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 13, 2020

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CATHERINE CHAMBERS

February 13, 2020

COURT OPENED (09:35 HRS)

THE COURT: Good morning.

COUNSEL: Good morning, Your Honour.

THE COURT: Mr. Murray.

MR. MURRAY: Yes, Your Honour. We were in the midst of Ms. Chambers' evidence, Your Honour.

THE COURT: Catherine Chambers?

CATHERINE CHAMBERS, still sworn, testified:

THE COURT: When we adjourned yesterday, Ms. Chambers was testifying, she's still under oath, thank you. Mr. Murray?

DIRECT EXAMINATION

MR. MURRAY: Thank you, Your Honour. Good morning, Ms. Chambers.

A. Good morning.

Q. So when we left off yesterday we were in the process, I think, of going through your recollections of your interactions

with Mr. Desmond and how you recorded those in your assessment report. I wanted to ask you this morning specifically about your interaction with Mr. Desmond on January 3rd, 2017.

A. Okay.

Q. I understand you had some contact with him on that day and it was by telephone?

A. Yes, that's correct.

Q. Can you just kind of, first of all, walk us through how you came to be speaking to him that day? I understand there was a little back and forth between the two of you.

A. Sure. So on January 2nd I was arriving back home from being away visiting family in California and when I was at the airport I checked my messages, and this was January 2nd, and I had received a voicemail from Mr. Desmond asking when his next appointment was. And so I tried to call him back that day but he was ... he didn't answer the phone so the following day I called him back in the early afternoon to confirm our appointment time.

Q. So the contact you had received when you arrived home was on January 2nd?

A. Yes, that's correct.

Q. Was that another voicemail to text?

A. No, I checked the voicemail and heard the voicemail.

Q. Okay. And the content of that message on January 2nd from Mr. Desmond was what?

A. Was asking when his next appointment time was.

Q. Was there anything more in that telephone message?

A. No.

Q. All right. And so, sorry, I cut you off.

A. That's okay.

Q. You attempted to return his call?

A. Yes, I called him back to try to confirm with him but he didn't answer and I didn't leave a voicemail.

Q. Was that also on January 2nd?

A. That's correct.

Q. And do you have any recollection of the time that Mr. Desmond's message would have been left for you and when you returned the call?

A. I don't recall. I could check when the plane landed, it was shortly thereafter.

Q. Okay. And the message that you received from Mr. Desmond, you got it or were able to access it on January 2nd?

A. Correct.

Q. Was it sent on January 2nd?

A. I believe so.

Q. All right. Okay. So did you leave a message for him on January 2nd?

A. No, I did not. I called him back the following day.

Q. So did he have voicemail on January 2nd and you chose not to leave a message or ...

A. I can't recall.

Q. Okay. So you called him back on January 3rd?

A. Yes, I did.

Q. Okay. And what time of day did you call him back on January 3rd?

A. That was early afternoon.

Q. Okay. Just before that then, if we could have a look at Exhibit 77 and just the last of the messages there. That one, it says voicemail and it's January 2nd, do you recognize that?

A. Yes, I do.

Q. And what's that?

A. So that would be the voicemail to text conversion of Mr. Desmond saying that he had missed my call, to touch base with him tomorrow.

Q. So that was the first message that you received when you came back to Canada?

A. I can't recall if there was an earlier message, then I

had called him back after that, and he might have been calling me back after I left or called him on the 2nd. So it's possible that this was a third back and forth.

Q. Okay. So this could be the original one when you got back to Canada or a second one from him on the 2nd?

A. I'm just looking at the time of 6:53 p.m. ...

Q. Yes.

A. ... and I recall checking the message and calling while it was still light out, so my hunch is that there was ... that this is an additional call to touch base with him tomorrow ...

Q. Okay.

A. ... about confirming the appointment.

Q. So this voicemail to text message was from 6:53 p.m.?

A. Yes.

Q. And, again, I have a sense that maybe there might be some words misconstrued in the voicemail to text conversion but can you indicate what the message says?

A. So my understanding of the message is that he had missed my call earlier in the day and that I should call him tomorrow. I'm not sure what "great, I'll be in town" means.

Q. Okay. And so to your recollection was that the last communication between the two of you of the 2nd?

A. Yes, to my recollection.

Q. All right. So on the 3rd you returned his phone call?

A. That's correct.

Q. And do you recall the time of day that you returned his phone call?

A. Early afternoon at maybe approximately 1 o'clock or so.

Q. All right. And you called him?

A. Yes, I did.

Q. Okay. You had a cell phone number for him?

A. Yes, I did.

Q. Was it your recollection that it was a cell phone as opposed to a land line?

A. Yes, there was an area code 3-0-6 which is a Saskatchewan area code, I believe.

Q. Okay.

A. And so I knew that it was a cell phone.

Q. All right. So you called him and did you get an answer?

A. Yes, I did.

Q. Okay. And what was your intention in that call? What was the reason for the call?

A. The reason for the call was to confirm his appointment

time which was January 5th.

Q. Okay. You had made the appointment of January 5th previously when you'd seen him in December?

A. I believe we made that appointment after he had missed the December 19th appointment ...

Q. Right.

A. ... when we talked about re-booking, that was the date that we had decided on.

Q. Okay. When you spoke to him after the missed December 19th appointment?

A. Yes.

Q. Okay. Did you anticipate speaking to him prior to the January 5th?

A. No, I didn't anticipate speaking with him, however, he had called me on the 2nd wondering when the appointment time was so I believe on the 2nd we had a bit of back and forth trying to get in touch with one another. When I did receive that message, I made a mental note to contact him the next day to let him know the appointment time and, to my knowledge, that was the only purpose of the call was to just confirm the appointment time.

Q. Okay. So the message that he left you originally on the 2nd was asking about the appointment time?

A. Yes, he wasn't sure when the appointment time was and wanted to confirm it.

Q. Okay, all right. So you called him back around 1 o'clock-ish on the 3rd?

A. On the 3rd.

Q. Right. So I want you to tell us about that call.

A. Sure. Well, my initial thought was that I would confirm the time of the appointment and that would be the end of the call. However, once I contacted Mr. Desmond, he immediately started to talk about the events of January 1st and 2nd. So he proceeded to tell me about the automobile accident that he had been in and the circumstances surrounding the accident.

Q. Now yesterday when you testified, you had said that in the calls you have with clients you tend to want to just confine those organizational-type topics like, you know, appointment dates and the like?

A. That's correct.

Q. On this occasion, though, Mr. Desmond began to talk about more substantive issues?

A. Yes, that's correct.

Q. Did you feel it was appropriate to do it on that occasion or did you think it might be better to stop him and say,

We'll talk about this when you get in to my office?

A. Well, he began to talk about the accident and so the judgement call that I made at the time was that it was better to see if he was in crisis rather than hang up and wait until Thursday to speak with him.

Q. Is that your practice if a client is potentially in crisis?

A. Yes, if someone calls me in distress then I will switch the focus of the conversation to a crisis intervention.

Q. Did you get a sense as he began to talk about these topics that he was in crisis?

(09:45:00)

A. Yes, I did.

Q. Okay. And can you define what "being in crisis" means in that context?

A. Sure. In this context I would see that he was in crisis based on the fact that he just experienced a single-incident trauma so he had been in an automobile accident and sometimes when a person is working through a previous trauma, when something traumatic happens in the present day it can activate their PTSD symptoms and it can cause them to be more symptomatic, it can cause them to have thoughts of wanting to

hurt themselves or someone else, it can cause them to feel agitated, to feel depressed and to be in a lot of distress. So when he began to tell me about that, the mode of the call for me switched then into a crisis management situation.

Q. And that was a crisis management situation that you felt should be dealt with by phone?

A. Yes, I wanted to hear what was going on for him and try to make a safety plan. I technically was on vacation and so it wasn't possible for me to go in and to meet with Mr. Desmond in person but I did want to make sure that he was connected with the resources that he needed at that time up to and including going back to the hospital if that's what the situation required.

Q. Can you tell us, and I'm sorry I interrupted you, but can you tell us the content of the call, what he was conveying to you?

A. Yes. He shared with me that he was at a New Years party with his wife and family I believe and that he had had something to drink, his wife had had something to drink. He said that he had a good time but that on the way back from the party, I'm just saying in his words, he shared with me that his wife had been, in his words, "backseat driving" and wanted him to drive further to the right side of the road. He didn't want to do that

but did and the car went off the road and so he shared that with me.

He also shared that they had gotten into an argument after the accident and that his wife had asked for a divorce and had insisted that he go to the hospital. So he shared with me that he did go to the hospital on the night of January 1st and had stayed overnight in the hospital until January 2nd.

I asked him at that time if he had received any medications at the hospital or if he had seen a psychiatrist. He said that he didn't receive any medication, he didn't answer my question about seeing a psychiatrist. And then I wanted to ask him where he was, if he was safe, if he was away from the home, if he was thinking about hurting himself or anyone else and started to create a safety plan with him until I could see him on the 5th.

Q. As he described these events to you, can you tell the Inquiry if you made any observations about how he was speaking, about his speech, tone of voice, those types of things?

A. Everything was the same as during our appointments. He did not sound particularly agitated, that's something that I was listening for. He was calm. He said that he didn't have any plans to hurt himself or anyone else.

He shifted to speaking very specifically about his plans for

the future. He noted that he was going to have to look for safe and affordable housing. He also talked about wanting to make sure that he had access to his pensions and talked a lot about banking and housing, in particular, so he was oriented to the future.

He was speaking in very practical terms about what his next steps would be. And I asked him how he would know if he needed to go back to the hospital. And he said ... first he didn't answer, and I said, Well, what about those thoughts that you told me about, wanting to be blown up? And he said, Yes, if I have those thoughts or they get worse. And, I said, or if you have thoughts of hurting yourself or someone else that would be a reason to go back? And he said, Yes.

Q. So the manner of speech that you were hearing, that was the same as when he was in your office?

A. That's correct.

Q. You've described his manner of speech as, I think, kind of flat?

A. Yes.

Q. That was similar on the phone?

A. That's correct.

Q. And you had described earlier that his thought process

or manner of speech was sometimes non-linear and somewhat tangential. I don't know if you used that word, but a bit confused?

A. Yes.

Q. How did he seem on the phone?

A. Similar, yes.

Q. What do you mean by that?

A. Well, he was sharing events with me. I'm conveying them to you in a linear way but that's not how they were conveyed to me. The phone call was 26 minutes and it took me 26 minutes to cover everything that I just shared with you in the past couple of minutes.

Q. When he began to discuss more substantive issues, was it he who launched into that?

A. What do you mean by substantive issues?

Q. Well, anything apart from just confirming the appointment date. When he started to talk about the events of December 31st and January 1st and 2nd, was it Lionel Desmond who launched into that?

A. That's correct.

Q. Did you have to ask questions of him or ...

A. Yes, I did.

Q. ... did it kind of come pouring out?

A. It sort of came pouring out. At the same time I was asking questions like what had happened at the hospital. It was a little bit unclear what exactly had happened at the hospital, whether he had received medications, whether he had seen a psychiatrist or not, that was a bit unclear. The accident as well, he came back to it a couple of times as well as the housing and the banking. That seemed to be, once he told me what had happened, his primary focus and talked about that in kind of spits and starts. So I was trying to ask him a little bit more about it and at the same time reassuring him that we didn't have to have that all figured out today and that I wanted to make sure that he had a safe place to go and that we could talk about it on the 5th which I believe was a Thursday. And that we could, you know, reach out, speak to the case manager, speak to Helen Boone and that he would have lots of support and wouldn't have to navigate this alone.

Q. He indicated that his wife had asked for a divorce in this phone call?

A. That's correct.

Q. Did that appear to be something new?

A. Yes, it was.

Q. He had conveyed to you I think previously in the visits that there were some issues, marital discord, that their relationship was in flux I think is the term you used?

A. Yes.

Q. But there hadn't been reference to an actual request for a divorce until this call?

A. That's correct.

Q. Did you get a sense of what was bothering him the most, whether it was the accident, whether it was the request for a divorce, or something else or could you tell?

A. His primary concern after he shared with me what happened was where he was going to live and his banking situation. He was quite preoccupied with how he would have access to his pensions so he started to think about going to the bank and opening a new bank account, he went into some detail around that. He mentioned that he thought that Antigonish was too expensive, that he might move back to New Brunswick where it was cheaper, so he focused quite a lot of time on those aspects.

Q. He was unable to tell you whether he had received any medication at St. Martha's?

A. Yes, he was unable to tell me that.

Q. Did you specifically ask him that?

A. Yes, I did.

Q. And he didn't seem to have a memory or he wouldn't answer the question?

A. I'm not sure if he didn't have a memory or didn't answer the question or just shifted to another topic but I didn't get a clear answer to that question.

Q. And he was unable to answer whether he had seen a psychiatrist at the hospital?

A. That's correct.

Q. And same question, do you think that was that he didn't remember, wouldn't answer, couldn't focus?

A. I'm not sure if it was not remembering, a case of frontal lobe being offline, brain injury related, not being totally forthcoming, I'm not 100 percent sure what the reason was but I wasn't able to get a clear answer to those questions.

Q. He was, as you understood it, admitted to the hospital overnight or stayed in hospital overnight and this was as a result of the crisis that he was experiencing?

A. That's correct.

Q. In your experience, and maybe you don't know, but in your experience would a patient who is admitted to hospital overnight for this type of a crisis typically see a mental health

professional?

A. Yes, typically.

Q. Would there have been benefit following up with, again he didn't identify a person I appreciate, but if you were able to identify a person, to follow up with that person?

A. Yes, if I would have been able to meet with Mr. Desmond on the 5th, the focus of our work would have shifted to really ensuring that he could make it through this transition which had the potential to blossom into a crisis. I would have asked for permission to speak with the mental health professional and hopefully collaborate on a way moving forward.

(09:55:03)

Q. You said that the reason that, and correct me if I'm misstating this, but the reason that you engaged in a more substantive conversation with him was because he appeared to have had an event or a traumatic event, the accident, do I understand that?

A. That's correct.

Q. So is that ... that would be a single-incident traumatic event?

A. Correct.

Q. Did you get a sense of how serious this motor vehicle

accident was?

A. No, I didn't get a sense of how serious it was in terms of the actual accident. He didn't share too many details with me about it but it did register that it had upset him.

Q. Okay. And would the situation in his marriage and specifically his wife asking for a divorce, would that be characterized as a traumatic event as well?

A. Diagnostically probably not but I would consider it as falling on that spectrum.

Q. Okay. Did you have a sense of where he was when he was calling you?

A. My sense was that he was not in the family home, that he was calling me either from an aunt's house or another location.

Q. You had asked him, did you, or the topic came up of whether he had any intention of hurting himself or someone else?

A. Yes.

Q. Can you describe how that topic came up?

A. And that was a question that I asked when I was trying to get a sense of where he was at following these incidents. As we were talking it's something that I brought up so I asked him, you know, have you been having thoughts since this has all

happened, have you been having thoughts of hurting yourself or someone else and he said no.

Q. And did you phrase the question the way that you phrased it here?

A. That's correct.

Q. Okay. Any additional questions or discussions on that topic?

A. Yes. At the ... as we were making our safety plan and I was asking Mr. Desmond how he would know if he needed to return to hospital, he at first again didn't say much and I prompted him by reminding him of the disclosure he had made in a previous session around thoughts of feeling like he wished he would have been blown up and I said, you know, Is that the kind of thing that you might go back to the hospital for? And he said, Yes. I said, So if something ... if you have those thoughts again and they get worse, that would be a reason to go back? And he said, Yes. And I asked him, If you have those thoughts of hurting someone else or yourself would that be another reason to go back? And he said, Yes.

Q. Is that something that you would typically engage in a client, and I guess we're still in the assessment phase, in a conversation with a client in every appointment or is it

something that might be triggered by a traumatic event or some change?

A. It's something that I check in on. If someone has disclosed suicidal ideation, I do check in regularly around that, not necessarily every session. In this case, definitely checking in due to the trauma and the request for a divorce.

Q. Was there anything in his presentation, apart from the content of what he was saying, that was different or more concerning than when you had seen him in your office?

A. With regards to his presentation, no.

Q. Okay. But this obviously caused you some concern ...

A. Yes.

Q. ... because, as you said, you engaged in the safety planning and in the conversation about what had happened, is that correct?

A. That's correct.

Q. Now the concept of safety planning, what does that mean?

A. Safety planning is a way to try to ensure that a person who may be in crisis or there may be a potential for crisis, to ensure that they are somewhere safe, that the people around them are safe, and if there is a change in their circumstances that

they agree to follow the safety plan, to keep themselves and the people around them safe. It's not a guarantee but it's one of the tools that we can use as clinicians to try to make an agreement with a client who may be struggling in that way.

Q. Is that term "safety planning", is that a clinical term, is that something likely used by your colleagues as well?

A. I believe so.

Q. So the, I guess, safety planning, so the question is, of course, safety primarily for whom. So when you made a safety plan with him, who were you thinking about most particularly?

A. Sure. Primarily I'm thinking about Mr. Desmond because he had not revealed, again, in any of our interviews that there was a history of violence in his relationship. However, the safety plan also takes into account the safety of those around him including his family. So I would want to make sure that he was staying somewhere outside the family home and somewhere safe.

Q. Okay. And I think you used the term "safety plan and contracts"?

A. Yes.

Q. Okay. So a contract suggests an agreement?

A. That's right.

Q. What was it that you agreed with him about, I guess, in

the area of safety?

A. So the agreement was that if his suicidal ideation thoughts became worse or he felt like he might hurt himself or someone else, that he would return to hospital.

Q. And where did you understand that he would be living going forward or staying?

A. He shared an aunt's house, I believe.

Q. Was that what he said, an aunt's house or ...

A. Yes, a family member.

Q. Okay. So your primary concern, I guess, in terms of safety was for him and the concern about self-harm?

A. Well, the concern is is he going to hurt himself or anyone else so by making sure that he's in a safe place away from the family home and has an agreement to return to hospital if his symptoms worsen, it's safety for him and also for his family.

Q. Okay. You said that your conversation, your recollection was you said around 26 minutes?

A. Yes, I saw that call record so ...

Q. Okay. And that's from the call record which we have as an exhibit so and it indicates that the call was 26 minutes, does that accord with your memory of the length of the call?

A. Yes.

Q. Where were you when you took the call?

A. I was at home.

Q. At home, okay. And you were on a cell phone as well?

A. Yes.

Q. Okay. And you didn't take notes of this particular call as well?

A. No.

Q. Okay.

A. I did however follow-up immediately after the phone call and contacted Marie Doucet, the Veterans Affairs case worker, to let her know about the motor vehicle accident and Mrs. Desmond's request for a divorce and also informed her of the safety plan and Mr. Desmond's status at that time.

Q. Status?

A. As in we had made ... that he hadn't had any thoughts of hurting himself or anyone else, that we had made an agreement that he would return to hospital if things worsened for him, that's what I mean by status.

Q. Okay. So mental health and kind of living and social status?

A. Correct.

Q. Do you recall when you contacted ... that was Ms.

Doucet, then, was it?

A. Yes.

Q. And when was that in relation to the call?

A. That was immediately following the call.

Q. Okay. Can you give me a sense, when you deal with clients who are funded by Veterans Affairs, I appreciate that regular updates are required at some intervals. When is it understood that you might contact a case worker to give them an update about something a little more significant or urgent?

A. Well, if the person's living situation has changed, if the status of their relationship has changed, if there's been a significant change, if someone in their life has died, if there's a significant loss, if there's an additional trauma, something that we would need to access additional supports, then I would want to make sure the case manager knew about that.

Q. And the types of supports that might be necessary because you did call her here ...

A. Yes.

Q. ... what kinds of supports did you see him as needing going forward?

A. So certainly the support of Helen Boone, clinical case manager. I would have also recommended ongoing psychiatric

support. I would have recommended a referral to the post-concussion program at CBI where he would have received occupational therapy, physical therapy, massage therapy.

Q. Were these all things though, I'm just talking about the call with Marie Doucet on the 3rd of January and perhaps I'll be a little clearer. Did you talk about what supports in that call he might need?

A. I primarily talked with Marie Paule Doucet about engaging her and Helen Boone in additional support for Mr. Desmond at that time.

(10:05:03)

Q. Okay. And what was the information that you conveyed to Marie Doucet in that call on January 3rd?

A. I gave her my ... a summary of the call that I had had with Mr. Desmond including the disclosures that he made about the automobile accident, about the request for a divorce, about his concerns around housing and banking, and about the safety plan that we had made.

Q. And the two events that seemed most significant there again are the motor vehicle accident and the now pending divorce and change in circumstances arising from that. Can you say which of those was most significant to him?

A. I can't say which was more significant to him. I know that once he told me what happened, he shifted quite quickly into more practical matters so it would be hard to say what affected him more and what his main concern was but he was also very concerned about the practicalities of what he was going to do from here.

Q. Is there anything else about the content of that call that you can remember beyond what you've told us here?

A. No.

Q. The appointment that you had scheduled was for January 5th?

A. Correct.

Q. And so you speak to Marie Doucet on the 3rd of January about that call.

A. Yes.

Q. Was there, and you've answered some of this, but and I appreciate that, you know, you were on vacation, I understand all that, but was there any sense that he should be seen either by you or by hospital more immediately?

A. I didn't assess any imminent risk or any imminent risk of harm so I didn't determine that there was any immediate need to be seen or to ensure that he made it to hospital immediately.

Q. Do you remember how the call ended?

A. Yes, I spoke with Mr. Desmond and just reassured him that this was not something that he had to do on his own, that he had lots of support, and that we didn't have to have all of the answers today and that we could figure out where to go from here when we met on Thursday.

Q. Which was the 5th?

A. Correct.

Q. All right. Did he seem ready to end the call?

A. Yes.

Q. Okay. So after updating Marie Doucet, was there anything additionally that you did on the 3rd of January?

A. No.

Q. Do you recall when you heard the news, which day it was?

A. Yes, it was January 4th in the morning.

Q. Okay. And do you recall how you heard the news?

A. Yes, I believe it was on either I looked on Twitter or some kind of social media.

Q. Okay. And this is a big question but how did you feel when you heard that news?

A. It would be hard to put into words. Devastated.

Q. Practically after hearing the news, what was your next point of contact on the file I guess?

A. Can I request a five-minute break?

MR. MURRAY: Sure.

THE COURT: Thank you. We'll take a recess until Ms. Chambers feels like she can return. Okay, you can let us know, thank you.

COURT RECESSED (10:09 HRS)

COURT RESUMED (10:39 HRS.)

THE COURT: Mr. Murray, we'll begin again. Ms. Chambers, if circumstances arise you would like a break, you know that you would like to have a break before you actually require it, you let us know.

A. Thank you very much.

THE COURT: All right. We'll find time for you. Thank you.

A. Thank you.

THE COURT: Mr. Murray.

MR. MURRAY: Thank you, Your Honour.

Ms. Chambers, I appreciate, I know this is incredibly difficult but we're working our way through it.

A. Yes, we are. Thank you.

Q. I had asked you prior to the break about your next point of contact on the file after you received the news. Do you recall when and with whom that was?

A. In terms of my follow-up call with Marie Doucet?

Q. You said that you had done a follow-up call with Marie Doucet after your call with Lionel Desmond on the 3rd.

A. Yes.

Q. You learned of the news the next day, on the 4th.

A. Um-hmm.

Q. And after that, with whom had you spoken next?

A. I spoke with Marie Paule Doucet again on January 4th. We spoke about the fact that she was looking for the assessment as far as I had gotten along with it.

Q. Right.

A. And was requesting that I send that in sometime over the following week. And we had talked about what happened and offered each other some support.

Q. Okay. And so that was, I guess, the reason for the creation of Exhibit, the number escapes me, but your assessment report?

A. That's correct.

Q. And that document you ultimately provided to Ms.

Doucet on the 10th of January?

A. Right.

Q. Perhaps if we could bring up Exhibit 117. Maybe we will go to the first page just briefly. This is a document entitled "Case Plan". I don't know if this is a document that you, in the normal course of your practice - it's a Veterans Affairs document - that you would have familiarity with?

A. No.

Q. Okay. This is a document not produced by you and it's not shared with you then?

A. That's right.

Q. All right. You have had an opportunity, I think, to look at certain portions of this particular document in preparation for today, is that correct?

A. That's correct.

Q. All right. I just wanted to ask you a couple of things. On page, if we could go to page 6 of this document, near the top there's an entry here that appears to be from January 10th, 2017, an entry made by an M.P. Doucet, which I assume is Marie Paule Doucet, and it says:

> On January 4th C.M. contacted H. Boone, CCM, who confirmed she had last spoken to the

veteran on Monday, January 2nd, by telephone. She provided a summary of their conversation. He was concerned about having to look for his own place given recent conflict with his spouse. CCM, who had recently attempted to connect veteran with a local family-focused agency, FSENS (which I believe is Family Services of Eastern Nova Scotia) revisited his reluctance to engage. She described how the people there could assist with resources such as housing. The veteran ultimately agreed to connect with a particular contact CCM provided once the agency re-opened its doors the next day, January 3rd. She also recommended touching base with his counselor. They hung up after agreeing to reconnect by phone before the end of the week to see how he had made out.

Did he mention in his conversation with you, in his telephone call with you of January 3rd, that he had spoken to Helen Boone the preceding day, January 2nd?

A. No.

Q. Did he tell you that or indicate to you that she had suggested that he call his counsellor, who, I assume, was you, on the 3rd of January?

A. No, he didn't indicate that.

Q. You did say earlier in your conversation with him that you had talked about him connecting with his clinical case manager?

A. Yes.

Q. And that he didn't mention having spoken to her the day before?

A. No, he didn't.

Q. And you had said that you spoke to Marie Paule Doucet after your telephone call with Lionel Desmond on the 3rd of January?

A. That's correct.

Q. Did you get a sense of whether she was taking notes or recording or making notes of your conversation with her?

A. I'm not sure if she was taking notes, but she did indicate at the time that she was going to follow up with Mr. Desmond after our phone call.

Q. All right.

THE COURT: Sorry, that was January 3rd conversation?

MR. MURRAY: The January 3rd call.

A. That's correct.

MR. MURRAY: Okay. And then you spoke to Ms. Doucet again on the 4th.

A. Yes.

Q. And you said you gave each other some support.

A. Mmm.

Q. And she asked you to complete the progress report of what you had to that point within a week?

A. Yes, approximately, yes, to get that to her within a week or so.

Q. All right. Did you have additional contact with Marie Paule Doucet after that?

A. Yes. We spoke on the phone, I don't know the exact date, could have been the 10th when I sent over the report and that was less of a professional contact as just to see how each other was doing.

Q. Okay. Did Marie Paule Doucet give you any indication of - and I appreciate you're not familiar with 117, except for review afterwards - but whether she was making entries as she was speaking to you or recording the contents of your conversation?

A. She didn't indicate that. I'm not sure.

Q. Okay. And if we could just go down a bit there, to the next block down, there's an entry here from January 10th, 2017, that refers to, it would appear, your telephone conversation with her of January 3rd.

A. Mm-hmm.

Q. Ms. Doucet didn't indicate to you anything about when she made that entry or anything of that nature?

A. No.

Q. All right. So you spoke to Marie Doucet on the 10th of January and you provided her with the report?

A. Mmm.

Q. Did you have any additional involvement in the matter?

A. No.

Q. Until this, obviously?

A. That's correct.

Q. Had this tragedy not occurred and had you continued to see Lionel Desmond in the assessment phase of the process, I guess you would have had more sessions by way of assessment, would you?

A. Yes.

Q. Had he attended at your office on January 5th, having had the conversation on the 3rd and having had those concerns

about safety planning, what would you have done with him on the 5th?

A. On the 5th I would have done a mental status, a brief mental status exam to see what his level of activation in terms of his PTSD symptoms were. I would have done a thorough risk assessment, including suicidal ideation, homicidal ideation, any other kinds of self-harm. I would have re-engaged him in safety planning. I would have connected him to not only his case manager and clinical case manager but I would have inquired about psychiatric support and connected him also to resources that could potentially support him with the transition in terms of housing, and we would have focussed on his immediate situation.

Q. And if we could go to P76, page 5. From the last page of the main part of your assessment, you had made recommendations. Do these refer to, I guess, the steps that you would have seen happening had things gone forward?

(10:49:09)

A. Yes, that was my intention in filling out the "Recommendation" section, even though it was moot at that point, but I did want to convey in the report what I would have done had I been able to meet with Mr. Desmond on January 5th and going forward.

Q. It would have been your intention to continue to engage in further assessment ...

A. Yes.

Q. ... history taking and treatment planning?

A. Yes.

Q. To collaborate with his care team, Marie Doucet and Helen Boone, as well as his GP and any psychiatrist he might be seeing?

A. That's correct.

Q. What would the nature of your collaboration have been with his GP and/or psychiatrist?

A. Well, the nature of the collaboration would be to ensure that we were all working with the same information, also to ensure that we were all assessing for risk and that we were all conveying the same messages to Mr. Desmond in terms of supports, what was necessary, and how we could be of service to him. So it would be about collaborating and offering sort of a wraparound with his care so that we weren't operating in silos. That would have been the point of that consultation.

Q. When you use the phrase "wraparound", I think you made reference to it yesterday, what is that, when you use that phrase?

A. Well, that's the idea of working in a more collaborative way with the supports that exist in a person's life, so that can include formal supports, medical professionals, GPs, psychiatrists, any other mental health professionals. If the person is seeing a crisis counselor, for example, at the hospital, we would speak to and collaborate with them, and it's the idea of sort of creating a circle of safety and support around the person. That may also include family and friends if the person is agreeable to that. Of course we need their consent to do that.

Q. Would you have foreseen sharing, for example, your psychotherapy assessment report with a GP and/or a psychiatrist?

A. That's common practice.

Q. You would do that normally, would you?

A. Yes, I do that normally.

Q. Okay. And going forward, if they had, in particular, let's say a psychiatrist, if, again, Lionel Desmond consented, would you foresee obtaining records from any visits with a psychiatrist?

A. Yes. I think if we had the opportunities to collaborate in that way, that that information would have been shared.

Q. In your "Recommendation" section you said you would have consulted with his case worker or case manager about the possibility of his participating in the CBI's post-concussion rehabilitation program, and you had mentioned that yesterday.

A. Yes.

Q. You had also talked about the necessity or the value in a neuropsychological assessment for Mr. Desmond.

A. Yes.

Q. Is that something that you feel would have been appropriate for him?

A. Yes, I do.

Q. I don't believe you had a lot of specifics, though, about where those are offered or wait times for those.

A. No, that's something that would be done in consultation with an MD, so either a psychiatrist or a GP, they would be the ones who would have to put the referral in for that. So that would be done in consultation.

Q. All right. In the time that you did speak to Lionel Desmond did you have any conversation with him about his accessing military medical records or did he indicate to you if he had attempted to do that or if he had any ... met any, I guess, obstacles or barriers in doing that?

A. He didn't reference that in our conversations.

Q. Okay. In your experience more generally with veterans has that topic ever come up?

A. Yes, it does come up. There are veterans who, many veterans that I work with who would like to have access to their military records. The only situation where I've ever seen a person be able to access those was a psychiatrist writing on behalf of the client in order to obtain those records.

Q. Have you ever, I guess, worked with either a case manager or with a client to attempt to get those records?

A. No, I haven't. It's something, typically, I believe the request has to come from the medical professional.

Q. Okay.

A. Someone with an MD, so ...

Q. Given that Lionel Desmond was a veteran who had a diagnosis of PTSD, are you aware from your clinical experience as a counsellor of any other programs that might have been available to him that might have benefitted him?

A. Not in our area, no.

Q. Okay. Do you have any additional thoughts from your experience with respect to the issue of information sharing among clinical professionals? You referenced the term silos, and

we've heard that before.

A. Um-hmm.

Q. Is that typically a problem and do you foresee any changes to that or ways to improve that?

A. Yes, I think that the sharing of information and taking a collaborative approach to treatment is, I think, a very important direction that our profession needs to take very seriously. And I think that having an opportunity to review someone's, specifically their mental health records, going back to their time in the military, through their transition, with Veterans Affairs, so that any treating professional can have a sense not only from the disclosures that a client makes but from medical records, as well, would allow us to have a fuller picture of the history, the challenges, and what our focus for treatment needs to be going forward. So I think reference has been made in some of our conversations, as well, about the possibility of a database where anyone who engages with a veteran uploads or shares information and can also access information from other professionals who have interfaced with the veteran would be extremely helpful.

Q. You've heard the phrase "one patient one chart" that's sometimes referenced by the Nova Scotia Health Authority?

A. Yes.

Q. Is that something you would see of value?

A. Yes, I do think it would be of value. I think it would be quite a large challenge but I think it would be of tremendous value.

Q. Okay. I just had one additional question that I meant to ask you. On the Exhibit 77, which is your screenshots from your text messages, your thought, if I understood you, was that the last one on that page from January 2nd was the second contact from Lionel Desmond on the 2nd of January?

A. I believe so.

Q. Okay. You're not certain but you think so?

A. I'm not certain but I believe so.

Q. On your phone is there a functionality that automatically converts voicemail to text or is there something you have to do to do that?

A. On my previous phone it was automatic. On this phone I haven't been able to figure it out but, yes, that happened, that was an automatic feature on the phone I had at the time.

Q. Okay. Was there a voicemail to text, then, prior to that, for the first call?

A. No. No. That would have all shown up under his ...

the heading of his phone number.

Q. Okay. And perhaps not a big issue but I just wanted to be clear, you said there was a voicemail when you first got back to Canada.

A. Yes.

Q. And your best recollection is you called him back and then he called you back.

A. Right.

Q. You played telephone tag. This is the second voicemail; it was converted to text.

A. Yes.

Q. Any reason why the first one wasn't converted to text?

A. I don't know.

Q. Okay. All right. Thank you, Ms. Chambers. Those are all the questions that I have.

A. Okay. Thank you.

THE COURT: Thank you. Ms. Ward?

MS. WARD: Thank you, Your Honour.

CROSS-EXAMINATION BY MS. WARD

(10:57:41)

MS. WARD: Ms. Chambers, my name is Lori Ward and I

represent the Attorney-General of Canada and that includes Veterans Affairs and other federal departments.

A. Okay.

Q. I just want to get some clarity on the process involved in becoming a registered service provider. So you have a private practice where you provide therapy to your clients?

A. Mm-hmm.

Q. How do you become registered so that you're on a roster that you would be contacted by Veterans Affairs?

A. So if I recall, the process is to contact Blue Cross, provide a copy of my license as well as my proof of insurance, and then I was given a provider number, and from there I was able to then direct bill on behalf of veterans for my services.

Q. So you became registered with Medavie Blue Cross, I think it's called.

A. Yes.

Q. And that means that you could be contacted by other funders besides VAC?

A. Right.

Q. When was the first time you were contacted by VAC in respect of taking on a veteran as a client, do you recall?

A. Well, I started practicing and opened my clinic in

February of 2016, so it was not ... shortly, it was very shortly thereafter, so either February or March of 2016.

(10:59:04)

Q. And you said you have many clients who are veterans or of the Forces?

A. Yes.

Q. So it's your understanding, then, you talked about direct billing, so when you take on a client, or I understand Mr. Desmond may not have ultimately been your client because he was still in the assessment phase, but is it your understanding that when you take on a client who has a funder like VAC, that all the billing passes between you and the funder and Blue Cross and that the client doesn't deal with any of that paperwork?

A. That's correct.

Q. Okay. And so you would, aside from providing your updates to Veterans Affairs, you would send your bills to Veterans Affairs or would they go to Blue Cross?

A. That goes directly to Blue Cross through the portal. There's an online portal through Medavie that you can log on and register for with a username and password, and then we use the Veterans' K-number in order to enter that into the system, and there's a drop-down menu with codes in terms of what service

we've provided. And the case manager would authorize sessions and communicate that to Blue Cross so that it would be updated in the portal.

Q. Okay. And the veteran client doesn't see any of that paper?

A. No.

Q. Those are my questions. Thank you.

A. Thank you.

THE COURT: Ms. Lunn?

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

THE COURT: Thank you. Mr. Macdonald?

MR. MACDONALD: Good morning, Your Honour. Mr. Morehouse will be doing the examination.

THE COURT: Okay. Mr. Morehouse?

MR. MOREHOUSE: Thank you, Your Honour.

CROSS-EXAMINATION BY MR. MOREHOUSE

(11:00:54)

MR. MOREHOUSE: Good morning, Ms. Chambers.

A. Good morning.

Q. I'm Thomas Morehouse. I'm co-counsel with Tom Macdonald in the representation of Shanna's parents, Ricky and

Thelma Borden, and also Shanna's brother, Sheldon Borden, and we also share representation of Aaliyah Desmond with my friend, Tara Miller, but you can call me Tom.

Ms. Chambers, I want to clarify one point, my friend Ms. Ward touched on it, was Mr. Desmond your client or wasn't he?

A. He was not officially a client of psychotherapy. He was a client for the purposes of an assessment.

Q. Okay. Was Mr. Desmond aware of this sort of limbo period in his treatment or would he just say, like, You're my counsellor?

A. No, from his perspective he would have seen me as his counsellor.

Q. Okay. Ms. Chambers, we've heard that you have a lot of experience treating veterans, specifically veterans with PTSD, is that correct?

A. Yes, I do.

Q. Okay. Ms. Chambers, I want to take you back to your Individual Psychotherapy Assessment Form, which is Exhibit P76. I'll refer to it if I have to. Now you sent this document to Marie Paule Doucet on January 10th, 2017?

A. Correct.

Q. You found out about the event on January 4th, is that

correct?

A. Yes.

Q. And in your call with Marie Paule Doucet that day she requested this Individual Psychotherapy Form?

A. Yes.

Q. Why did it take you until January 10th to submit the form?

A. Well, I immediately started documentation when I learned of the events on January 4th, starting with a very detailed timeline of events, and wanted to take my time to ensure that the information that I was submitting was accurate and to the best recollection that I had of events. And it was a very distressing time in the days following the events of January 3rd and I wanted to make sure that I was being as clear as possible and that I had the timeframe to do that, so that it wasn't written with any kind of emotion.

Q. Mmm. So you have six days to kind of mull over this Individual Psychotherapy Assessment Form. Would you say it's as close as possible to being exhaustive of your recollection at the time?

A. I would say it's as close to exhaustive as I can remember, yes.

Q. All right. Thank you. Now Ms. Chambers, I want to go through some of the content in your Individual Psychotherapy Form. So leading in to this January 3rd, 2017, call with Lionel Desmond, you were aware that Lionel Desmond was a combat veteran with PTSD, is that correct?

A. That's correct.

Q. You were aware that Lionel Desmond was relatively isolated, he only had one friend in Nova Scotia, which was his cousin?

A. That's correct.

Q. You didn't have a firm diagnosis but you suspected that Lionel Desmond suffered from depression, is that correct?

A. That's correct.

Q. Mr. Desmond also reported to you that he had a poor response to therapeutic treatment at Ste. Anne's?

A. That's correct.

Q. You also reported in his post-traumatic symptoms that he had feelings of hopelessness, is that correct?

A. That's correct.

Q. You also noted that he felt he had no purpose in life, is that correct?

A. It's not something we were able to explore in depth,

but that was my sense, that he was a bit lost after being discharged from the military.

Q. Okay. Through your two 50-60 minute face-to-face meetings with Lionel Desmond and your January 3rd call with him, you suspected that Lionel Desmond may have been suffering from some form of brain injury?

A. Yes, that's correct.

Q. And this was, to the best of your knowledge, due to multiple concussions that Lionel Desmond had reported to you?

A. That's correct.

Q. You also note in your Individual Psychotherapy Assessment Form that Lionel Desmond suffered from impairments to his judgment and decision-making, is that correct?

A. That's correct.

Q. You also noted that Lionel Desmond reported to you that he experienced emotional lability, is that correct?

A. He reported that. It was not directly observed.

Q. Can you explain to me what "emotional lability" is?

A. In layman's terms it would be mood swings.

Q. Okay. Would it be, you know, just general mood swings or would it like a clinical term for mood swings?

A. It's more of a clinical term for mood swings. It

means that a person can experience fluctuations in their mood and their emotions can be intense and a little bit unpredictable.

Q. If I get angry because I'm hungry and my mood kind of shifts that way, would I be emotionally labile? Is that the correct term? Or is it something more severe than that?

A. I don't think being hangry would be considered emotionally labile.

Q. Okay. Now you also noted in your form and you testified in your evidence yesterday that Lionel Desmond reported to you frequent suicidal ideations, is that correct?

A. Yes. He reported that he frequently felt like he wished he would have just gotten blown up.

Q. And this isn't in your report but you stated in your evidence yesterday that when you explored the issue of suicidal ideation with Lionel Desmond, he reported to you that the reason why he wouldn't follow through with a suicidal act was because of his wife and daughter, is that correct?

A. That's correct.

Q. Okay. Now I want to move to your phone call with Lionel Desmond on January 3rd. During this phone call you became aware that Lionel Desmond's wife was asking for a divorce, is that correct?

A. That's correct.

Q. You were also ... you also became aware that Lionel Desmond's living situation all of a sudden became, it came into flux, he didn't have a permanent place to live anymore?

A. That's correct.

Q. He also reported to you that he was feeling stressed and anxious, is that correct?

A. Yes, he did.

Q. He also reported to you that he was experiencing an increase in his PTSD symptoms?

A. That's correct.

Q. So ultimately at the end of this phone call you have with Lionel Desmond you negotiated a safety contract with him, is that correct?

A. That's correct.

Q. Did you negotiate a safety contract with Lionel Desmond after your meeting on December 2nd?

A. No.

Q. Did you negotiate one with him after your meeting on December 15th?

A. No.

Q. So you negotiated one on January 3rd for a specific

reason that wasn't present in your meeting December 2nd or December 15th, is that correct?

A. That's the change in his circumstances.

Q. Okay. And you ... I think you testified that he was experiencing some form of crisis, so you negotiated a safety contract because of that?

A. That's correct.

Q. Now after you ended your call with Lionel Desmond, you said you immediately called Marie Paule Doucet, is that correct?

A. That's correct.

Q. Can you give an estimation of the time it took between the close of your call with Lionel Desmond to when you ultimately called Marie Paule Doucet?

A. Under five minutes.

Q. Under five minutes? You testified yesterday that in the normal course of a counsellor/client relationship where VAC is a funder, VAC requires an update once every six months, is that correct?

(11:09:02)

A. Approximately.

Q. So this update to Marie Paule Doucet, this was uncharacteristic, is that correct, of a normal file?

A. It was characteristic in the sense that if anyone I'm working with is struggling or in crisis, I would let the case manager know.

Q. Okay. Ms. Chambers, would you agree with me that somebody expressing explicitly a suicidal intent or plan is not the only indicator of suicidal risk?

A. I would agree with that.

Q. Ms. Chambers, would you also agree with me that somebody could actually be at a high risk for suicide without ever stating a suicidal intent or plan?

A. Yes, it's possible they could be at high risk, based on various factors such as the ones that you mentioned. However, as a clinician, we need to make the distinction between high risk and imminent risk. And if someone denies the fact that they are going to act on the thoughts that they have, it is not up to me to ensure ... I can only do what I can do in terms of asking, and if a person says that they are not going to act on their thoughts, it's not my role to call the police and have the police escort them to the hospital. There's a difference between being at high risk and being at imminent risk.

Q. Okay. Ms. Chambers, you mentioned in your testimony today that if Lionel Desmond hadn't done the act that he did and

that you had the counselling session with him, as scheduled, on January 5th, you would've done a thorough risk assessment. Was your risk assessment on January 3rd less than thorough?

A. No, it was not.

Q. Okay. Ms. Chambers, I want to clarify another point from your testimony yesterday. You said that in your experience of treating veterans, you found that, you know, moreso in the general population, veterans struggle more with expressing their struggles. Is that correct?

A. I would agree with that.

Q. Ms. Chambers, I want to pose a hypothetical to you. If, during your phone call with Lionel Desmond, you became aware that Lionel Desmond had the intention or potential to place him or others in imminent risk of harm, you would take steps to prevent that harm. Correct?

A. That's correct. And I just want to also point out that that's something that I've done many, many times throughout the course of my career. If anyone expresses even a slight hesitation when I ask the question ... so if I ask the question, Do you have any thoughts of hurting yourself or someone else, and the person pauses and then they say yes, that's something that I would pick up on and explore. I might say something like, Oh,

you paused there. Are you a little unsure about that? So it's up to me to probe in a thorough way to make sure that that person is not at imminent risk of suicidal or homicidal intent and plan an action.

I have conducted dozens of suicide interventions in my office as well as over the phone. If someone expresses that they're imminently suicidal, it's up to me to negotiate with them a plan to get them to the hospital. If they refuse to participate in the plan, then I call the police and have the police escort them to the hospital. And I've done that on multiple occasions in terms of both suicidal and homicidal ideation and risk.

Q. Did you ask any of these probing questions to Lionel Desmond during January 3rd?

A. What probing questions are you referring to?

Q. You just mentioned that if you got a sense that somebody may be hiding something or not being entirely forthright, you would ask probing questions to get at any potential risk. Did you ask any of these probing questions to Lionel Desmond on January 3rd?

A. Mr. Desmond did not present on the phone call as though he was at imminent risk. He answered decisively when I asked the

question and I did not get the impression at that time that he was at imminent risk, based on the manner of ... the way he answered the question as well as the content of his answers.

Q. Okay. Ms. Chambers, let's continue with the hypothetical. If you thought that a safety contract with Lionel Desmond would be ineffective in preventing any imminent risk of harm that may have existed, you would do something else to prevent the harm. Is that correct?

A. That's correct.

Q. Ms. Chambers, let's just explore the safety contract that you did form with Lionel Desmond on January 3rd. If I understand your evidence correctly, the safety contract you negotiated was that if Lionel Desmond's suicidal ideations got worse, he would go and check himself into a hospital. Is that correct?

A. Yes. If his suicidal ideations became worse or he felt like he was going to hurt himself or someone else.

Q. Okay. In your form, you state that the safety contract you negotiated would be if Lionel Desmond became overwhelmed or unable to cope, he would check himself into hospital. So are you equating overwhelmed and unable to cope with an increase in suicidal ideations?

A. I was explicit with Mr. Desmond on the call that if his suicidal ideation became worse or he felt like he was going to hurt himself or someone else, that that would be an indication to return to hospital.

Q. Okay.

A. The report is a summation or summary of that.

Q. Okay. And just so I'm clear, you said that you asked Lionel Desmond forthrightly, Do you have any intent or plan to hurt yourself or anybody else? And he answered definitively, No.

A. That's correct.

Q. Is that question and answer in your report?

A. No, it's not.

Q. Okay.

A. Just to be clear, the report is not a verbatim transcript of the call. It's a summary of the conversation.

Q. Okay. Yes, I appreciate that. I believe that Allen Murray touched on this, but as part of your safety plan with Lionel Desmond, you didn't discuss with him if he had access to lethal means. Is that correct?

A. No, I didn't.

Q. Were there any other aspects of the safety plan that you discussed with Lionel Desmond that's not in your report?

A. I don't believe so.

Q. Ms. Chambers, you'll agree with me that in order for this safety plan to work, Lionel Desmond would have to use his judgment in assessing his own feelings and then make the decision to go to the hospital all on his own. Is that correct?

A. Well, he had a history of going to the hospital, as evidenced by the January 1st visit, so I trusted that he would do that based on that history.

Q. Were you aware that he went to hospital at the insistence of his wife, Shanna?

A. No, I was not aware of that.

Q. But you were aware that Lionel Desmond struggled with judgment and decision-making. Is that correct?

A. That's correct.

Q. You also suspected he had a brain injury.

A. Yes.

Q. Okay. Let's just continue with the hypothetical. If you believed Lionel Desmond posed an imminent risk of harm to himself or others and you didn't think the safety contract would work in preventing that risk of harm to others, what would you do?

A. If I didn't feel that the safety plan was enough?

Q. Yes.

A. Then in terms of suicidal or homicidal ideation or both?

Q. Let's run with suicidal ideation for now.

A. Okay. Then I would have to let Mr. Desmond know that our next order of business was to ensure that he made it back to the hospital. And so we would negotiate a way for him to get to the hospital. I would ask him to either call me when he got there or to call the hospital ahead of time and then check in with him afterwards to make sure that he arrived. If he was unable to do that, I would've called the police and found out his location and the police would have gone and escorted him back to hospital.

Q. Okay. Would there ever be a situation where you would disclose the risk to a significant other in Lionel Desmond's life?

A. Yes.

Q. Okay. How would you have done that in this case?

A. In this case, I would've let Mr. Desmond know that I would've had to ... if he had expressed a desire or an intent or a thought or a plan of hurting someone else in his life, it would be up to me to contact the person and to let them know that there

was an imminent risk to their life or their safety. And then I would call the police and let them know as well.

Q. Okay. Let's just continue with the hypothetical. If Lionel said, I have intentions to hurt my wife, Shanna, did you have Shanna's contact information?

A. No, I didn't.

Q. So how would you have contacted her in this case?

A. I knew that she was a psychiatric nurse at the hospital. I likely would've called the hospital and found a way to get her contact information.

Q. Okay. Did you have Lionel Desmond's cousin's contact information?

A. No.

Q. Is that something you would typically get in a counsellor/client relationship? The contact information of significant others?

A. No.

Q. Why not?

A. Just to be clear, I'm a community-based psychotherapist. What I do in my office is quite different than what happens at the hospital when someone arrives for a risk assessment. I am looking at a wide variety of factors. Risk is

one of them. It's not up to me what ... the choices that people make when they leave my office are their choices. I'm not responsible for their choices. I can do what I can to try to keep them safe but that's the most that I can do within the scope of my clinical practice as a community-based psychotherapist.

(11:19:23)

Q. Okay. Those are my questions, Ms. Chambers. Thank you.

A. Yeah.

THE COURT: I think that in the normal course, I would've gone to Mr. Rogers. I know Ms. Whitehead ...

MS. WHITEHEAD: No questions, Your Honour.

THE COURT: No questions? Thank you. Ms. Miller?

CROSS-EXAMINATION BY MS. MILLER

(11:20:14)

MS. MILLER: Thank you, Your Honour. Good morning, Ms. Chambers.

A. Good morning.

Q. As you've heard, my name is Tara Miller and I share representation with Mr. Macdonald and Mr. Morehouse of Aaliyah Desmond, and I also represent Brenda Desmond through her

personal representative.

I want to go back over this timeline of your interaction with Veterans Affairs and then, ultimately, with Lionel Desmond. As I understand your evidence from yesterday and today, you don't have any records of any kind in your practice in terms of calendars or notes when you would've been first contacted by Veterans Affairs.

A. No, I don't.

Q. Okay. So other than references in the Veterans Affairs' records, you wouldn't have anything to contradict those dates?

A. No.

Q. Okay. So just to help clarify and pin down the timing, I'm going to take you to Exhibit 117 which my friend, Mr. Murray, referred to earlier. And I'm looking at page 7 of Exhibit 117. And, again, I appreciate these aren't your notes, but I understand you've had a chance to review some of them at least.

THE COURT: Ms. Miller, I'm going to stop you just for a minute.

MS. MILLER: Yeah.

THE COURT: Ms. Chambers, the notes are up on the screen

and as the exhibits are referred to, they'll come up on the screen in front of you as well, but just so you know, in the exhibit books also beside you on the desk that there's a paper copy of the same exhibit. So if you want to review the paper copy, some people, for ease of reference, would prefer paper.

A. Okay, thank you.

Q. Some don't mind the electronic format. So just to let you know that you have that option. Thank you.

A. Thank you.

MS. MILLER: And so I'm looking in the middle of this page, page 7 of 17, and it's a progress note and it indicates, November 7th, 2016, at 12:24:14: "MP Doucet phone communication with psychologist." We understand that that's an error, that you are a clinical psychotherapist. So:

> Phone communication with Catherine Chambers of Antigonish, Nova Scotia. Provider recommended by Nova Scotia colleague. She confirmed she has availability for new clients at this time. Works with many veterans and specializes in trauma/PTSD work. Without providing any information through which veteran could be identified, case

> manager and psychologist (that would be you) came to the following agreement. Veteran will be asked to be in touch with her to set up a first appointment informal appointment. Once that is confirmed, case manager will send consent forms to her office for veteran to sign. Psychologist can keep a copy for herself if needed and return. Once they are returned, case manager can provide psychologist with some information that is relevant to the veteran's psychological health.

So from my read of that note, Ms. Chambers, you would've received first communication from VAC through the case manager on November the 7th?

A. I actually believe the contact was earlier. There's a note further down the page that references an earlier phone call that I had with Marie Paule Doucet. I believe it's at the bottom of that page. So it's a bit confusing. "Veteran said he had misplaced the sheet with psychologists' names on it and inquired about the gym but it was too costly." And that was a note from a phone discussion on November 4th.

Q. Right.

A. So my recollection is that she had contacted me earlier than November 7th.

Q. Okay. So when I read that, I was thinking "psychologist".

A. Uh-huh.

Q. But is it your understanding that the information that had been given to Corporal Desmond about psychologists was actually information about you as a counsellor?

A. That's my understanding.

Q. Okay. And we'll clarify that certainly with the case manager. But at that point, November the 7th, things are in place with you from the ... prior to that, your understanding is that Corporal Desmond was supposed to reach out to you on his own?

A. Yes. Marie Paule Doucet shared with me that she had shared my information with Corporal Desmond and that he would be contacting me directly.

Q. Okay. You didn't hear from him directly. And then it looks like she then contacted you on November the 7th and confirmed with you that you had availability for new clients at that time?

A. Yes.

Q. Okay. All of that accords with your memory as of November the 7th?

A. Yes.

Q. Okay. She talks about once the first informal appointment is in touch to set up an appointment, the case manager is going to send you consent forms? Did you receive those consent forms from the case manager?

A. I can't recall.

Q. Okay. Certainly, you've shared with us yesterday that you received no additional information with respect to Corporal Desmond's medical treatment, either at the Fredericton OSI clinic, the three-month inpatient stint at Ste. Anne's, or any other medical records.

So I take from that that whether or not these consent forms were, one, sent to you by the case manager; two, returned by you to her, in any event, you never received any additional information.

A. No, I did not.

Q. And to be clear, you don't remember if you received consent forms from the case manager or you're not sure?

A. I don't believe I received any consent forms and those

would be ones that Corporal Desmond had signed to allow Veterans Affairs to communicate with me.

Q. Yeah.

A. I don't recall receiving that.

Q. Okay. You talked earlier about you certainly have extensive experience treating veterans with PTSD, and through the Veterans Affairs system. And you had dealt earlier with a different case manager. Had you ever received forms before, consent forms, that you had to have the veteran sign and send back before you could get additional medical information?

A. No. It wasn't something that I had to sign. It was a release between Corporal Desmond and Veterans Affairs that would allow them to release information to me.

Q. Okay. So from your perspective, there's no need for you to be involved in having him sign forms.

A. That's correct.

Q. That that was something that had happened in the past directly between VAC and the veteran.

A. That's correct.

Q. Okay. In any event, you didn't receive any additional information, as you've said.

I'm going to move up to the top of the page. And

this is a progress note dated November 22nd, 15:24:26, Marie Paule Doucet·
Call received from Catherine Chambers, counsellor, based out of Antigonish, Nova Scotia. She simply wanted to advise case manager she has not heard from veteran who was to call her. Case manager therefore called veteran back. He stated he had received her message and apologized for not following up. Case manager said no need to apologize but reminded him that a counsellor was ready and willing to work with him. Ms. Chambers' phone number was provided a second time and the veteran committed to calling her.

And we understand from you that you did then hear from Corporal Desmond at some point after November 22nd?

A. That's correct.

Q. And before you first saw him on December the 2nd.

A. That's correct.

Q. So you were able to get him in pretty quickly once that contact was made?

A. Yes.

Q. Okay. Ms. Ward reviewed with you the process for getting set up to be a funder with VAC and how your bills get paid and that that has nothing to do with the client. So that certainly helps expedite treatment because the client doesn't have to worry about how they're going to come up with funds and get reimbursed.

Did you or have you ever received from VAC any kind of policy or retainer agreement that sets out what you're expected to do generally when you're treating clients that are being paid for by the VAC system?

A. That information is a part of the process of becoming a provider. There is a document provided by Medavie Blue Cross about my obligations in terms of note-taking and more practical, logistical things like that. And policies around billing.

Q. And that document that's provided by Medavie Blue Cross around documenting and notes, is that specific to anyone who's going to be a funder through that system or is it specific to Veterans Affairs?

A. I'm not sure. It was through Medavie Blue Cross.

Q. Okay.

A. And it's sort of a disclaimer that you have to agree to

and sign before you can become a funder. I'm not sure if its application is more broad.

Q. Okay. So, for example, you indicated that you treat clients through the Workers' Compensation system?

A. Yes.

Q. Is that through the Medavie Blue Cross system that you would receive funding there?

A. No, no. That's separate through Workers' Compensation.

Q. That's a separate. Okay.

A. Right.

Q. So to your knowledge, other than the guidance and parameters provided by Medavie Blue Cross, you've not received anything directly from Veterans Affairs.

(11:29:03)

A. No.

Q. Okay. So with respect to treating Corporal Desmond once you heard from the case manager, did you know how many sessions with him were approved in November or at any point thereafter?

A. I'm not sure. I'm not sure how many were approved.

Q. Okay. And as you've indicated, other than providing a written update every six months, there was no other requirement

for you to report outside of you initiating reporting when situations had changed, as you did on January the 3rd.

A. That's correct.

Q. Okay. Did you have any agreement with Veterans Affairs as to how much you were going to be paid for each session?

A. Yeah. That's a set amount based on my designation as a registered counselling therapist candidate

Q. Okay. And how often were you to bill Veterans Affairs?

A. I usually submit the invoice after every session.

Q. After each session? And that, again, would be through Medavie Blue Cross.

A. Correct.

Q. Okay. You certainly understand as we've heard from you and from these notes that you knew that Lionel had a case manager and that in this case was Marie Doucet. That's the first time that you had dealt with this particular case manager?

A. That's correct.

Q. What was your understanding, Ms. Chambers, as to the role of this case manager with Corporal Desmond?

A. My understanding of the role of the case manager is to coordinate benefits, to ensure that the veteran has a plan, whether it's a rehabilitation plan or something else where they

receive the appropriate supports that they need, sort of looking after forms, approvals, timelines, benefits and things like that.

Q. Okay. Had you ever worked with a Veterans Affairs clinical care manager before Corporal Desmond's file?

A. No.

Q. Okay. You understand that he ultimately had a clinical care manager and as we look through these progress notes, we see the first time that she actually ever met with Lionel was on November 30th. Were you aware that he had had any contact with a clinical care manager through Veterans Affairs when you saw him on December 2nd?

A. No, I wasn't aware of that.

Q. Okay. You did know (a) he had clinical care manager, correct?

A. No, I believe in my conversations with Marie Paule Doucet she did reference Helen Boone and that Helen Boone was available as a support to Corporal Desmond.

Q. You had never worked with a clinical care manager before?

A. No.

Q. What was your understanding as to the role to be played by the clinical care manager versus the case manager, for

example?

A. My understanding was that the clinical case manager would do more sort of on the ground planning so if a veteran needed support with transportation, if they needed support with housing, if they needed support with their sort of general life situation, rather than coordinating benefits which would be at sort of that case manager level, my understanding was that they would help with sort of the logistics on the ground type supports.

Q. As a further support from the team that was gathering around Corporal Desmond, or the veteran, to support them. Did you ever have occasion to speak with the clinical care manager?

A. No, I didn't have a chance to speak with her.

Q. So from November 30th when she would have been engaged through to when you last spoke with Corporal Desmond on January 2nd, you had no contact or communication either way, between you to her or her to you?

A. No.

Q. Okay. If you needed to get ahold of her, did you understand that you could get ahold of the clinical care manager?

A. Yes, my understanding was that Marie Paule Doucet would be communicating with Helen Boone and that Helen would be

reaching out to me so if I needed to reach her, I could have gotten the information from the case manager.

Q. Okay. And the reason I ask that question, if you understood that you could freely reach out to her, and it's because in your progress note that's found at page 6 of 17 on Exhibit 117, it's in the middle of the page. This is a progress note that's dated 2017-01-10, 17:32:25. It is the note from the case manager that talks about the call that you made to her and my friend, Mr. Murray, already reviewed that with you, I'm not going to go through that again, but if we go down to almost the bottom third of that it says: "Writer (meaning the case manager) suggested Ms. Chambers obtain from the veteran at this week's appointment consent to communicate with his clinical care manager. Ms. Chambers says she was already aware about having other resources that may be needed."

So I infer from that note that you weren't able freely to communicate with this clinical care manager without having another discussion with Corporal Desmond and having more consent provided by him to access somebody in the Veterans Affairs' system, and you were all working together, but you didn't have access to communicate with her.

A. Yes, it would be I would have to get a consent from Mr.

Desmond to communicate with the clinical case manager and sign a release.

Q. Okay. So I appreciate this is what you understand and it just strikes me that you're engaged under the Veterans Affairs' system, you're working alongside of the clinical care manager with the case manager to support him, and it seems to me that this extra level of getting consent to communicate with those people with the team is a barrier.

A. I would characterize it as a barrier.

Q. Thank you. You talked about in terms of moving forward items that would be helpful and you said it would be really helpful to have a database and that everybody who engages with a veteran can upload and access information. I take it from your comments that given your role as a funder through the VAC system and a clinician treating a client under the VAC system, there's no such database that exists for you to upload, access?

A. No.

Q. No. You gave us insight into the treatment plan that you would have likely rolled out with Corporal Desmond had these unfortunate events not happened. You indicated that typically you do an assessment phase of three to six sessions and I think I heard you say that after the first session with Corporal Desmond

on December 1st, you understood that he would have to have at least six sessions for the assessment?

A. Yes, that was my best estimate.

Q. Okay. So that is you said at least six sessions when you had initially said, you know, in that assessment phase it's usually three to six sessions. What was it about Corporal Desmond that left you with the impression after the first session that you were going to need to have more than the normal range?

A. It was quite a lot of complexity in Corporal Desmond's case. He had a lot of additional challenges and as well, the way that he shared information, because of the disorganization and some of the confusion, it took extra time to gather that information beyond the normal timeline.

Q. You also told us yesterday that generally the whole process of the assessment phase, the stabilization phase, and the exploring the trauma phase and I forget the name of the third phase.

A. Integration.

Q. Thank you, integration phase, that that in your mind would take between two to three years or a couple of years had it been able to unfold with Corporal Desmond?

A. I would say it would be several years, I'm not sure two

or three, it would have been longer than that I believe.

Q. Did you convey to Corporal Desmond in either of those sessions you had with him that your expectation was that this whole process would take several years with him?

A. No, that's not something I would typically communicate with someone. That could be experienced as discouraging.

Q. Okay. I'm going to move now into your recall of what went on from December 2nd to January 3rd. We've heard your evidence in terms of your creation of notes from your memory at that point. You did indicate in the response to my friend, Mr. Morehouse, when he asked you about contacting Corporal Desmond's wife and you indicated that you, I appreciate this didn't have Io happen, but you said in response to his question how would you have contacted her, how would you know how to contact her, and you said I understood she was a psychiatric nurse. Where did that information come from?

A. Mr. Desmond shared with me that his wife had gone back to school and she was working at the hospital.

Q. Okay. Did he specifically say she was a psychiatric nurse or a nurse at the hospital?

A. No, he said a nurse. That could be information that I read about following the events.

Q. So you recall that he shared she had gone back to school, was a nurse ...

A. Yes.

Q. ... but the psychiatric nurse is not something that you ...

A. I don't believe he disclosed that specifically.

Q. Okay, thank you. You've also said several times that after the events of January 3rd and when you spoke with Marie Paule Doucet and you took some time between January 4th and January 10th to create a comprehensive, accurate summary of what had unfolded.

A. Yes.

Q. You also said you created a detailed timeline.

A. Yes.

Q. Have we seen that detailed timeline?

A. No, that's something that I shared with my counsel and can make available.

(11:38:59)

Q. Okay. That document, you haven't seen it here at the Inquiry, you haven't seen it in the documents?

A. No, that's correct.

Q. Okay, thank you. The divorce information that was

conveyed to you by Corporal Desmond on the 3rd of January in that 26-minute phone call, we have those hospital records for January 1st and 2nd, I appreciate you didn't have them, there's no mention in those records of a divorce. There's a mention of an argument and his wife asking him to leave the house. So my question to you is particularly given you didn't keep sort of contemporaneous notes, are you certain he was told about a divorce on January 1st or is it possible that that divorce was raised by his wife on January 2nd after his release from the hospital or can you say?

A. I can't say whether it was January 1st or January 2nd but he did specifically say divorce on the call.

Q. Okay. So you're not clear if it was January 1st or January 2nd. We know that at some point after the New Years truck going off the road, in that window of time, a divorce was raised but you cannot say for certainty that he was told that on January 1st?

A. Yes, that's correct.

Q. So it is possible that that information was conveyed to him by his wife on the 2nd of January?

A. That's possible.

Q. Your assessment report, Ms. Chambers, talks about

nightmares and it seems to be in the context solely with respect to Corporal Desmond's time in the military. We heard evidence from Dr. Slayter, the psychiatrist who did a detailed outpatient consult with Corporal Desmond on December 2nd, we heard from his evidence that nightmares that Corporal Desmond had experienced were initially about battle but more recently they had moved into nightmares about his wife cheating on him and jealousy arising from that. Is that news to you, the jealousy piece?

A. Yes, he didn't disclose that to me. He shared that he had nightmares and I didn't probe the content of the nightmares for the same reason that I don't probe about trauma content in the first several sessions.

Q. Okay. In Dr. Slayter's consult report which is found at Exhibit 67, page 26, on the last page. This is, as I indicated, Dr. Slayter's psychiatric consult and he, at the very final page, is identifying a treatment plan. We know (a) that you weren't aware that Lionel had seen Dr. Slayter literally the morning of the day that he came to see you for the first session, right?

A. Yes.

Q. And he didn't tell you he had just come or at any point seen a psychiatrist?

A. No, he didn't.

Q. Okay. So if you look three paragraphs down, Dr. Slayter's assessment from a psychiatric perspective was that:

> He needed (Corporal Desmond needs) intensive psychotherapy for the PTSD and jealousy regarding his wife. He's seeing a new therapist today in Antigonish. (We all assume that's you because there's no other indication of another therapist.) I do not know whether she provides the type and level of therapy needed for PTSD. She should be able to help him work on the jealousy issues.

You certainly addressed in your evidence and your experience, your abilities to address the PTSD therapy. How about the jealousy piece? If that had been identified for you by a psychiatrist or Veterans Affairs, is that something that you would have been prioritized given that a psychiatrist that same day had identified it as something needing immediate attention?

A. Yes, absolutely I would have addressed it, particularly given that we were in the assessment phase, I would have explored what that looks like, what goes through his mind, what he's thinking, what he's feeling, does that contribute ever to

feelings of wanting to hurt or harm his wife. If it was disclosed to me ever that things had gotten physical between him and his wife, I would have referred him to Bridges which is a counseling center in Truro that focuses on working with men who use violence. So I would have been able to work with him on that up to a point. If it was disclosed that there was any physical violence then I would have provided a referral for that particular issue.

Q. Okay. When you say physical violence, do you mean physical hitting as between the husband and wife or physical violence in terms of hitting furniture? Is that ...

A. Including any objects as Il.

Q. Okay. So knowledge about jealousy and certain prior physical interaction with objects and family members would have been all important things for you to know?

A. Yes.

Q. And would have also been risk factors, I'm assuming, for you to be aware of?

A. Absolutely, yeah, and that was not disclosed to me.

Q. Okay. I'm almost done.

You talked yesterday about the safety and stabilization phase of your treatment with any individual and you said it's

equally important to establish external safeties, the person needs to have safety in their home environment and physical space. Again, when I look through these case manager records, which is Exhibit 117, I'm going to read you a couple of entries and get your assessment as a clinician as to whether or not these were ... they would have been indicators of the absence of external safety for Corporal Desmond for a long period of time.

A. Okay.

Q. So the first one is a progress note at page 10 of 17 and this is, to give you some context, Ms. Chambers, this is at Ste. Anne's in the inpatient treatment and there was a stabilization plan there. He leaves shortly after this date to return to Nova Scotia. So midway through that paragraph, this is a summary, I guess, of the case manager's participation in the case conference. It says: "Some concerns are related to the veteran's lack of a sound plan for accommodations upon his discharge next week." Would that be a cause for concern for you in terms of establishing external safety?

A. Yes, it would. Having a safe and stable home is one of the pillars of the safety and stabilization phase of treatment.

Q. And then if we look further up the page which is the continuation of an entry that starts on page 9

of 17 which again is from the same, it's August 15th so five days later. It says:

> With respect to housing, veteran was still unsure exactly what he would be doing. He planned to visit his grandparents and his daughter in Nova Scotia upon arrival. Despite case manager and Ste. Anne's team encouraging him to think about renting an apartment for himself, a safe place for him to retreat to if needed, the veteran has expressed it's overwhelming for him to have a back-up plan and will likely stay with wife and her family despite this having been problematic for him in the past.

And is that a concern for you, would that have been relevant for you in terms of assessing the safety, the external safety, of where Lionel was staying?

A. Yes, it would have been.

Q. So these are, when I read them, they're examples of external safety not being a new issue with Corporal Desmond, this is something that was identified in, certainly, August of 2016 but that information was never shared with you?

A. That's correct.

Q. This is more of, and I preface this by being candid, that this is more of a reflecting back and getting your clinical view on this. We know from the detailed records we've reviewed that Lionel left Ste. Anne's, really from August until October, there was no real treatment of any kind. He was certainly in touch with his case manager. On October 24th he initiated a visit to the Emergency Room where a detailed crisis assessment was done. On November 30th he meets with his clinical case manager for the first time and a detailed assessment is done. December 1st he goes to the Emergency Room again and deals with a triage clerk but leaves shortly thereafter without being seen. December 2nd he sees Dr. Slayter for a detailed assessment. December 2nd he sees you for a detailed assessment. Then he's back to see you on December 15th for more detail, and then back on January 1st and 2nd to the ER.

Now it's clear that he wanted help through all of that and I think you have said that yesterday, that was very clear. I'm wondering if you think he might have been overwhelmed with all of the talking and medical appointments that all seemed to come to fruition really in a month's span. Is that something, from your perspective, that has any relevance for His Honour and this

Inquiry to consider, that after a period of really no treatment, it's sort of all hands on deck and he has to tell his story over and over and over to a variety of different people. Is there any relevance to that from your perspective?

A. Yes, I would say that is relevant. I think you raised an important issue which is continuity of care and so one of my recommendations going forward would be that to offer some kind of bridging between the time of discharge from the military to support a return to civilian life. So I understand there's a gap between the Department of Defence and Veterans Affairs and that sometimes that gap in service can be problematic for people. So I think what you're speaking to there in terms of continuity of care is a really important issue and I think going forward would like to see maybe a task force or a team devoted specifically to that transition time. But, yes, after having been in an intensive inpatient treatment and then going two months without treatment and then having to possibly even tell his trauma story, that's not what we engaged with in our session, however it's possible that he did have to tell many of the details of his trauma history in other appointments and that is possible that that was overwhelming to him.

(11:49:46)

CATHERINE CHAMBERS, Cross-Examination by Ms. Miller

Q. My last area that I wanted to cover with you again from your clinical experience and expertise. We can go back to the Exhibit 117 but there's a comment at page 11 about a clinician saying that it's a struggle to get straight answers from Corporal Desmond. This is in the context of his admission at Ste. Anne's. It's on the middle of the page, 2016-07-28, in particular, there has been a struggle getting straight answers from him.

You described that when you asked Lionel on January 3rd about what medication he had been taking, he didn't really answer that question, you had a hard time getting that information but you indicated it could have been a combination of not remembering, could have been his frontal lobe was offline, and/or a combination of the brain injury.

A. Yes.

Q. And so my sense and I'll get you to confirm this, is that given all of his conditions, his inability to give clear answers was actually reasonably to be expected, is that fair to say?

A. Yes, I think that's fair to say.

Q. He wasn't being untruthful, he wasn't withholding things deliberately, but it was more likely consistent with a combination of the cognitive impacts as a result of all these

things?

A. I don't know if we can say that definitively. Certainly those are factors but in my experience clinically, I wouldn't call it not being truthful or forthcoming but people are also protecting their dignity and not necessarily sharing everything that's vulnerable in the first few sessions. And it does happen also that people do omit and choose not to share certain details with a therapist for various reasons, not wanting to be judged, you know, wanting to be treated with respect, not wanting to be treated, you know, disrespectfully and so there could be a lot of reasons why it was confused and disorganized and why everyone didn't get all the information. So it could be a combination of the factors you mentioned and also not perhaps being 100 percent forthcoming in some instances as well.

Q. That to me further reinforces the value of this collaboration we've talked about and sharing of information to set you up and Lionel up for success of his treatment.

A. Agreed.

Q. My very last point, sorry, it is my last point, is I wanted to hear your definition of dissociation and dissociative disorders, you talked about it a little bit yesterday. Can you give us a sense from your experience what that means?

A. Sure. Dissociation is a kind of protection mechanism that happens. It's completely involuntary, it happens at the level of the brain and nervous system when whatever the circumstances that a person finds themselves in overwhelm their ability to cope, the brain will disassociate and that's sort of a cluster of experiences where the person's perception starts to change so there's a sense of sometimes time slowing down, a sense of disconnection from the present moment. It could be, you know, that things feel almost like you're in a movie and they feel kind of surreal or unreal, it could be difficult to hear, so a general sense of being disconnected from reality.

Q. Could it also include people doing things actions like completely out of character with what they would normally do in a dissociative state?

A. Yes.

Q. Okay. And is it fair to say that dissociation can be brought on by something very stressful or traumatic?

A. Yes.

Q. And certainly you've indicated that from your perspective on January 3rd, in addition to the long-term trauma that Corporal Desmond had experienced, he had a single-incident trauma with the motor vehicle accident?

A. Yes.

Q. He also had recently been told, and it could have been as recently as January 2nd, that his wife wanted a divorce, correct?

A. Yes.

Q. And another stressor was that he had, as you alluded to, a stress about how he was going to secure housing, how he was going to pay for that?

A. That's correct.

Q. Those are all things, stressors, that could have played a role in a dissociative state for Corporal Desmond?

A. Yes, I didn't directly observe any dissociation but that doesn't mean that it wasn't there. Again, I had such a limited time with him that I didn't directly observe that though but it is possible.

MS. MILLER: Thank you, Ms. Chambers, I appreciate your time.

A. Thank you.

THE COURT: Mr. Rodgers?

CROSS-EXAMINATION BY MR. RODGERS

(11:54:44)

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

I wanted to start off by asking, we've seen your *CV* and obviously you have lots of training and experience in PTSD and trauma-related fields. I wanted to ask if you could outline for us perhaps what would be in there specific to military veterans and the military experience?

A. Sure. Much of the training that I participated in in the area of trauma and complex trauma covered not only sexualized violence which was the area I was working in at the time but also PTSD that shows up in a wide variety of other populations, including the military population, so I did receive some training specifically to military populations.

Also the kind of trauma treatment that I do is also neurobiologically informed which relies on survival, an understanding and a treatment of survival mechanisms that are universally biological. So although there are some specific, you know, factors to military life, the treatment of PTSD doesn't look a lot different between survivors of sexualized

violence and veterans.

Q. And is it your sense that there is good widely available education for counsellors in this area?

A. Yes, there is quite a lot available.

Q. When you were answering questions of my friend, Ms. Ward, on the process of becoming ... of qualifying as a service provider to Veterans Affairs, it seemed and correct me if I'm wrong, that that was a process to qualify for a range of providers through Medavie Blue Cross, is that true?

A. The process at the time was specific to Veterans Affairs and RCMP, that was, I believe, an umbrella program through Medavie. That's recently changed where now it is more broad in the way that you're referencing. So to be a provider with Blue Cross when I registered in 2016 was specific to Veterans Affairs and RCMP. Now when you register as a provider, it allows you to be a provider more broadly.

Q. And so in that line, if somebody wanted to become a service provider to Veterans Affairs, they would submit a broader application which would allow them to be a service provider to other agencies as well, that's correct?

A. That's correct.

Q. So would it be your sense that that wouldn't

necessarily capture any kind of specialty when it comes to PTSD or trauma but, rather, a broader range of counseling experience?

A. Yes, the requirement would be to have an active provincial license but there is no indication in the application form of needing to specialize.

Q. From your experience and you've indicated you've counselled 50 or more veterans in your time, would you view it as being important to have that kind of specialized training and education?

A. Yes, I would.

Q. In servicing a veteran in particular?

A. Yes.

Q. So do you have any sense of why that requirement was changed to one of being more of a specialized requirement that you went through to a broader requirement now?

A. I'm not sure the reasoning for that.

Q. I'd like to ask you a little bit about PTSD therapy. You talked a little bit yesterday about some of the treatments and theories that you use. I wanted to ask you about, I guess, what's the leading theory or what's the leading kind of treatment that seems to be effective?

A. Well, there's a wide range of evidence-based treatments

for post traumatic stress disorder. Cognitive behavioral therapy is one that's evidence-based. Mindfulness is also evidence-based. There are other treatments including EMDR which are also evidence-based. There's actually quite a broad range, dialectical behavioral therapy, cognitive therapy, there's a wide range.

(11:59:05)

Q. All right. And would it be fair to put these under a broader theme of exposure therapy that a veteran needs to or someone who has experienced trauma needs to go back into the trauma mentally, either re-experience it or think about it in an in-depth way to deal with it that way?

A. There are varying theories about that. There's a school of thought that proposes that exposure therapy is the best or only way to move through trauma. However, there's also some research that's been done over the past 20 years that shows that exposure therapy can actually be highly re-traumatizing. And so especially because we now have the technology to look and see what's happening in people's brains as they're talking about the trauma, if they're not talking about it in a way that metabolizes and digests it and they're just reliving it, that's not conducive to healing.

Q. Okay. So as a counsellor without ... I don't want to presume, but ... I'll presume for a moment that you don't have the equipment to do the ... to hook up somebody's brain to ...

A. No.

Q. ... be able to read that in real time as you're undergoing therapy. So can you give us a sense of how you would make that determination about whether you would continue with exposure therapy or else change?

A. Sure. So that has to do with this notion of neuroception as well as clinical observations. So perception would be like our five senses, how we see the world; neuroception is how our nervous system is perceiving the world and all of the information that our nervous system is perceiving.

So all of us, this happens ... this is universal. Our nervous system is perceiving information mostly about threat detection. And so part of my role as a therapist is to observe what's happening physiologically for the client that I'm working with. So I'm looking for a tension in the jaw, furrowing of the brow, tension in the striated muscles of the face, tension in the body. I'm looking for rapid, shallow breathing, perspiration, as well as a change in the tone of voice or affect. So those are the ways that I can also see what's happening for the client in

the office real time as we're talking about trauma content.

Q. So that would cause you to either slow down the questions or else change the strategy.

A. That's correct.

Q. Okay. We heard Dr. Slayter. He didn't go into depth on this but he did mention the EMDR, the eye movement desensitization and reprocessing technique, which ... are you familiar with this technique ...

A. I'm familiar with it. I'm not trained in it but I'm familiar.

Q. Do you have any ... it seems to be somewhere where you're doing the therapy and ... doing some sort of exposure therapy but also holding a finger or an object in front of a person and they move their eyes back and forth while they discuss that.

A. Yes.

Q. Do you have any sense of its effectiveness or ...

A. Yes. I think there's quite a big body of evidence to suggest that that's a helpful treatment for some people.

Q. Okay. Again ... and I know you're not trained in it, but do you have a sense of why that is ... why that is effective?

A. I'm not a hundred percent sure what the research or the

theories are around that, but from what I understand, which is a limited understanding, it has to do with integration of the left and right hemispheres of the brain. The right brain is where all the traumatic memories are stored and the left brain is the sort of going on with normal life, the side of the brain that's responsible for going through daily life, coping, eating, drinking, hygiene, planning. You know, so there's some theories that say that by having a bilateral stimulation of the left brain and right brain, that that allows for integration of traumatic memories.

Q. Okay. We're going to get into the particulars momentarily, Ms. Chambers, but a few other questions on PTSD generally. Is there a distinction, when you're in a counseling environment, when you're dealing with somebody whose PTSD has resulted from something they've seen versus PTSD resulting from something they've done? And is that a relevant distinction that you see in your ...

A. Neurobiologically, it looks the same. So there's no real distinction there other than the person's perception and feelings about it.

Q. Yeah.

A. Yeah.

Q. So how would that ... so if somebody has seen something traumatic, and we can imagine what that would be in a combat situation versus they've done something that, you know, may have surprised themselves and maybe have gone against what they thought was their own moral code in some way, would that be a different kind of a PTSD trauma that you would deal with in a different way?

A. Not necessarily in terms of an approach, but it would be part of the trauma processing to explore, you know, what feelings and beliefs about the self and ideas about the world resulted from a person engaging in something that might have gone against their moral code. So I'm thinking, in particular, about shame. And so resolving shame is a part of most trauma treatment but that would be part of what we would look at when it came to that part of the therapy.

Q. In your initial assessment and information you had on Corporal Desmond, you know, he presented as a complex case because of the PTSD and the brain injuries and their interactions and potentially other things that you've mentioned. We've also heard some evidence about sleep issues. And I wanted to get a comment from you as to how lack of sleep, whether on, you know, an immediate basis, just didn't sleep well for a night, and a

cumulative basis and how that might affect somebody with these kinds of conditions.

A. Sure. I think a lack of sleep would amplify PTSD symptoms that were already there.

Q. And would it be ... would you see it as a risk factor or, I guess, a factor of concern, I don't know how you'd like to put it, for somebody who had a particularly bad night's sleep or just didn't sleep very much on a single night?

A. I don't think it's possible to generalize. I think it would be sort of specific to each person. But I wouldn't imagine that one night of a lack of sleep would be as significant as an accumulation of lack of sleep.

Q. Okay. You talked about, in my first sort of series of questions, about how there's some distinctions but not all from a neurological perspective on PTSD and brain of veteran versus somebody else who's experiencing trauma. But what about from a suicide risk perspective? And I'm not talking necessarily about Corporal Desmond specifically. But are there things you might look for in a veteran's presentation, military combat veteran versus another individual who's not, in terms of suicide risk identification?

A. My understanding from the research that I've looked at

following this event is that ... and there was a large study done in the United States with the Department of Defence, Department of Veterans Affairs, Department of Health, with a very large sample size. That there was ... it was a clinically insignificant difference between rates of suicide and violence in veteran versus civilian population.

Q. Thank you. When you were giving your evidence, you talked about how Corporal Desmond was expressing himself in a non-linear way and was having difficulty expressing his thoughts in a linear fashion in some topics but not others. Is that common? So if somebody is non-linear ... is expressing themselves in a non-linear fashion, is that something that is going to be specific to a topic or is that going to generalize? In other words, would you expect then that they would present in a non-linear fashion to other people in other circumstances?

A. I would expect that they would present in a non-linear fashion in other instances, specifically if those instances involved talking at all about the trauma content.

Q. Would it be surprising that they would be able to pull themselves together to give a linear narrative on topics that didn't touch on the trauma?

A. No, it wouldn't surprise me if they were able to also

have some moments of clarity or lucidity and be able to talk clearly about the trauma. So it's not universal. People sometimes can move in and out of feeling more or less clear.

(12:09:00)

Q. Okay. Now I want to change topics, Ms. Chambers, and talk a little bit about obtaining records from Veterans Affairs. And my friend Ms. Miller has covered that area, but I want to ask a question about when you receive a referral or ... and I don't know whether to call it a referral or potential referral, but a referral from Veterans Affairs, is it often the case that you turn it down?

A. No. Usually, I would at least meet with the veteran to see if it was a good fit, if I thought I could be helpful and if they felt that they were comfortable with me.

Q. Is there any reason you can think of why those records ... some relevant records, at least, shouldn't be provided to you in the first instance, before you meet with the veteran?

A. No, I can't think of a good reason why it wouldn't be helpful to have that. I think client confidentiality is one concern that I think is shared amongst providers.

Q. Yes.

A. However, I think a conversation ... most conversations

that I've had with clients over the years, they're extremely open to the sharing of information if they know it's going to be helpful in their treatment.

Q. And certainly if you were required to, you would be comfortable signing a confidentiality document ...

A. Yes.

Q. ... to agree to keep anything confidential even if you didn't take on the person as a client.

A. Yes, of course.

Q. This relationship involves ... you're in private practice and this is your ... you have a relationship with Veterans Affairs. Does that create any concerns ... and I'm going to ask you if there's good or bad sides to this. Any concerns with you potentially not wanting to disclose information from the veteran to Veterans Affairs or concerns that the veteran might not want to disclose information to you, knowing that it might get to Veterans Affairs?

A. I think that's a possibility.

Q. Yeah.

A. Yes.

Q. How do you deal with that?

A. Well, I think ... first, it's important to note that

the psychotherapeutic relationship is one that's built on trust. And because mistrust is a hallmark of post-traumatic stress disorder, particularly complex trauma ... and I mentioned yesterday this betrayal trauma that can happen when the people who are supposed to be there to support you end up hurting you. So it's really important in the context of psychotherapy to ... I would say it's "the" primary goal, along with gathering information and assessing risk, is to build a strong trusting therapeutic relationship where a person feels safe and they can open up and trust you. Can you repeat your question?

Q. Well, there was two elements of it. I guess one is if there was ... if there might be information that you wouldn't want to pass on to Veterans Affairs in the veteran's interest, I suppose.

A. So I mean I think, you know, one challenge is that the veteran knows that I'm going to be providing reports back to the case manager. The case manager is also the one who, you know, is, in a way, together, you know, with other Veterans Affairs' personnel making determinations around benefits.

Q. Yes.

A. So, yeah, I think it's fair to say that people might censor what they share with a therapist, knowing that that

information could get back to the case manager.

Q. Can you think ... particularly, I'm thinking in rural areas where maybe Veterans Affairs might not have an established office or presence. Do you see benefits to an arrangement where it's a private provider that is providing the counselling services?

A. Yes.

Q. And I guess availability is one of those benefits. What about quality of care? Recognizing your qualifications and history, but do you have a sense of the counseling community and how many others might be in the same situation as you and be able to provide trauma and PTSD specialized therapy?

A. My sense is that those resources are less than what's needed, particularly in Nova Scotia. I would say that as counsellors, therapists, psychiatrists, nurses, et cetera, that we all have an ethical responsibility to operate within our scope of practice. So if we don't have training in a particular area, then we wouldn't be working with clients of that population.

Q. Would you see some benefits in having kind of a structured or some kind of an educational program or availability for private counsellors through Veterans Affairs that would at least give them some training in the trauma and PTSD area?

A. Yes. I think that would be beneficial. There's quite a lot of training available for counsellors and therapists who might want to pursue working with trauma. But if that's something that Veterans Affairs wanted to support the counseling community with, I think that would be embraced.

Q. I'm going to switch topics with you, Ms. Chambers, and ... don't have too many more questions left yet. But I wanted to ask you, in the description that Corporal Desmond gave, one of the things I think he described to you was that he was in the military band. Given his brain injuries and his PTSD ... well, his brain injuries maybe in particular, does that seem ... does that strike you as a particularly bad idea to have him in a military band and the noise and the chaos that that ... well, they're not supposed to be chaotic but you know what I mean for ...

A. Yeah.

Q. ... the noise elements of it.

A. Yes. I think especially because Mr. Desmond said that he had trouble reading the music and seemed like he was struggling in the band. He didn't share this with me, but my assumption is that he would have shared that with someone, that he was struggling, or someone would have noticed. And I don't

think it's helpful to keep people in environments and situations where it's a set-up for failure. I would hope that the powers-that-be would respond and put him somewhere more appropriate.

Q. And I want to ask you then about ... so the timing. And we've gone through ... you've gone through some of the timing of when he left the Ste. Anne's clinic and then when he engaged in some level of service in Nova Scotia. This was also a time when he was back living with his wife for the first time ... well, I guess ... were you aware of his ... the history of his marriage and, in fact, you know, the fact that he was married in his early 20s, had spent basically ten years without spending a lot of significant time living together with his wife?

A. He alluded to that but we didn't get to explore it in any depth.

Q. Okay. And here he is leaving an in-house treatment program and moving back without services arranged and moving into that situation, into a relationship of a full-time living arrangement. Do you see that as a particularly bad time to be without services for that reason?

A. I think, again, you know, it speaks to continuity of care. So if someone is going to be discharged from an inpatient program where they're receiving daily care into the community,

then I do think it's prudent to try to ensure that supports are set up during that transition time.

Q. And, finally, Ms. Chambers, you mentioned how ... and it's in your report, what your, I guess, immediate plans would have been with Corporal Desmond had he been able to continue therapy with you. Can you give us a sense or have you considered maybe what your approach would have been over the longer term and how you would have tried to address his symptoms and his condition?

A. Well, I think if Mr. Desmond had returned to treatment on January 5th, again there would have been some time needed to resolve his current situation. So before we began any kind of intensive work around even nervous system, grounding, tools and strategies, that's even a step farther than what would have been possible at the time, which would be to make sure that his ... he had safe and secure housing, first of all. That would be the primary aim of treatment and, as well, managing any risks that I would have assessed for on an ongoing basis.

Q. All right. Thank you, Ms. Chambers. Those are the questions I have.

A. Thank you.

THE COURT: Mr. Hayne?

MR. HAYNE: Thank you, Your Honour.

CROSS-EXAMINATION BY MR. HAYNE

(12:18:55)

MR. HAYNE: Ms. Chambers, I ... my name is Stewart Hayne. I represent certain physicians who encountered Mr. Desmond.

Just a few questions. I'd like to turn your mind back to the ... January 2nd. And my understanding is that there was some exchanges with Mr. Desmond by voicemail or text messages on that date relating to logistics of when your next session was going to be held and the time for that. Is that right?

A. Yes. That's correct.

Q. And was it January 2nd that you returned to Canada and you were at the airport when you received a voicemail from Mr. Desmond?

A. Yes. That's correct.

Q. And was it sort of when you turned your phone back on when you got off the plane that you were presented with the voicemail?

A. That's correct.

Q. Okay. And have you noticed with your phone, is that maybe a reason why that voicemail didn't get converted to text

messages, for example, or have you noticed any pattern?

A. No, I'm not sure.

Q. Okay. But, in essence, on January 2nd, the various communications that you had with him related to the logistics. There was no ... and we heard earlier about how you try and separate phone calls and reserve those for logistics and not substantive things.

A. That's correct.

Q. On January 2nd, your various communications with him were of that nature. Correct?

A. Yes. Were about logistics.

Q. Okay. And confined to logistics.

A. That's correct.

Q. Just a little side step here. You noted that your assessment form, which is Exhibit P73, that you created that on January 4th.

A. Yes.

Q. And then ultimately submitted it on the 10th. You said a few times, I think it's correct, that your evidence was that the form represented your best recollection of events. Is that fair?

A. That's fair.

Q. Okay. And just during your testimony here today or yesterday, you noted that when you inquired with Mr. Desmond about his ... and this would have been on the January 3rd phone call, I think, about his time recently in hospital, that you didn't get a clear answer as to medications that he was provided with.

A. That's correct.

Q. So I just want to turn your attention ... just a little point to clarify. It's at page four of that assessment report. And it's the end of the first full paragraph. It states, Mr. Desmond responded ... sorry. I'll read the whole sentence. "When asked if he received any medications at the hospital, Mr. Desmond responded that he only received his regular medication and was not given any *p.r.n.*s."

So is that a more accurate statement of what Mr. Desmond conveyed to you?

A. Yes. As I recall, I asked him if he had received ... like if he was dispensed any medications at the hospital, anything extra, above and beyond what he was already taking and he said that he wasn't given anything extra. And so I believe I said something like, Oh, you just got your regular medication, and he said, Yes.

Q. Okay. That's fine. Today, you recounted sort of a sequence of events and I'll characterize it this way, that Mr. Desmond conveyed to you on the phone call on January 3rd, that he had been in a vehicle accident coming back from a New Year's Eve party and you discussed how that occurred and that the vehicle ended up in the ditch, which led to an argument, and then led to the request for the divorce. And Ms. Miller took you to that request for divorce and you said on cross-examination that you weren't sure if that request had been made on the 1st or the 2nd. You weren't sure about that.

A. Yes. I'm not sure.

Q. Okay. And you didn't ... there was no opportunity to seek any collateral information about when that request for divorce, I'm calling it, was made.

A. No.

Q. And in addition to not being sure whether it was January 1st or January 2nd, is it fair to say that it was possible that that request for divorce may have actually even occurred on January 3rd?

A. The way that Mr. Desmond described it, it seemed to me as though it had happened in the previous days, not the morning before we talked.

Q. But when you had the call or the communications with Mr. Desmond, albeit brief, on January 2nd, you didn't perceive that he was in any distress at that point. Correct?

A. No. He didn't present as though he was distressed, although the events that he described would lead me to believe that anyone in that situation would be. But he didn't present that way on the phone.

Q. Right. On January 2nd, he didn't present in a distressed manner.

A. No.

Q. And on January 2nd, through your communications, there was no mention of divorce on those ... through those communications.

A. No. Only on the January 3rd phone call.

Q. And I want to take you to your report again, this time to page two, under the section "Health and Medical History, Part D". And you reported here that: "Mr. Desmond reports hitting his head and incurring multiple concussions during his time in the military, which he states resulted in him frequently feeling mixed up in his head."

Right? That was your assessment of Mr. Desmond?

A. Yes. That's correct.

Q. And Mr. Desmond discussed the impact of the concussions, including frequent episodes of confusion and disorganized thinking. That was your assessment of Mr. Desmond?

A. Yes, based on his disclosures. Yes.

Q. And also that ... you record at the end of that paragraph, "Short-term memory impairments". Correct?

A. Yes.

Q. So I guess with that in mind and noting that he hadn't reported any ... or didn't present in a distressed manner on January 2nd or didn't report the divorce issue on January 2nd and keeping in mind that you reported earlier that he had a 26-minute phone call with you, which you then recounted fairly quickly to us the substance of that, is it possible maybe that Mr. Desmond was confused again about when the request for divorce had occurred and possibly that that request for divorce could have occurred on the 3rd, which resulted in his distress on that day?

A. That's possible.

Q. Okay. Just my last question, the last point, is aspects of this Inquiry are forward looking and we heard evidence earlier from the psychiatrists and the nurses about a tool that they have or a suicide risk assessment tool that they employ. And we saw two versions of that tool. And in the first version,

there was categories of suicide risk assessment or suicide risk, rather. In the first version the categories were ... and I think I have this correct; none, low, moderate, and severe. And then the second version, the more recent version had categories of low, moderate, and high. And then today in your evidence you used another term "imminent". And I think you used "high" versus "imminent". And I guess my point is just whether you think there would be benefit in training to counsellors, for example, therapists about suicide risk assessment and, in particular, whether there could be some universality as to at least the categories of suicide risk so that everyone is speaking the same language.

A. Sorry. I think having a tool that's shared, perhaps in the same way that we talked about the database in terms of sharing information, if there were forms that were shared by people on the team and that everyone was using the terms in a similar way, that would be of benefit.

Q. Thank you. Those are my questions.

THE COURT: Ms. Hickey, do you have any questions?

MS. HICKEY: Just one, Your Honour, if I may.

EXAMINATION BY MS. HICKEY

(12:29:57)

MS. HICKEY: Ms. Chambers, you've had an opportunity, through some of the questions that have been asked here today to give your views on what recommendations you would make, knowing the situation as you've come to learn of it over the time that you've been aware of it and you touched on a few things at different points in your testimony. And I just wanted to give you the opportunity, before you conclude your testimony, to indicate what are some of the recommendations that you think would be beneficial to address situations such as the tragedy that we're discussing here.

A. Thank you. Yeah. So I've made a reference to kind of a shared database of information/reports that could be accessed by people who were on a veteran's treatment team. I would highly recommend that as a recommendation going forward.

(12:29:10)

I also believe that having ongoing access to psychiatric care is extremely important when a veteran moves from being in the military to being in the community. And in my work in other provinces, that's been a little bit more readily available than here in rural Nova Scotia. So I would just implore the Health

Authority to work on providing greater access to ongoing psychiatric care, not just single-incident visits or medication reviews.

I would also recommend that either a task force or some kind of team be set up to address transition times between being discharged from the military and returning to civilian life. Maybe there's a specific worker that gets assigned to the case as a transition worker who could mobilize and wrap around supports during the time of transition.

I would also recommend that a detailed battery of assessments be completed before someone joins the military, that might look at prior trauma history, neurodevelopmental, other psychiatric issues, possible co-morbidity with other psychiatric disorders, and a detailed history that would give more information around a soldier's potential vulnerability for developing PTSD at a later time in life.

And I've since learned, since the events of January 3rd, over the past three years, that Mr. Desmond was given mefloquine as an antimalarial treatment. I have other veterans who also take ...

THE COURT: I'm going to stop you for a second.

A. Yes.

THE COURT: I need to ask you a question. So where did you learn that he took mefloquine?

A. I believe I read a transcript of his sister testifying to that in Ottawa.

THE COURT: All right. So I will say this that I've provided to counsel all the disclosure material that's come to us during the course of preparation for this Inquiry. I've looked through it myself on many occasions but I think I've had counsel look through it, as well, to find out if there's any references to mefloquine or Corporal Desmond having ever taken mefloquine. We have no evidence of that.

A. Okay.

THE COURT: So whatever you have read in a public report or a newspaper report, or somebody else's belief, I predict is not likely to be evidence here because we don't have it.

A. Okay.

THE COURT: Right? So whatever you might have to say about that is, at this point in time, not particularly relevant, and it may, at the end of the day, wander outside the terms of what this Inquiry can really look at. It might be different if we actually had the evidence of it, but I don't think we're going to have

evidence of it. So thank you.

A. Okay. Thank you for the clarification.

THE COURT: Mm-hmm.

A. That's it.

THE COURT: Thank you.

MS. WARD: Your Honour, I have some brief follow-up questions.

THE COURT: Yes.

MS. WARD: Very brief.

THE COURT: Yes.

CROSS-EXAMINATION BY MS. WARD

(12:33:09)

MS. WARD: Ms. Chambers, I just want to follow-up on a question that my friend, Ms. Miller, asked because I'm not sure I understood what the question was. But I think she asked you about policies you might've received from either Medavie Blue Cross or from VAC at the time that you were engaged in reference to Mr. Desmond. And I think you said that the only things you received were from Medavie in terms of billing and such. Is that correct?

A. Yes. There's a disclosure, an agreement that we have to sort of click and sign online. It does cover aspects like documentation and the possibility of our records being audited. So it does go over a variety of issues in addition to billing.

Q. Okay, thanks. So in terms of the actual treatment of your client, be it a veteran or anyone else, you would not be expecting any funder to be telling you how to do your job, in effect.

A. No.

Q. And they did not do that.

A. No, they did not.

Q. In terms of the confidentiality issue, we know from you and from other health care professionals that confidentiality in this realm is very important and paramount. And you need to build the trust relationship with your client. And you spoke about, I would term it, an ethical obligation to keep in confidence what the client tells you, with some exceptions. Understandably, I think you mentioned, if you thought there was imminent risk that that client would harm themself or someone else, that you would disclose that to, possibly the police, possibly the person at risk. Correct?

A. Correct.

Q. So in terms of sharing information with other people, it's certainly not unusual, and you would expect to need Lionel Desmond to provide consent for you to freely share information. Be it with Marie Paule Doucet, the case manager, or with the clinical case manager. Is that correct?

A. Yes.

Q. So it's not unusual that they would seek those consent forms to be in place before you would do that.

A. Yes. That's standard practice.

Q. And you're aware that there is also legislation, both provincially and federally, about protection of private information. Right?

A. Yes.

Q. And then just one more thing. My friend, Mr. Rodgers asked you about Medavie Blue Cross' sort of broader registration now for ... You said that in terms of when you signed up, it was strictly a sort of Veterans Affairs and RCMP initiative, and it's since become a broader roster of service to broader clientele.

A. Mmm. That's my understanding.

Q. Even so, is it your understanding that when you were contacted by Ms. Doucet in respect of Mr. Desmond that you were contacted specifically because you had an expertise with veterans

and/or PTSD and such things?

A. Yes. It would be my understanding that, possibly, Marie Paule Doucet had spoken with other case managers for clients I had worked with in the past and understood that I had a specialization in trauma.

Q. Okay, thank you. Those are my questions.

A. Thank you.

EXAMINATION BY THE COURT

(12:37:00)

THE COURT: I have a couple of questions, Ms. Chambers. I'm going to try and go back and deal with some of the evidence as it arose.

So my first question is – and I'm going to use the word "clients" – how many clients did you have referred to you prior to Corporal Desmond being referred through a case manager at VAC?

A. I would say between six and ten.

Q. Between six and ten? All right. And that was as of when you first opened your practice.

A. That's correct.

Q. Okay. At that point in time.

A. Yes.

Q. All right, thank you. And Corporal Desmond was the first client that had been referred to you by Case Manager Doucet?

A. Yes.

Q. Is that correct? Okay. Since that time, has that case manager referred other matters to you?

A. No, she hasn't.

Q. Okay, thank you. I take it that there was, at no time during your relationship with Corporal Desmond, that you asked the case manager, Ms. Doucet, to send you copies of any reports, whether medical, psychological, psychiatric, or of any nature whatsoever?

A. No.

Q. You had indicated that when you first spoke with, or at some point in time, one of your conversations with Ms. Doucet, you thought that based on what she had shared with you that you could be of some assistance to Corporal Desmond, and I think your words were that you "felt it would be a good fit".

A. Yes. After our first two sessions, based on ...

Q. I'm sorry. That response ...

A. I, sorry.

Q. ... that you gave was in response to a question and it

was in relation to information that had been given to you by Ms. Doucet. Not Mr. ...

A. Oh.

Q. ... or Corporal Desmond. Sorry.

A. I see. Yes. Based on the information she shared with me, it did seem like Mr. Desmond would be the kind of client that I would work with and that would be a good fit.

(12:38:58)

Q. Okay. So let me share some information with you. Now, I'm going to read you some passages from a variety of documents.

A. Okay.

Q. Okay. And it seems to me that this may have been the state of the knowledge or the information that was available at the time that you had your first kind of several conversations with Case Manager Doucet.

A. Okay.

Q. Okay? And at the end of it, I'm going to ask you a question about what the cumulative effect of all that knowledge might have on your decision-making.

A. Okay.

Q. And it's going to be pretty clear, I think.

A. Okay.

CATHERINE CHAMBERS, Examination by the Court

Q. So appreciating that ... let me see here. Let me just provide it in a historical context. So what we do know, we have Exhibit 115 and it's a letter that was written with regard to a recommendation that Corporal Desmond attend at the Ste. Anne's Stabilization Residential Program. It's signed by Dr. Murgatroyd and it says, in part: "This letter is to strongly recommend the admission of the above client to Ste. Anne's Stabilization Residential Unit. Client is diagnosed with chronic PTSD. Quite severe." The date of this letter is December 15th, 2015:

> Quite severe. Major depressive disorder. Co-morbid alcohol use disorder. Currently in remission. He does have chronic pain. He is prescribed medical marijuana but is aware and agreeable to your admission criteria of no medicinal marijuana usage. Client continues to struggle with disabling symptoms of PTSD that directly affects his social and occupational functioning.
>
> The goals of admission are for medication reassessment, improving his coping skills, increasing his structure and daily activities, and psychosocial rehabilitation.

> Once stabilized, client will have outpatient follow-up with his psychologist, his psychiatrist here at the OSI clinic. He does not have a family physician. He is medically fit. Client is not actively suicidal or homicidal.

It goes on to the next paragraph: "His suicidal support network is limited. Client is motivated to actively engage in treatment process and would highly benefit from psychosocial interventions."

Then it says: "A teleconference is recommended prior to discharge for collaboration of care. Review recommendations to ensure appropriate follow-up."

So it would appear that when the referring psychiatrist sends this recommendation, that they have in mind some of the things that you were speaking of which, in fact, was kind of, review, collaboration and appropriate follow-up. All right?

We know that we have Exhibit 116 which is entitled "Interdisciplinary Discharge Summary from Ste. Anne's Hospital". Have you ever read that, by the way? Have you ever had a chance to read it?

A. No.

Q. No? Okay. So as a result of the letter of referral - so we have that December - we know that, come May of 2016 that Corporal Desmond was admitted to the stabilization program in the Residential Treatment Clinic for Operational Stress Injuries in Ste. Anne's. He was admitted, as I said, on that date, May 30th. He was transferred to the residential program July 4th and he was discharged August 15th.

"There was a telephone conference that took place August the 9th with the residential treatment clinic team and Mr. Desmond's outside care team to share observations and recommendations in preparation for his charge and to ensure his continuity of care in the community."

So it would appear that the expectations were that there was a sharing of observations, a sharing of recommendations, to ensure continuity of care in the community, which is also what you had mentioned as well.

A. Mmm.

Q. Right? And we know from looking at Exhibit 117, page 10, the case note from August the 10th, which would be the next day, this is what the case manager writes. This is Ms. Doucet who you interacted with. So she's writing this on August the 9th.

Case manager participated in case conference with Ste. Anne's Hospital treatment team, Fredericton OSI psychologist, Dr. Murgatroyd also participated as per case manager's request. Many details regarding veteran's participation were shared. Veteran spent more than average time in stabilization unit and will be leaving the treatment program a bit early.

I take it you would not have known that.

A. No.

Q. ... earlier than expected as per his request to spend time with his daughter before school starts.

Overall, minor progress was observed and the team expressed several concerns based on their observations of behaviour in what appears to be cognitive limitations. A neuropsychological assessment will be part of formal recommendations, and further insight in his cognitive functioning is believed to be necessary.

That would not have been shared with you.

A. No, I ...

Q. Okay.

A. This is the first time I've heard any of this.

Q. Okay.

> Some concerns are related to the veteran's lack of sound plan for accommodation upon his discharge next week. Case manager in Ste. Anne's team discussed some of the final steps/discussions to be had with him prior to his departure since he will be relocating to Nova Scotia and will require new support.

So they were aware that he was coming to Nova Scotia and ...

A. Mm-hmm.

Q. ... that he required supports. The possibility of him setting up with services of a clinical care manager was mentioned. They make arrangements for transportation. Later it says: "Ste. Anne's report will be completed and forwarded to both case manager and OSI clinic team via fax." So it would appear that the report that is Exhibit 116 was going to be made available to the case manager but you never told that it was there or that there was a report.

A. No.

Q. Okay. All right. The report says in part as well, these are the observations and recommendations of the Psychology Department and Dr. Gagnon, and this is at page 2 of that exhibit:

> In periods of emotional dysregulation Mr. Desmond was encouraged to continue to take part in treatment in valued actions and self-care behaviours and the usefulness of his habits seemed to be partially integrated. However, though Mr. Desmond was able to recognize a pattern of damaging interpersonal behaviours as the end of treatment neared, the client seemed to express growing doubts about the intentions of the treatment team, which led to increased distress and isolation.

Were you aware that that had developed?

A. No, I was not.

Q. That relationship had developed?

A. No.

Q. With regard to recommendations; firstly, due to the observed and reflected difficulties in

the area of behaviour and inhibition and memory, as well as a reported incidence in which head injuries might have been present, we recommend a detailed neuropsychological evaluation.

Part of the reason I'm reading this to you is I want you to just have an appreciation for what was known ...

A. Mmm.

Q. ... at the time that he was discharged. Okay? And then it was coming to you without you having any idea who was coming to sit in your office and have discussions with you.

(12:49:02)

Under "Occupational Therapy" it says:

The results of the evaluation did, indeed, indicate the presence of mild cognitive dysfunction. The nature of the test done does not allow the identification of the proportion to which different elements may have influenced the performance.

It goes on to say that, "The neuropsychological evaluation is recommended in order to determine Mr. Desmond's cognitive capacities."

COUNSEL: I don't know, Your Honour, if ...

THE COURT: Sorry.

A. I'm okay. It's okay.

Q. Would you like to take a little break, Ms. Chambers?

A. No.

Q. Because I'm going to read a number of passages and I think it's important for you to have a full understanding. Because I'm going to ask you to apply a little bit of hindsight ...

A. Yes.

Q. ... back on your own experiences. Okay? And I think ...

A. I'm prepared for that.

Q. And I think part of the reason is, as well - I think you'd recognize it – when you talk about the question of the sharing of information in a database, I mean it's important to appreciate that all of this information was sitting there, right? And you had none of it.

A. That's correct.

Q. All right? And so it's important, I think, for people to understand exactly what was available, and the impact it had and how that may ultimately have affected your assessment and

your determination of, you know, those words, "It looked like a good fit." Well, I'll be asking at the end of this. You may very well say, Well, I guess it didn't look like as good a fit as I may have thought it did if I had all this information, and the question ...

A. Yes.

Q. ... of whether or not you would have looked at it and undertaken it in a different way, right? I make this observation as well.

A. Yeah.

Q. We know that he left that clinic in August, and I don't think that we can point to any kind of therapeutic intervention or a therapeutic moment up to and including January the 3rd as you were still doing your assessment.

A. Yes.

Q. And so even though there was a recognition that there needed to be some continuity of care and there was a plan, I think perhaps one of the best remarks about the plan came out of some remarks of Dr. Slayter. So this is Dr. Slayter, who sees him December the 2nd, and Dr. Slayter says ... this is Exhibit 67. It's page 28. He says:

In part, I would normally see someone with

PTSD once only to confirm the diagnosis and make recommendations. However, given the complexity of his case, and given that he seems to have been 'falling through the cracks' in terms of follow-up by military and veterans' programs I said I would follow him for a short while to help him get connected. I shall focus on treatment in subsequent sessions rather than on further elucidation of the details of his disorders, as that needs to be done by others at a higher level of service.

At the time that you saw Mr. Desmond a psychiatrist had seen him and prepared quite a detailed report. I don't know if you ever saw the report.

A. No, I did not.

Q. Was there the view that Mr. Desmond had fallen through the cracks in terms of follow-up by military and Veterans Affairs?

A. Mmm.

Q. The information would have been valuable to you to know that the person who was coming to see you had, by the view of Dr.

Slayter, fallen through the cracks?

A. Yes, it would have been and also what you just mentioned in terms of requiring a higher level of care so far, based on what you've read, would indicate that that's the case. Inpatient treatment specifically.

Q. Mm-hmm. Again, this is from the Exhibit 116. It's page 3 under the "Recommendations". It goes on:

> Having a clear portrait of the actual impact of cognitive deficits in the client's functioning, if any, will serve to orient treatment in that it will support the process of setting realistic therapy goals which are to help Mr. Desmond attain a satisfying level of participation in his activities and develop a sense of having an improved quality of life. The impact of his OSI symptoms would also be considered in the context of an evaluation. An assessment of the functional capabilities will make it possible to identify the most appropriate level of support and strategies to be given to Mr. Desmond in order to help maximize his

participation in carrying out obligations related to his different occupational roles: father, spouse, worker, friend, et cetera.

The work at that clinic in Quebec had identified the need for that, and also in the progress note, the fact that Ms. Doucet had recognized and had written that, "A neuropsychological assessment will be part of formal recommendations, as further insight in his cognitive function is believed to be necessary."

And at least in your point in time when you were doing your assessment you had been given no heads-up that that was an important part of what was being recommended. Because I guess without cognitive wellness your interventions are going to be frustrated?

A. Yes, our ...

Q. Would that be a good way to put it?

A. Ineffective.

Q. Ineffective?

A. Yes.

Q. All right. You don't have any recollection of having received any consents from Ms. Doucet that needed to be signed and returned to her before she would share the psychological information that she had on ...

A. No.

Q. I know that Ms. Miller had made reference and had read from Exhibit 117, page 7. It was the case note dated November 7th, 2016 and it says in part: "Once this is confirmed, then a case manager will send consent forms to her office for veteran to sign. Once they are returned case manager can provide psychologists with some information that is relevant to veteran's psychological health." So that never happened.

A. No.

Q. And the next sentence. And I know Ms. Miller didn't read it because it wasn't pertinent to her question, but it says: "No new psychological assessment needed at this time." And I understand that would be in the context of her having access to the RTCOSI report. That's my observation.

The case manager's file that we have as Exhibit 117. Have you read the entire file?

A. No, I have not.

Q. You've read parts of it?

A. Parts of it.

Q. Okay. And you were directed to various parts of it?

A. Yes, through my counsel and interactions with the Crown.

Q. Okay. Thank you.

MS. HICKEY: Your Honour, just to be clear on that point, Ms. Chambers. We had been provided by the Crown with pages 6 and 7 of that report.

(12:59:04)

THE COURT: Pages 6 and 7? Thank you. And that's not to suggest there's anything wrong with that, by the way. All right?

Let me ask you the question. I might say that there's more that I can read from the report, but I think you get the theme about the information and findings and the recommendations that they made that were not conveyed to you and, in fact, that from August till December I haven't seen anything to suggest there had been a real therapy session anywhere any time ...

A. Mm-hmm.

Q. ... that you kept getting passed off. It actually would seem to me that once the transition went to Nova Scotia the first person that they may have really been in touch with in relation to some kind of former continuity of care to pick it up was you in November.

A. Yes.

Q. That's a big gap. Would you agree with me that it's a big gap from a person that's coming out of a residential

treatment facility with a follow-up plan that's going to get him to another OSI clinic and the neuropsychological assessment and all the reviews and the reports, to then go to nothing?

A. Yes, I would agree with you.

Q. And does that impact how your fit might be with Corporal Desmond at that point in time?

A. Certainly in light of the information that you've shared from this report, I don't believe Mr. Desmond would have been a candidate for community-based psychotherapy but would have required further inpatient care.

Q. Okay, so I'm going to back up to things that you've come to recognize. One is, I think it helps recognize the fact that when you were going to be contacted by someone, and were just dealing, in particular, with Veterans Affairs, I think you said that on some occasions you might be offered some additional reports. But that ...

A. No.

Q. ... didn’t happen in this case?

A. That's correct.

Q. Okay. So does that change your practice and make a recommendation for change in a practice that whenever you get a referral from Veterans Affairs, and in particular let's just

focus on military veterans or currently serving with PTSD, complex or not, that you would like to have in hand every piece of medical information that you might have available to make a determination as to how you might work with him to determine, first off, whether or not somebody has missed a step here? He was not suitable for community-based but needed to go back ...

A. Mmm.

Q. ... in a different setting, and that perhaps was missed?

A. Yes.

Q. So you'd like to have all of that available to you?

A. Yes, I would and ...

Q. Useful?

A. Yes, and since the events of January 3rd my experience has been that that information has been provided more regularly ...

Q. Mm-hmm.

A. ... and more predictably and it's been my practice now, as well, to ask for that information before seeing the veteran.

Q. Okay. So apart from you reassessing your own involvement with Corporal Desmond and how you would manage that time with him and the relationship you had with Veterans Affairs

and the information documentation, I would assume that you've gone back and reassessed your approach? I mean insight's always important, I would think, in the work that you do?

A. Yes, I agree, yes.

Q. So have you had any discussions with any of your professional associations about your insights and what you've learned and so that they can share that with other practitioners and maybe develop or look at developing or giving advice for best practices in these types of circumstances?

A. I haven't spoken directly with my governing body or my professional associations but I have sought out quite a lot of professional development in clinical supervision, specifically around record-keeping, documentation, but I think what you're referencing is a good suggestion.

Q. Have you had any discussions with anyone, for instance, from Veterans Affairs to say to them ... maybe after today you might. But ...

A. Mmm.

Q. ... perhaps up until this point in time there may not have been any need for you to do it because you didn't have all the information available?

A. Yes.

Q. Because my question would have been, did you have an opportunity, or think about, going back to anyone at Veterans Affairs and saying to them, Listen, you know, this could have been handled in a little different way - I won't use the word "better" or not, but perhaps a different way - if we had been able to access all of this information in a more timely basis?

A. Mmm.

Q. And I appreciate there may not have been any reason for you to do that, not knowing that there ...

A. Right.

Q. ... really is a reason to do that.

A. Yes.

Q. Would you agree?

A. I would agree with that.

Q. Thank you. All right. Counsel have any questions?

MR. HAYNE: Your Honour, if I may. Just a quick ...

THE COURT: Mr. Hayne? Yes.

MR. HAYNE: ... follow-up. Thank you.

CROSS-EXAMINATION BY MR. HAYNE

(13:05:18)

MR. HAYNE: His Honour took you through some reports,

including a passage from a report of Dr. Ian Slayter, who is a psychiatrist in Antigonish. You noted that you hadn't seen that report before. Correct?

A. That's correct.

Q. So all you know of that report is the passage that His Honour read to you. Correct?

A. Yes.

Q. And part of that report suggested that Dr. Slayter used the words that ... his view, that Mr. Desmond may have fallen through the cracks? And then you were asked a question and you suggested that ...

THE COURT: Sorry. I'm going to stop you, Mr. Hayne. So falling through the cracks. In terms of follow-up by military and veterans programs ...

MR. HAYNE: Yes, thank you.

THE COURT: ... was what I read. Thank you.

MR. HAYNE: Certainly, and my question is just around your comment that you believe that maybe what Mr. Desmond required was inpatient therapy and I just wanted to understand what you meant by that term. Because there was the Ste. Anne's program which was a program where he was resident at the facility and that could be considered a form of inpatient

therapy.

A. Yes.

Q. And I want to contrast that with inpatient admission to a hospital in a psychiatric ward.

A. Yes.

Q. And I just want to understand what your meaning was with respect to the inpatient component.

A. Sure. Inpatient residential treatment versus a short stay in the hospital to mitigate imminent risk of harm to self and others.

Q. Right, so when you were saying what you suggested may have been the more appropriate approach in terms of inpatient was the residential therapy program. Correct?

A. Correct.

Q. Okay. Thank you.

THE COURT: Mr. Murray, do you have any questions? Or Mr. Russell?

MR. RUSSELL: I don't think so, Your Honour.

THE COURT: No. All right. Thank you.

Ms. Chambers, thank you for your time. I know it was difficult for you at times but very important to have the information you have available and your insights are a value to

us as well. So thank you very much.

A. Thank you for the opportunity.

THE COURT: Thank you. All right. Thank you, Ms. Chambers. You can step down. You're free to go.

A. Thank you.

EXAMINATION BY THE COURT

THE COURT: Oh, one last thing. I'm sorry. I forgot to ask. About the timeline. You said you prepared a timeline. Did you prepare that in and around January the 4th?

A. Yes, the week between the 4th and the 10th approximately.

Q. And you prepared that for Ms. Doucet or you prepared it as the basis to assist you in making the report?

A. It was for myself.

Q. Yourself.

A. As it was fresh in my mind, to create a timeline that would most accurately reflect what I recalled from our sessions and our phone call and, yes, I did reference the timeline as well when completing the assessment report.

Q. All right. So is it a handwritten timeline? Or is it

a typed or, you know ...

A. No, it's typed.

Q. It's typed? All right. Do you have any difficulty sharing that with us?

A. Not at all.

Q. Thank you.

A. I'm happy to share that.

Q. Maybe you can make arrangements through Ms. Hickey to get a copy to Mr. Murray.

A. Certainly.

Q. Or Mr. Russell. And then they'll make it available to counsel. If there's any questions that arise from that, then maybe we'll deal directly with Ms. Hickey about it.

A. Okay.

Q. Okay. Otherwise thank you for your time.

A. Thank you.

Q. Appreciate it. Thank you.

WITNESS WITHDREW (13:08 HRS.)

THE COURT: I take it we're finished for the day?

MR. RUSSELL: That's all the witnesses we have ready for today, Your Honour.

THE COURT: Thank you. So we're adjourned to Tuesday

morning. Tuesday morning, 9:30. Thank you.

COURT ADJOURNED (13:09 HRS.)

CERTIFICATE OF COURT TRANSCRIBER

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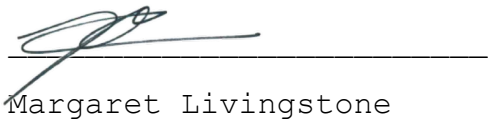

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