was written on January 4th, 2017 and you said, "Physician, unsure. Follow up with Marie Doucet for further information."

A. Mm-hmm.

Q. Again forward looking like something that you would have been doing.

A. Exactly, would have been doing. Correct.

Q. Okay, and psychiatrist. Again, do you recall if you specifically asked if he had seen a psychiatrist or ...

A. No.

Q. You don't recall whether you asked him that? Or you

did ask him that?

A. I don't think I asked him that, no.

Q. Okay, so again, the "unsure" would be it didn't yet get addressed.

A. Correct.

Q. All right. Along with that, would outpatient visits, especially relating to mental health, that would be relevant to you, would it?

A. Yes, it would be relevant.

Q. Okay, and would that be something that you would have asked, you know, Have you been to the Emergency Room for anything? Would you get that specific?

A. I think, you know, he had mentioned he had some suicidal ideation but no plan or intent to act on the thoughts that he had. So in my mind, there wasn't any imminent risk there. I didn't ask about hospital visits. I think if he would have disclosed a previous attempt or a higher level of risk I would have inquired about that but it didn't come up organically in the course of our conversation.

Q. All right. So he did have a visit to the Emergency Room at St. Martha's on October 24th, 2016.

A. Okay.

Q. He didn't disclose that to you and it didn't ...

A. No, he didn't.

Q. ... come up in the conversation?

A. No.

Q. All right. You knew he was coming from a military background, obviously, and you knew that he had a diagnosis of PTSD.

A. Yes.

Q. So obviously that diagnosis had to come from somewhere. He had to see a doctor.

A. Mm-hmm.

Q. Did you have an opportunity to ask about that, about who he might have seen previously in terms of doctors who might have given him that diagnosis or treated him?

A. Not specifically doctors but he did mention that he had been in an inpatient treatment program and also to the OSI clinic. And so knowing that he would have interacted with psychiatrists there, my assumption was that that's where he received those diagnoses.

Q. Okay. Okay, and this may be my own ignorance as to the process, but one would assume to be referred to OSI clinics or to the inpatient treatment facility in Quebec one would have

already had the diagnosis of PTSD. Perhaps I'm wrong about that. That didn't come up, that he would have seen a psychiatrist prior to that who would have diagnosed him or treated him?

A. I'm not sure if he did see someone prior to that. He didn't disclose that he had seen a psychiatrist at any earlier point. It didn't come up in our conversation. It wasn't a line of inquiry that I pursued during the two meetings that we did have.

From working with other veterans who have PTSD, they did meet with psychiatrists in the military while they were still enlisted.

Q. Right.

A. I didn't have any information about whether or not that was the case.

Q. Okay. All right. Is that something that you would have followed up on had you continued to see him?

A. Yes, I would have liked to have known what diagnosis he did receive and who made those diagnoses, how long he had had those diagnoses as well as what treatments had already been offered. That would help me to determine what treatments had been helpful and what treatments had not been helpful.

Q. So you did know about the inpatient facility in Quebec.

A. Yes.

Q. Did he discuss that with you?

A. Yes, he said that he had been to an inpatient treatment program but that most of the work that he had done there was in the context of a group and he found that overwhelming and not helpful. He found that it was very noisy. I think he had made mention to the fact that there were, you know, lots of therapists and doctors and that it was kind of overwhelming the number of professionals that he was interacting with, and I think he found the environment over-stimulating in terms of noise and the amount of people that were there.

Q. Okay. So sensory overload?

A. Right.

Q. Okay. So he said too much noise, group-based treatment, the number of professionals he was seeing. All of those were things that he found challenging about the program?

A. Yes, that's what he shared with me.

Q. Okay. But again, you weren't really familiar with the details of it or how it was set up?

A. No, I wasn't familiar with the details of the program.

Q. Okay. You had said how and why did these experiences end, which is referring to the inpatient treatment. This is on the top of page 2. You said: "It's unclear whether or not Mr. Desmond completed the inpatient rehabilitation program or if he was discharged early." Is that lack of clarity again because you didn't get to the point of discussing how it ended or he couldn't remember?

(15:59:58)

A. Well, I didn't have any information from Veterans Affairs about whether or not it was completed or he was discharged early. So I didn't have that information from them and it wasn't clear. As Mr. Desmond was talking about the program he talked about how difficult it was, and so I wondered to myself, Well, was he actually able to complete it.

But he wasn't able to really answer my question clearly. So I was left unsure as to whether or not he had completed that program or whether, because of the sensory overload and the challenges that he had, that he wasn't able to complete the program. I was unclear about that.

Q. In conjunction with that last sentence, you said his speech and narration of events is confused and disorganized.

A. And yes, non-linear.

Q. Okay, so he had some difficulty recounting to you the ...

A. What had happened there.

Q. ... narrative, I guess, from Quebec?

A. Yes.

Q. Did you get a sense, though, whether there were any kind of recommendations or any kind of a final report that emanated from his time there?

A. If there was I didn't have access to that.

Q. Okay. And he said he saw a lot of professionals there. Did he say what kind of professionals they were?

A. No. My assumption would be psychiatrists, psychologists, social workers, therapists, occupational therapists. That would be typical. But I don't know the details.

Q. Okay. All right. Now in "Health and Medical History" you do have a number of conditions listed that you indicate he had been diagnosed with. Or at least that were mentioned. "PTSD, chronic back pain, and the effects of multiple concussions." So the PTSD, obviously we know about that because that was, fair to say, I guess, the basic reason for the referral.

A. Right.

Q. So chronic back pain. He raised that himself?

A. Yes, he did. He offered that information.

Q. Okay. And did he say how he came to have chronic back pain?

A. No, he didn't.

Q. Just that he had it.

A. Yeah.

Q. Okay.

A. He said he had chronic back pain, yeah.

Q. So the effects of multiple concussions, so he talked about having had concussions?

A. Yes.

Q. Do you recall how that came up in the conversation?

A. He had brought up, as well, that he had hit his head several times while he was in the military and that he had had several concussions, and he felt that those concussions were still affecting him. So I asked him a little bit about how he felt that those had affected him, and he said that it contributed to him feeling kind of confused sometimes, that it was difficult to think clearly. He attributed the concussions to his inability to read music once he was transferred to the

military band.

He made the connection between the concussion and feeling like maybe that was part of the reason why he felt, like, the compulsive need to clean all the time and that maybe it affected his memory.

Q. And did he say when the concussions were sustained?

A. He didn't give me specific dates or a timeline, but I understood that it took place while he was in the military before he was discharged.

Q. And did you understand when he had been in the military?

A. He didn't give me exact dates and I didn't have any other corroborating information. But he did share that he had been deployed to Afghanistan in 2007 and discharged in 2015.

Q. Okay. So somewhere between 2007 and 2015. Perhaps before 2007 but prior to 2015 he sustained these three concussions?

A. I'm not sure it was three. He just said several.

Q. Sorry. Okay. And did he say if he had actually been diagnosed with a concussion? Or that was just his impression?

A. He didn't say whether or not he had been formally diagnosed, no.

Q. Okay. Did you get a sense, or did he offer, whether he had received any treatment for the concussions?

A. My understanding was that he hadn't received any treatment for his concussions. I did let him know that there was a post-concussion program at the CBI Clinic in Antigonish and that perhaps we could speak with a case manager about the possibility of attending that program to address the impacts of the concussion.

Q. Okay. Well, I guess you didn't know even if he had been formally diagnosed with a concussion.

A. Yeah, I didn't know.

Q. Are you familiar with post-concussion syndrome?

A. Yes, I am.

Q. And did you get a sense if that diagnosis might fit his presentation?

A. Difficult to say within the context of two meetings, but my impression, having worked with other people who have experienced post-concussion syndrome and who have concurrent post-traumatic stress disorder and post-concussion syndrome, it resonated with me as a strong possibility.

Q. Okay. And you had listed, I think, the things that he attributed to the concussions that he had sustained:

> Mr. Desmond reports hitting his head and incurring multiple concussions during his time in the military, which he states have resulted in him frequently feeling mixed up in his head. He discussed the impact of the concussions, including frequent episodes of confusion and disorganized thinking, inability to read music, not feeling like himself, abrupt changes in mood, increased compulsions around cleaning and short-term memory impairments.

So it was Mr. Desmond who attributed all of those symptoms to the concussions he had sustained?

A. Yes, when he was talking to me about the concussions he related the experience of the concussions to some of the current challenges that he was having. That's my language. It's not a verbatim ...

Q. Sure.

A. ... you know, what he said. But sort of clinical language to convey what he had shared with me during our meeting.

Q. Did he attribute any of those symptoms or problems to

his PTSD?

A. I'm not sure. I don't know how he saw that.

Q. Okay. It seems like many of the problems he was suffering from he actually attributed more to concussion than to PTSD?

A. That was my impression during our conversation, that the concussions were something sort of concrete that had happened that he, in his mind, was relating some of his challenges and difficulties back to. You know, as a clinician, I do think that some of what he attributed to the concussion could also be attributed to post-traumatic stress disorder.

Q. Is it easy to parse out which symptoms are ...

A. No, it's not easy to parse out, no.

Q. Okay. You said you've treated patients before with both. Can I say brain injury? Is that fair?

A. Yes.

Q. Okay. And PTSD?

A. Yes.

Q. Okay. The approach to treatment where somebody has a brain injury and post-traumatic stress disorder, does mode of treatment change?

A. No, but it is important to have professionals on board

who are specifically treating the post-concussion syndrome. So that would involve a physiotherapist, occupational therapist, massage therapy. Those are all important components of dealing with post-concussion. My role in treating post-concussion syndrome is more about how to support the person in dealing with their change in circumstances as a result of the concussion.

So not being able to do the things that they were able to do before and the psychological impact that that can have. There can be a sense of depression that can come after a traumatic brain injury. Also a sense of grief, not being able to do the things that a person was able to do in the past, having lost abilities and faculties that they would have, you know, had before.

So it's more about adjustment, and also the safety and stabilization work that's done in PTSD treatment is also indicated for the treatment of post-concussion syndrome.

Q. You said that the CBI Clinic in Antigonish was an option for him. Going forward, though, I assume he would need some more intensive treatment for his post-concussion syndrome or traumatic brain injury?

A. So you know, typically if we're able to do a referral to CBI my hunch is that they probably would have wanted some

additional testing, neuropsychological testing or some neurological testing, scans and things like that. So it doesn't mean that that had to take place before he could start the post-concussion program but it would have probably happened simultaneously, too.

Q. And the neuropsychological testing that you speculate he might have been offered or might have been suggested for him, where does one get neuropsychological testing?

A. That's something that a referral would have to be provided for. I'm not sure who the providers are in Nova Scotia, but that's something that would be done either from a physician or a psychiatrist. Or the CBI Clinic, as well, could offer those referrals, I believe.

Q. Not done locally, though?

A. No, I don't believe it's done locally. I believe that that would be done in Halifax.

Q. But the treatment for PTSD can continue despite the fact that the person has a brain injury?

(16:10:03)

A. Yes.

Q. So those were the three diagnoses that you became aware of from him.

A. Yes.

Q. Were you aware that he had been diagnosed with a major depressive disorder?

A. No, I wasn't aware of that.

Q. Did you see signs of depression?

A. Yes, I did.

Q. Okay. Does that diagnosis surprise you or not?

A. No, it doesn't surprise me.

Q. There was a suggestion in another report that he possibly suffered from attention deficit disorder. Is that something that you had been able to have any thoughts on?

A. No, not necessarily. It's not really my area of expertise. However, and this is also not my area of expertise, but I would wonder now, knowing what we know now and looking back, I would be curious, if there was neurological testing or neuropsychological testing, if it wouldn't have been prudent to assess for autism spectrum disorder.

Q. Oh really?

A. Yes.

Q. And why is that?

A. Well, it's a combination of factors. A flat affect is one component. Lack of interpersonal relationship. Lack of

friends. There was a few other things that, in the aftermath of this, made me wonder. The sensory overload at the clinic in Montreal. Those are all, you know, potential clues of something else, neurodevelopmentally, that might have been going on. That's outside my scope of practice, but if you're asking me what else I might have been curious about, I would have added that to the list.

Q. Right. And you weren't aware of what his medications were at the time, if any?

A. No.

Q. Okay. And he didn't have any medication with him?

A. He didn't.

Q. He didn't have prescriptions with him? Anything like that or forms.

A. No.

Q. Okay. Would knowing what prescriptions he was taking, if any, would that also be something that would've been helpful to you?

A. Yes, it would be helpful. It would give me an indication of, you know, possibly what some of the other underlying conditions might've been. For example, I know prazosin is often used for treating nightmares. So, you know,

knowing what a person's medication background is might give me a better sense of how they're struggling.

Q. Okay. You mentioned prazosin. Were you aware that he was taking prazosin?

A. No, I was not aware. No. Just as an example.

Q. Okay. You talked about his coping skills, as he described them, and those primarily related, it would appear, or the ones that he mentioned, involved cleaning vigorously and leaving the house either to walk or drive?

A. Mm-hmm.

Q. How did he describe those things or what did he say about them?

A. Well, he shared with me, when I asked him, you know, What do you do when things get difficult, when you have a hard time, when you're struggling? And he shared with me that he tries to distract himself. That's quite common. When a person doesn't really have other tools available, it's kind of a way to avoid or try to, you know, get rid of the negative thoughts and the intrusive images. And he reported that cleaning was a way that he could, you know, distract himself from the intensity of some of his symptoms. That he would go to the grocery store and wouldn't really be interested in buying food, but would really

be interested more in buying cleaning supplies. And that seemed to be one of the primary ways that he would distract himself when he was triggered and when his symptoms were more intense, that he would go for a walk or go for a drive, talk to his cousin, or maybe go to his aunt's house as well.

Q. When you reference alcohol and drugs, past and present, you say that: "Reports of alcohol and drugs have not been a primary coping mechanism for him."

A. Mmm.

Q. For some people, self-medicating with alcohol and drugs is a coping mechanism for dealing with trauma, is it?

A. Yes. Yes, it's quite common.

Q. Okay. Did he discuss with you his use of marijuana medically?

A. No, he didn't.

Q. Were you aware that he had taken marijuana?

A. No, I wasn't.

Q. Okay. Did you ask specifically, or have an opportunity to ask, about the use of cannabis or marijuana?

A. No, not specifically. I mean I asked him about alcohol or drugs and he shared with me that he didn't drink or use drugs. And so that was the extent of our conversation

around that.

Q. So there was a question, at least.

A. Yes.

Q. You know, Do you use, or have you used, alcohol or drugs?

A. Yeah. I think I asked him, Do you use alcohol and drugs? Is that something that you use to cope? And he said that it wasn't.

Q. Okay. So it was posed to him, I guess, in the ...

A. Present day.

Q. In the present day and in relation to coping?

A. Yes.

Q. Okay. So he didn't offer to you that he had been prescribed, or was a user of, marijuana to treat his symptoms in the past?

A. No, he didn't share that with me.

Q. Okay. In your clinical experience, have you had patients who use marijuana to treat the symptoms of trauma or post-traumatic stress disorder?

A. Yes. Quite a few.

Q. In your experience, is that helpful to patients or is it very patient-specific?

A. It's very patient-specific. It depends on how the person experiences the effects of the cannabis. If it's something that they find sort of relaxing. Some people find that it makes them feel more paranoid and more anxious. So it's not something that works for everybody but it has worked for some of the people I have worked with in the past.

Q. Okay. And we talked a little bit earlier about, generally, in the assessment phase, how you address or assess risk.

A. Mm-hmm.

Q. And you ask questions both about thoughts of self-harm and thoughts of harming others.

A. Yes.

Q. There was suicidal ideation here.

A. Yes.

Q. And what did he say that you characterized as suicidal ideation?

A. When I asked him, Do you have thoughts of killing yourself? He talked about he just wished that he had gotten blown up in Afghanistan. And I asked him, you know, Well, do you ever think about how you would do it if you were going to do it? And he said, No. And I said, Well what stops you? What

prevents you from taking action on these thoughts? What stops you from doing it? And at that time, he mentioned that it was his wife and daughter that prevented him from acting on those thoughts.

What he revealed at the time was more of a passive suicidal ideation. He didn't have a plan and didn't seem to me, anyways, at the time, that he was at imminent risk of acting on those thoughts, but that he wished, sometimes, that things were so difficult that he just didn't exist anymore. He wished not to live, even though he, in our conversations, didn't disclose that he was planning to act on those thoughts.

Q. You would describe that as a passive suicidal ideation?

A. Yes.

Q. Okay. And so that's to be distinguished from a situation where a person has an apparent intent to carry it out and perhaps progress to forming a plan?

A. That's right. So that would reflect more imminent risk. If someone has a plan and they are not able to say reasons why they wouldn't act on it or they're not able to say that they won't act on it. To me, those would be indicators of imminent risk. And then we would have to take next steps to

make sure that the person was safe, such as making sure that they were safely able to get to hospital.

Q. Apart from asking the question in the way that you do, do you use, in your practice, any suicide risk assessment tools?

A. No. It's informally woven into the context of the conversation. I don't use any formal assessment tools.

Q. Are you familiar with any suicide risk assessment and intervention tools?

A. Yes, I'm aware of some tools that exist.

Q. Okay. And, specifically, there is one that's used by the Nova Scotia Health Authority, I believe.

A. Mm-hmm.

Q. Locally. Are you familiar with that particular tool?

A. Yes, I've seen that tool before in my interactions with the Nova Scotia Health Authority.

Q. Okay. Is that a tool that you would ever consider using or would need to use or do you feel would be helpful?

A. I mean, typically, I'm assessing risk in many ways throughout my conversation with someone. I'm asking specific questions. I'm also looking at what's happening in the body. If they're activated, if they're in fight/flight, you know, what's their demeanour, in addition to the content of their

questions.

(16:20:00)

It could be possible. I mean it could be useful. But those are questions that we are covering in the course of the assessment anyways.

Q. Okay. And he described to you perhaps that his suicidal ideation was frequent.

A. Mm-hmm.

Q. Okay. And how would you describe "frequent"?

A. Well, I asked him, How often do you feel that way? And he said, A lot of the time.

Q. Okay.

A. Which is not uncommon. You know, most people that I work with, especially with complex trauma, sometimes have chronic suicidal ideation. It's a part of what they think about. It's an escape hatch. It's a way to think about what it might be like not to have to suffer anymore. So it wasn't uncommon to hear that it was frequent.

Q. In the "History of Violence and Homicidal Ideation" section of your report, you said that: "He and his wife argue frequently, particularly when his PTSD symptoms are active and when he has been triggered." So you've, I guess, spoken about

this a little bit, but there was an interrelationship then between his PTSD and the marital discord?

A. Yes. So particularly in the, you know, first probably one to three years following discharge from the military. That's when PTSD symptoms are typically most active, when there hasn't been an opportunity for treatment yet. There's also an adjustment time of the person coming back and they're reintegrating back into the home and into those relationships.

So when someone is triggered and they're in fight/flight, the fight in fight/flight often gets expressed as anger. And so that can manifest as marital conflict.

Q. Did you ask or did he indicate whether he had had any interaction with the police?

A. No. He didn't share that with me and when I asked him if any of his arguments escalated to the level of physical violence and he said that they didn't, I didn't pursue that line of questioning any further, you know, in part because I'm trying to make a safe and trusting relationship so that he will open up to me and tell me more about what's going on for him in the future.

So I don't want to, you know, go too deeply into risk management, you know, that he might feel that I was profiling

him or racially profiling him or, you know, that focusing too much on risk might have, you know, jeopardized the, you know, fragile process of building a trusting therapeutic relationship in the beginning.

So when he shared with me that there was no history of physical violence, I didn't inquire further about that.

Q. All right. When you discussed the post-traumatic symptoms that he was experiencing - a little further down, perhaps on the next page, I believe - you mentioned some of these that we're becoming familiar with. Nightmares, re-experiencing symptoms including flashbacks and intrusive memories, emotional dysregulation, including abrupt mood swings and self-reported PTSD frontal lobe impairments in memory, focus, concentration, judgment and decision-making.

When you talk about PTSD-related frontal lobe impairments in memory, and I know you've discussed this a little bit before, but those impairments in memory here are related to PTSD.

A. Mmm.

Q. But we know that he had a brain injury as well.

A. Mm-hmm.

Q. From concussions. So those effects on his memory, could they not be fully attributable to the brain injury?

A. Yes, they could be attributed to the brain injury as well.

Q. Or both.

A. Likely both.

Q. Okay. You have a section where you talk about the observations that you made of Lionel Desmond throughout your interaction with him, and the things that are listed as things to observe here are eye contact, dissociation, emotional affect, orientation to time and place. What can you say about those particular things when you were looking at him?

A. Well, I noted that Mr. Desmond appeared quite neatly dressed and put together. Well-groomed. He was very soft-spoken and polite and kind of meek as well, I would say. Again, there was a flat affect. So even as he was describing things, you know, that I imagined were upsetting, that wasn't reflected in his facial expressions or in what I would be scanning for in terms of physiological reactivity. I didn't see that reactivity during the two times that we spoke.

Q. You said, "His demeanour was meek and childlike, his posture collapsed and he sat folded over in his chair. Only occasional eye contact." Those characteristics, did you take those to be more a function of his personality or more a

function of his conditions?

A. I think it was too early to say. I'm not sure. It's not an uncommon presentation, when someone is suffering, to feel the sort of collapsed-over posture, sort of feeling downtrodden or defeated, helpless, hopeless. That body posture correlates with that experience, so that's not uncommon.

Again, that's partially why the therapy includes postural work. So as you correct the posture, you're also allowing for a corrective emotional experience. But at this time, I observed him to be upset and suffering.

Q. You talked about hyper- and hypoarousal earlier.

A. Mmm.

Q. I take it then that his state would be better characterized as hypoarousal?

A. Hypoarousal, yes.

Q. Meaning what?

A. So hypoarousal is a sort of disconnected shutdown. Numb, flat affect. Not really able to maintain eye contact. Kind of, sort of, feeling dead inside, numb. That kind of thing.

Q. All right. And you said again that, "His speech was confusing, fragmented and disorganized and he was having

difficulty expressing himself in a linear fashion."

A. Mmm.

Q. And that was throughout the appointments you had with him?

A. Yes. There were some things that he was able to speak more clearly about and other things ... you know, when he started to talk a little bit about some of his experiences in the military, again, we weren't going into too much detail, but he wanted to share a few things with me, specifically around what happened after the tour, when he was transferred to the military band and how challenging that was for him. And he was able to ... when he was talking about those issues, things were a lot more disorganized and non-linear and confused, which makes sense. You know, he was able to answer some questions more clearly.

Q. Okay. It's 25 after, Your Honour. I don't know if this is maybe a good point to break?

THE COURT: If it's a natural spot, Mr. Murray, in your examination of the witness, to conclude for the day, then that's exactly what we'll do. Thank you.

Counsel, we're going to adjourn for the day and we'll return tomorrow morning, 9:30 please. Thank you. Ms. Chambers,

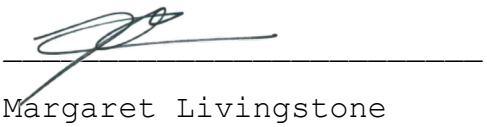
we'll see you tomorrow morning. Thank you.

A. Thanks.

COURT CLOSED (16:26 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.



Margaret Livingstone

(Registration No. 2006-16)

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