CANADA

PROVINCE OF NOVA SCOTIA

IN THE MATTER OF THE

*FATALITY INVESTIGATIONS ACT*

S.N.S. 2001, c. 31

# THE DESMOND FATALITY INQUIRY

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**TRANSCRIPT**

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**HEARD BEFORE:** The Honourable Judge Warren K. Zimmer

**PLACE HEARD:** Guysborough, Nova Scotia

**DATE HEARD:** January 27, 2020

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**JANUARY 27, 2020**

**COURT OPENED (10:03 HRS)**

**THE COURT:** Thank you. Good morning.

**COUNSEL:** Good morning. Good morning, Your Honour.

**THE COURT:** So today we are resuming the Desmond Fatality Inquiry and for this particular evidentiary session, I expect that we will be hearing from a number of relevant witnesses. Before I call on Mr. Murray, there's just a couple of things that I need to address. Counsel would have received, along the way, a list of exhibits. The first ten items are documents that I intend to have marked as exhibits.

The first document is Inquiry Document 52. It's going to be Exhibit 01. And that's the funding application from May 3rd, 2019. Inquiry Document 53 will be marked as Exhibit 2. And when I say "2," we're talking about P000002. I'll just short form it as "2." That's the affidavit of Mr. Rodgers in relation to that same application for funding. The next document is Inquiry Document 54, which will be Exhibit P3. That was a draft order. Inquiry Document 55 will be marked as Exhibit P4. That was the affidavit of Mr. Anderson, May 13th, 2019. Next document, Inquiry Document 56, will be P5. That was Mr.

Anderson's reply to the funding application. Inquiry Document 57, which will be marked as Exhibit P6, was a letter signifying an agreement with regard to representation of Aaliyah Desmond. And Ms. Miller and Ms. Morrow were signatories to that and Mr. Rodgers had signed, as well. Ms. Morrow is no longer involved in this matter. Mr. Macdonald has taken over representation and, in particular, I understand, Counsel, we're going to have a discussion about that relationship with regard to the representation of Aaliyah. How does that stand?

**EXHIBIT P000001 - INQUIRY DOCUMENT 52 - FUNDING APPLICATION FROM MAY 3RD, 2019**

**EXHIBIT P000002 - INQUIRY DOCUMENT 53 - AFFIDAVIT OF MR. A. RODGERS**

**EXHIBIT P000003 - INQUIRY DOCUMENT 54 - DRAFT ORDER**

**EXHIBIT P000004 - INQUIRY DOCUMENT 55 - AFFIDAVIT OF MR. ANDERSON, MAY 13, 2019**

**EXHIBIT P000005 - INQUIRY DOCUMENT 56 - MR. ANDERSON'S REPLY TO THE FUNDING APPLICATION**

**EXHIBIT P000006 - INQUIRY DOCUMENT 57 - LETTER SIGNIFYING AGREEMENT WITH REGARD TO REPRESENTATION OF AALIYAH DESMOND**

**MS. MILLER:** Your Honour, my friend and I have had that conversation and we are continuing on as per the agreement

reached between myself and Ms. Morrow, with no issues.

**THE COURT:** Thank you.

**MR. MACDONALD:** That's correct, Your Honour.

**THE COURT:** Thank you, Mr. Macdonald. So we'll enter that letter as was originally produced to the Inquiry. Inquiry Document 58 will be Exhibit P7. That was a production order that I had prepared and signed ... or had been prepared and I signed it in relation to Nova Scotia Health Authority. Inquiry Document 59, Exhibit P8 was a production order with regard to EMO. Inquiry Document 60 will be Exhibit P9. It was a production order in relation to Nova Scotia Medical Examiner's Office. Inquiry Document 61 will be Exhibit P10, which also was a production order related to the Chief Firearms Officer for the Province of New Brunswick and documentations from that office. I think the next document we're going to be dealing with is Inquiry Document 46, which would be marked as P11, which is the terms of reference. I think Mr. Murray is going to deal with that.

**EXHIBIT P000007 - INQUIRY DOCUMENT 58 - PRODUCTION ORDER RE NOVA SCOTIA HEALTH AUTHORITY**

**EXHIBIT P000008 - INQUIRY DOCUMENT 59 - PRODUCTION ORDER RE EMO**

**EXHIBIT P000009 - INQUIRY DOCUMENT 60 - PRODUCTION ORDER RE NOVA**

**PRELIMINARY MATTERS**

**SCOTIA MEDICAL EXAMINER'S OFFICE**

**EXHIBIT P0000010 - INQUIRY DOCUMENT 61 - PRODUCTION ORDER RE CHIEF FIREARMS OFFICER FOR THE PROVINCE OF NEW BRUNSWICK AND DOCUMENTATION FROM SAME**

**EXHIBIT P0000011 - INQUIRY DOCUMENT 46 - TERMS OF REFERENCE**

**THE COURT:** So, Mr. Murray, are you ready?

**MR. MURRAY:** Yes, Your Honour.

**THE COURT:** All right. Thank you. So you may call your first witness.

**MR. MURRAY:** Your Honour is going to ask for opening statements, I think, first, are you, or ...

**THE COURT:** Oh, please. Go ahead. Sorry.

**OPENING STATEMENT OF MR. MURRAY**

**MR. MURRAY:** Thank you. Your Honour, first, on behalf of myself and my co-counsel, Shane Russell, we would like to express our gratitude at having the opportunity to participate in this important and challenging process. As Your Honour had said in earlier comments, the tragic death of Aaliyah, Shanna, Brenda, and Lionel Desmond have impacted many, including the families and friends of the deceased and the broader community in a variety of ways.

Their untimely deaths have left many unanswered questions. It will be the work of all who are participating in this fatality inquiry to attempt to find answers for family members left behind and for the people of Nova Scotia. It will also be our challenge to present evidence to the Inquiry that will assist Your Honour in the challenging task that you have assumed.

I would like to make some comments about the role of counsel at a fatality inquiry. The role of counsel at a fatality inquiry, we have come to learn, is a unique one. The **Nova Scotia Fatality Investigations Act** gives some guidance and direction regarding the role of the Crown attorney acting as

counsel at a fatality inquiry.

Section 36 of the **Act** provides: "A Crown attorney or counsel for the Minister shall appear at a fatality inquiry and may examine and cross-examine witnesses and present arguments and submissions."

The **Act** provides no additional direction as to the specific duties and responsibilities of Crown attorneys who act as counsel at a fatality inquiry. Authors on the topic have considered, generally, the role of counsel at various forms of inquiries, and there are different forms. In his text, **The Conduct of Public Inquiries**, Professor Ratushny speaks about the role of counsel at inquiries more generally and references a number of functions they can fulfill.

Among the roles and tasks of Inquiry counsel referenced by Professor Ratushny, most relevant at this fatality inquiry are some of the following: to supervise and conduct the investigation into all of the information relevant to the terms of reference including gathering documentation and interviewing witnesses; to develop and maintain open communication with all parties and to encourage cooperation in facilitating the disclosure and presentation of evidence; and to call evidence at the hearings, including witnesses the parties seek to call.

**OPENING STATEMENT BY MR. MURRAY**

As Crown attorneys, Mr. Russell and I are accustomed to fulfilling our roles in the prosecution of offences often within the setting of a criminal trial. The fatality inquiry is obviously different than a criminal trial and, as such, our roles in this process are different as well.

This process is not a criminal trial. It is not an adversarial process. It is inquisitorial. It is a fact-finding, not a fault-finding exercise. It requires that all counsel work together to marshal and present evidence in furtherance of the Inquiry's mandates.

In this Inquiry, we have been given terms of reference which will guide our work. The evidence we call at the Inquiry will be designed to assist Your Honour in the work you will be doing, which will ultimately culminate in a written report containing findings which will be filed with the Provincial Court.

The terms of reference in this case are broad and they touch on a number of different areas for the Inquiry's consideration. Over the coming weeks and months, we will be calling witnesses who will give their recollections of key events in the lives of the Desmond family. We will be presenting documents with relevant and important information.

**OPENING STATEMENT BY MR. MURRAY**

As we started our work and thought about how to approach this, it became clear that there were a multitude of ways in which to proceed. Ultimately, in consultation with Your Honour, we determined the best approach for this first sitting of the Inquiry is to focus on events close in time to the tragic deaths of January 3rd, 2017. There is no magic in this. It is simply a place to start.

Initially, the Inquiry will hear from Dr. Matt Bowes, who is Nova Scotia's Chief Medical Examiner. It was Dr. Bowes' recommendation, pursuant to Section 26 of the **Fatality Investigations Act**, to the Honourable Mark Furey, Minister of Justice and Attorney General, that led to this Inquiry. Dr. Bowes carefully considered many factors before making his recommendation and the Inquiry will hear about his thought process.

The Inquiry is tasked with determining the date, time and place of death, as well as the cause and manner of death of the deceased. The Inquiry will hear from a number of police officers who responded to the tragic events of January 3rd, 2017 and from other officers and investigators, including from the Nova Scotia Medical Examiner's Office, who have the task of determining or attempting to determine what happened on that

day. Dr. Eric Mont, the Medical Examiner who conducted the postmortems on the deceased will testify. Obviously, this evidence will not be easy, but it is necessary to hear.

One of the main areas of the Inquiry for this process is a consideration of the health of Lionel Desmond and the treatment that he received. Several of the terms of reference touch on the issue of treatment and services received by Lionel Desmond and his family. In particular, one of the terms of reference requires that we consider the circumstances of Lionel Desmond's release from St. Martha's Hospital on January 2nd, 2017.

During this first sitting of the Inquiry, we will be calling evidence from a number of healthcare providers who saw and interacted with Lionel Desmond in the months and days before his death. These individuals will include psychiatrists from St. Martha's Hospital and other medical staff who interacted with him.

Another of the terms of reference relates to whether Lionel Desmond should have been able to retain or obtain a license enabling him to obtain or purchase a firearm. During this first session of the Inquiry, we will be presenting evidence from officials from both Nova Scotia and New Brunswick who have familiarity with the administration of the Canadian Firearms

Program in their respective provinces, including some who dealt with Lionel Desmond's application for renewal of his firearms possession and acquisition license as well as a review of that license.

It is important to note that this is the first of what will be a number of sittings of the Inquiry over the coming months. It is our goal in this first sitting and subsequent sittings of the Inquiry to call evidence which examines all of the terms of reference.

As we progress in this journey, Inquiry counsel look forward to working with Your Honour and all of the other counsel who are here. Although counsel represent different interests and different parties at this Inquiry, all of us, in a sense, are a team with a common goal. We are confident that this process will lead to recommendations for positive changes for the people of Nova Scotia. Thank you, Your Honour.

**THE COURT:** Some time ago when we had anticipated starting in November, I think that I had indicated if counsel had any opening comments they wanted to make, they would be given the opportunity, as well. So, Ms. Ward, do you have any comments you would like to make before we begin?

**OPENING STATEMENT BY MS. WARD**

**MS. WARD:** Yes, Your Honour. My name is Lori Ward. Melissa Grant is my colleague. We appear on behalf of the Attorney General of Canada. The events that have brought us here today are heart rending. It will be difficult for all involved to review them, but we are especially mindful that the Desmond and Borden families live this reality every day.

To the extent that the Government of Canada has relevant information to offer that pertains to factual matters captured in the terms of reference of this fatality investigation, we wish to be of assistance. As a member of the Canadian Armed Forces and later as a veteran, Mr. Desmond interacted with various federal entities when accessing federally-supported services and benefits. In addition, an investigation was carried out by the Royal Canadian Mounted Police. We have provided many documents to this fatality investigation and many federal witnesses will speak to these issues.

Judge Zimmer and Inquiry counsel, you have previously demonstrated that you are mindful of the constraints placed on us by the law relating to federal and provincial jurisdiction. However, the Attorney General of Canada is confident, based on

the terms of reference, that our participation can engage those factual matters within the knowledge of federal actors that are relevant to this Inquiry's investigation and which can assist in shedding light on this tragedy. Thank you.

**THE COURT:** Mr. Anderson?

**OPENING STATEMENT OF MR. ANDERSON**

**MR. ANDERSON:** Thank you, Your Honour. The Attorney General of Nova Scotia will be making submissions after the evidence, so as a closing statement. Thank you.

**THE COURT:** Mr. Macdonald?

**OPENING STATEMENT OF MR. MACDONALD**

**MR. MACDONALD:** Good morning, Your Honour. Thank you.

Your Honour, as you know, I'm counsel for Ricky and Thelma Borden, and Sheldon Borden, and also for ... co-counsel with Ms. Miller for Aaliyah Desmond. And Thomas Morehouse is here with me this morning and will be throughout the Inquiry.

The terms of reference have been alluded to. You know them, all the lawyers know them. They're in Minister Furey's terms of reference of February 14th, 2018; in particular, page two, item three. It sets them out in highlighting the release from St. Martha's; access to appropriate mental health; family and Lionel access to appropriate domestic violence intervention services; training for healthcare and social service providers relating to occupational stress injuries or domestic violence; the firearms issue and restrictions, if any, on accessing federal health records. And then, of course, the last one which is very wide, any recommendations of the judge about the foregoing matters.

So we would highlight two of those foregoing matters. One is with respect to firearms. A consideration down the road, Should there be an intermediate level, another level, a last

level, a final level of judicial review when a person in Lionel's situation applies for the reinstatement of a firearm license; in particular, a combat veteran suffering from the severe issues that Lionel did suffer from. He had access to guns and used guns in his job fighting for this country.

Secondly, in the broader range, there are other victims other than the Desmond family and those victims are, of course, the family members who are all still here who live this every day. I speak now of the Bordens, Ricky and Thelma, who live in the house where this terrible tragedy happened three years ago. They'll get up and have breakfast there this morning, dinner there tonight, sleep there every night as they have been for years. And so the victims in that respect shouldn't be forgotten in terms of what recommendations, if any, may come out of this Inquiry that could give assistance to them.

So what do the Bordens look for? They look for answers. How could this have happened? And they look forward to recommendations from you in terms of not having such a situation happen again. And they look forward to the adoption and the implementation of recommendations from you, whatever they are, by our provincial government and open mindedness in terms of other governments, whether they're other provinces or the

federal government in terms of implementing and adopting recommendations you may come up with. Thank you, Your Honour.

**THE COURT:** Thank you, Mr. Macdonald. Mr. Rogers?

**OPENING STATEMENT BY MR. ROGERS**

**MR. ROGERS:** Thank you, Your Honour. Together with my colleague, Karen Bennett-Clayton and Amanda Whitehead, we represent the Nova Scotia Health Authority and its staff, including nurses. The Nova Scotia Health Authority operates hospitals and health centres in the Province of Nova Scotia, including both the St. Martha's Regional Hospital in Antigonish and the Guysborough Memorial Hospital in Guysborough.

At the outset, the Health Authority would like to express its condolences to all affected family members and friends touched by this most tragic loss of life that has given rise to this Inquiry.

The circumstances here are obviously heartbreaking. We recognize that there will be difficult moments at this Inquiry for participants and for family as this Inquiry explores all the circumstances that it is charged to consider. Our hope is that our participation in this Inquiry will help shed light on the interaction Lionel Desmond had with the Nova Scotia Health Authority in the months before the tragic deaths.

Mental health and addictions care and support in Nova Scotia is delivered through a number of organizations and

providers. The Nova Scotia Health Authority provides various mental health and addictions services for individuals experiencing moderate to severe mental disorders that interfere with their functioning.

Services provided by the Nova Scotia Health Authority include a 24/7 provincial crisis line, outpatient and outreach services, inpatient services, and speciality services. In turn, those outpatient and outreach services include crisis and emergency response teams who work with hospital emergency departments, families, first responders and other providers, to conduct mental health assessments including risk assessments, crisis stabilization and care planning.

Presenting issues in emergency departments are complex. Crises are defined by the individuals experiencing them and there's a continuum of crisis presentations ranging from psychosocial crisis through the psychiatric emergencies and corresponding responses.

In addition to the Health Authority, Nova Scotians may receive mental health care from family physicians or private healthcare providers, including psychologists, psychotherapists, counselors, and social workers.

In Lionel Desmond's case we understand that he received

certain healthcare services directly or through the Canadian Armed Forces and Veterans Affairs. We anticipate that a number of Nova Scotia Health Authority employees will appear and testify at the Inquiry, including in this session, and that they will describe the contact between Lionel Desmond and healthcare providers at the Guysborough Memorial Hospital in Guysborough and the St. Martha's Regional Hospital in Antigonish.

By way of a brief summary, it's anticipated that the evidence at this Inquiry will show the following. In August of 2016, Mr. Desmond returned to Nova Scotia from Quebec where we understand that through Veterans Affairs that he had been an inpatient in the Ste. Anne Stabilization Program in the residential treatment clinic for operational stress injuries.

Then on October 24, 2016, Mr. Desmond presented, together with his spouse, Shanna Desmond, at the St. Martha's Regional Hospital Emergency Department complaining of poor sleep with nightmares and increasing symptoms of PTSD. He was assessed by the Mental Health and Addictions Crisis Response Service; specifically, by a mental health crisis clinician, Nurse Heather Wheaton, and psychiatrist Dr. Ian Slayter.

One week later, on November 2nd, 2016, Mr. Desmond saw a family physician, Dr. Ranjini Mahendrarajah, at the Guysborough

**OPENING STATEMENT BY MR. ROGERS**

Memorial Hospital Emergency Department, who provided a referral to psychiatrist Dr. Slayter, for psychiatric services. That referral was received the next day, on November 3, 2016, and Mr. Desmond was placed on a wait list for an outpatient appointment with Dr. Slayter.

On December 1st, 2016, Mr. Desmond came to the St. Martha's Regional Hospital Emergency Department looking to speak to someone in Mental Health. He was noted as having anxiety and situational crisis. The records show ... or will show that Mr. Desmond left St. Martha's after being triaged but before being seen on that day by an emergency department physician. As a result of learning that his daughter had injured her wrist, Mr. Desmond left St. Martha's to assist his daughter. That same day, Mr. Desmond received a call from St. Martha's Outpatient Mental Health and was provided with an appointment to see Dr. Slayter in Antigonish the next morning on December 2nd.

Mr. Desmond had a psychiatric consultation with Dr. Ian Slayter on December 2nd, 2016. A follow-up appointment was scheduled with Dr. Slayter for December 21, 2016, but Mr. Desmond did not attend at that appointment.

Next, in terms of interaction with the healthcare system, on January 1, 2017, Mr. Desmond returned to the Emergency

**OPENING STATEMENT BY MR. ROGERS**

Department at St. Martha's at 6:51 p.m. He reported that he had had a bad day and was not coping well. He was seen by St. Martha's nursing staff and emergency room physician, Dr. Justin Clark, as well as psychiatrist, Dr. Faisal Rahman.

ER patients accessing the emergency department can either be admitted into the hospital or discharged or kept in Observation. In Mr. Desmond's case, he was kept in Observation at the St. Martha's Hospital overnight on January 1/2, 2017. The next morning, January 2nd, Mr. Desmond was discharged from St. Martha's with a plan to follow up with Outpatient Mental Health. Mr. Desmond then returned to St. Martha's in the early afternoon of January 3rd, 2017 and booked that follow-up appointment with Dr. Slayter's office for January 18th, 2017.

While we may never be able to fully explain the tragedy that happened later that day on January 3rd, the Nova Scotia Health Authority appreciates the opportunity to assist this Inquiry in its fact-finding process and its consideration of possible recommendation that might prevent similar tragic events. Thank you.

**THE COURT:** Thank you, Mr. Rogers. Ms. Miller?

**OPENING STATEMENT BY MS. MILLER**

**MS. MILLER:** Your Honour, my name is Tara Miller and I represent Brenda Desmond, Retired Cpl. Lionel Desmond's mother, and share representation of Aaliyah, his 10-year-old daughter, through their personal representative Chantel Desmond, one of Lionel's four sisters. My role at this Inquiry is to represent family.

When the women and men of the Canadian Forces leave their families, their home, and our country to deploy to combat zones, they know the risks of the battle ahead of them. And when they return to Canada, they reasonably believe that the battle has ended, as they're coming home to safety. But this if often not the case.

Leaving the physical battlefield behind does not mean leaving the battle. And bringing the battle home to Canada means family members on home soil are inevitably caught in the crossfire of a battle they know very little about as they do their best to assist and support their loved ones readjust from the military theatre and the horrors of war which accompany it.

Family members know something is different with their loved ones but they struggle, themselves, to understand what has

happened. These family members need their own support through this time, but often don't receive it.

The horrors of war run deep with the consequences suffered for generations. Post-traumatic stress disorder, anxiety, depression, these are largely invisible illnesses broadly known as operational stress injuries which are a result of occupational trauma experienced in the theatre of war, which soldiers bring home with them. The impact of operational stress injuries is a societal one, one that we don't have a good understanding of but see the effects of on our military members and our veterans and their loved ones. This was the experience of the Desmond family.

Lionel Desmond was the victim of a system which, despite being well intended, failed him when he needed it most. As he valiantly battled to live with the legacy of the occupational trauma he experienced in Afghanistan, his family battled alongside him. Aaliyah, Brenda, and Shanna were the innocent and unintended victims of a war that impacted them daily after his return home and for which they paid the ultimate price.

Our military members, veterans, and their families deserve better. We know we can do better. And this Inquiry is about coming up with recommendations to do just that, do better. It's

about having a much deeper understanding of the battle our veterans and their families face after coming home from combat with operational stress injuries.

It's about finding better ways to support and assist families when their loved ones return home. It's about determining how we, as a society, can prevent what happened to this family from happening to other Nova Scotian and Canadian families.

This Inquiry will deal with heavy issues and difficult truths as we explore why these deaths happened and how these deaths might reasonably have been prevented. To date, the weight of these issues has been carried by the families who have dealt with this burden by themselves for far too long. This Inquiry will help take the weight of that burden off the shoulders of these families.

To our brave soldiers, whether in active service or a veteran, this Inquiry is for you. To parents, spouses, children and siblings of our Canadian Forces members, this Inquiry is for you. To the family and friends of all Nova Scotians employed in occupations where there is a high rate of occupational trauma, this Inquiry is for you. To the Borden and Desmond families and, in particular, to Brenda Desmond's children, Aaliyah's

aunts and Lionel's sisters; Chantel, Cassandra, Diane, and Kaitlyn. The loss of three generations of your family in one day is unimaginable. Yet through this grief, it was your unwavering dedication and commitment to calling for this Inquiry which resulted in us all being here today.

The result of this Inquiry will never heal the wounds in your heart, but I know that all of us collectively in this room are working to provide you with insight into how your loved ones became the unintended victims of a war they never enlisted for and, most importantly to you all, to prevent such a deep tragedy from happening again to any others, leaving a legacy of hope for the future. Thank you.

**THE COURT:** Thank you, Ms. Miller. Mr. Rodgers?

**OPENING STATEMENT BY MR. RODGERS**

**MR. RODGERS:** Thank you, Your Honour, and thank you for the opportunity to provide some opening remarks. In doing so, my hope is to provide some context for the work before us and the testimony we are likely to hear throughout this Inquiry.

In that context, representing Cpl. Lionel Desmond is an important responsibility. Cpl. Desmond's sister, Cassandra Desmond, as his personal representative, feels the weight of the responsibility and in bearing it she is supported by her family and her community. She is also supported by members of the Canadian Forces family from across the country. We have a responsibility to find answers and propose improvements. And all of that support is going to be important in giving us the wisdom and the strength to do this well. There are many questions.

Cpl. Desmond spent ten years trying to find answers to his questions. Why couldn't he stop the flashbacks? Would his nightmares end? Why would he become so angry? Would relationships ever be normal again? Why won't the pain go away? Cpl. Desmond never quite found those answers and now we are going to try to find them.

**OPENING STATEMENT BY MR. RODGERS**

There are two very important reasons for doing so. First, when a tragedy of such a shocking nature takes place, there is a very human need to try to understand how or why it could happen, how something so beyond our normal daily considerations could become part of our lived reality. Everyone experiences suffering of one kind or another. There is a great deal of suffering in the world, perhaps enough to say that it is a natural state of being or part of a natural state of being. Everyone has their fears, their pain, their bad dreams. And for many, the days are long.

And yet, despite all this, very few cross over into violent action as a way of expressing their suffering or into self-harm as a means of ending it. So when it happens, there is a public human need to understand the genesis of those actions, that this violence was taken out on the people who were most precious to Cpl. Desmond; his wife, his daughter, and his mother. It makes it all the more mysterious. That is one side of this.

There is also a need to look at this tragedy at a systems level to see how guidelines and procedures on such things as mental health development and treatment, head injury diagnosis, and treatment of post-concussion syndrome, firearms licensing, to name a few, might be improved so that current and future

service personnel and their families do not needlessly suffer the same fate as the Desmonds.

In recent years, post-traumatic stress disorder has been the top diagnosis for troops released from the military for medical reasons. Suicide rates among military personnel and military veterans far exceeds that of the general population, particularly among younger males. That tells us there is much more we need to learn about PTSD, what works and what doesn't.

Cpl. Desmond had several types of treatment over the course of ten years, as we will hear. Some of it seemed to work or at least have positive effects. Much of it is unclear. Physical activity and exposure therapy seemed to benefit Cpl. Desmond for a time. Other things seemed to exacerbate his symptoms. Being in a natural environment seems to help those with PTSD, but there are also challenges with service delivery and social isolation for those veterans living in rural areas. What is the most sensible, persuasive, or effective treatment for PTSD? We will want to hear expert opinions on that topic and see how widely available such expertise can be effectively distributed.

From the perspective of his personal representative, the study of the all-consuming nature and incendiary effects of PTSD is the area of analysis which, if done well, will have the most

far-reaching impact on our society of any of the topics which we may cover in this Inquiry.

Later, in the course of this Inquiry, we are going to hear from people that knew Cpl. Desmond well, both before and after the active combat portion of his military service. We will first hear about the tragic events of January 3rd, 2017 and the events that took place in the weeks leading up to that day. We will hear about treatments sought and received at St. Martha's Hospital, efforts to connect Cpl. Desmond with treatment providers in the local area and the complexities involved in such matters when the individual in need is a military veteran.

As his personal representative, Cassandra Desmond, wanted to ensure that there was some understanding of Lionel Desmond as an individual, as we begin these proceedings, some appreciation for how he was perceived by those around him who knew and loved him and who still cherish those memories. From his obituary, it states as follows:

> Lionel served the Armed Forces from September 2004 to July 2015 with the Second Battalion Royal Canadian Regiment at Gagetown, New Brunswick. He served his country proudly with two tours of

> Afghanistan. Lionel was known for his friendly demeanour and contagious smile. His can-do attitude was evident while serving his unit and community. He will be remembered as an amazing son, brother, father, husband, nephew, cousin, and grandson.

That is one way he will be remembered. Perhaps he will also be remembered eventually as the tragic genesis of change for the better for our military personnel and their families through the deliberations and recommendations from this Inquiry.

If this Inquiry is to fulfill the mandate the public has demanded, it must be far reaching, insightful, and committed to looking beyond one soldier and one family tragedy. Lionel Desmond was a victim of the service he gave to his country and far from the only one. Too many Canadian soldiers have followed a similar path with similar tragic consequences. Still others hover over that path and struggle on a day-to-day basis to find reasons to keep moving forward. The Desmond family feels a deep responsibility to these soldiers and their families to use their experiences to help educate decision makers and the public as to what can be done to strengthen our military and prevent future

tragedies.

It is said when soldiers go into battle that they are making an unlimited liability commitment for their country. Combat death is a risk that very few Canadians of our generations will ever have to take. Because of this unlimited liability commitment, both the Government of Nova Scotia and the Government of Canada owe these soldiers and their families the best support that Canadians can provide. It is the mandate and responsibility of this Inquiry to understand what happened to Cpl. Desmond and others like him and to recommend what can be done to reduce the chances of history repeating itself.

It has taken some effort to get to this point, much of which resulted from the pressure and insistence from Cassandra Desmond and her sisters, Chantel, Diane, and Kaitlyn. It has not been a clear path, however, and it is not the case that all parties have welcomed this opportunity to shed light on this tragedy and the issues it raised.

In October 2017, Cassandra and Diane Desmond travelled to Ottawa to bring their Rally for Change to the nation's capital. Incidentally perhaps, it was during this trip to Ottawa when Ms. Desmond was first asked about whether Cpl. Desmond had been administered the anti-malarial drug mefloquine which was

reported to have been widely distributed among Canadian Forces soldiers in Somalia and other locations. While the medical records do not reflect such, there are allegations that Cpl. Desmond was administered this drug which has been reported to produce PTSD-like side effects. Some investigation into this question would certainly be warranted by this Inquiry.

After being asked about Cpl. Desmond during Question Period that day, Veterans Affairs Minister O'Regan agreed to meet with Cpl. Desmond's sisters. The federal government, however, either through Veterans Affairs or the Department of National Defence, did not call an inquiry into those deaths despite having the legislative authority to do so. In addition to declining initially to call for an inquiry, the Premier and Justice Minister of Nova Scotia also initially declined to call for an inquiry into these matters.

It took the Chief Medical Examiner of Nova Scotia to do so, under legislation that provided that where he made such a recommendation, the Minister of Justice had no choice but to call an inquiry. The Premier of Nova Scotia initially said the responsibility for conducting an inquiry into this matter was the responsibility of the federal government. And he may not have been entirely incorrect in that view. National Defence is

a federal responsibility, as is Veterans Affairs.

Preparing a soldier to go to battle for our country is a federal responsibility. All of the treatment provided to Cpl. Desmond over the years after his deployment except for at the very last, was provided through the federal government. As noted, however, the federal government has not, of their own volition, called for an inquiry.

To their credit, the federal government has publicly pledged cooperation with this Inquiry and that is a very good sign. It is important because so much of the disclosure, so much of the information is going to come through departments of the federal government. So far, and again to their credit, they have lived up to their pledge.

We have seen much of this already through the documents we have been provided. We have ten years of psychological and counseling records. We have medical records for Cpl. Desmond and we have operation manuals and other documents that show the standards and guidelines for treatment of military veterans and involvement of their families at various stages. This is vital background information which will help us reach more accurate conclusions and will help better inform whatever good recommendations will emerge from this Inquiry.

**OPENING STATEMENT BY MR. RODGERS**

There is still more to come from the federal government, as well, such as documents and records that will help us have a better sense of Afghanistan, itself, and Cpl. Desmond's time spent there. The terrible nightmares and flashbacks he continued to experience were generated while he was in Afghanistan. It would seem important to have a more clear picture of what he saw and what he did while he was there. What kind of theatre was this and under what kind of rules of engagement was he operating?

Even in the absence of these records from Afghanistan, we will be able to have some sense of that from Cpl. Desmond's own descriptions of his persistent and frequent nightmares about what he saw and what he did while serving in Afghanistan. He gave these descriptions to some of his treatment providers and some of these were recorded at the time and we have requested these recordings.

But, of course, contemporaneous reports of operations, descriptions of the specific geography and culture of Afghanistan and a synopsis from a military point of view of operational considerations and dangers would help this Inquiry. I expect that among the areas we may explore is whether there is a way or a better way of preparing a soldier mentally for being

in a combat zone in a part of the planet that is vastly different than that to which they are ordinarily accustomed. Perhaps there are better preventative measures that may reduce the likelihood or severity of PTSD experiences. We will need to apply ourselves to that important question.

The personal representatives have important roles in this Inquiry. We have spoken previously about how important that is ... that it is that the Inquiry is provided the necessary judicial and operational independence to ensure that the investigation of the various arms of the provincial and federal governments is not constrained either bureaucratically or financially.

If the substantive contributions to this Inquiry are made only or even primarily by parties acting for and employed by the government, which is itself under scrutiny, it is much less likely that the goals of this Inquiry will be effectively met. Meeting this challenge is presumably one of the reasons my client is, and other personal representatives are, granted special statutory recognition under the **Nova Scotia Fatality Investigations Act**.

While there are certainly other stakeholders who are well deserving of standing, the **Act** grants the personal

representatives special recognition with respect to full involvement in the Inquiry itself. That is how Cassandra Desmond views her role, and my role as counsel.

The decision to hold the Inquiry here in Guysborough, far removed from easy accessability for most Nova Scotians and certainly for the mainstream media, has benefits and challenges. While this location is convenient for the Desmond family and the community, there is also some risk that it may minimize the public spotlight which this Inquiry deserves. Live streaming and the posting of evidence and availability of transcripts will help ensure that what we do here will reach those with an interest and the public generally. And those efforts by the Inquiry are certainly appreciated by my client.

We are here in Guysborough for this Inquiry and it is appropriate, for many reasons, that it is being held here. This particular space not long ago was used as the court for Guysborough County. Many parties will have driven here to Guysborough along Route 16 which takes you directly past the site of the tragic events that took place on January 3rd, 2017.

If we look out the window and up the hill, we will see the elementary and high school attended by Cpl. Desmond, where he was a well-liked and respected student athlete. Just a few

steps around the corner from here is the cenotaph where, for many years, Remembrance Day ceremonies were held before being moved indoors to the Performance Centre up at the school. Remembrance Day ceremonies took place a week before this Inquiry had been scheduled to start back in November and Cpl. Desmond was among the many residents and former residents from the Guysborough area who were honoured by their community during the ceremony. As part of a very moving slide show, Cpl. Desmond was pictured along with his Great Uncle Walter Jarvis who also served our country in combat.

Among the many men and women from Guysborough County who served in our military were proud ... many proud African Nova Scotian soldiers and service personnel. Other relatives, ancestors, and community members of Cpl. Desmond who served our country include his cousin and mentor, Albert "Junior" MacLellan (sp?) and many others such as Clarence Desmond, brothers Roland and Ronald Ash, Charlotte Ash, Walt Clyke, Joe Izzard, Barbara Ann Reddick, Mary Desmond, Great Grandfather Jim Reddick, Great Uncle William John Borden, and Step Great Grandfather George Washington Reddick, an infantry gunner in World War I.

Lionel Desmond was raised in a strong, proud, African Nova Scotian community. The question of race is not always easily

reconcilable in a military context. An unfortunate tension can arise for those who have decided to serve their country in such an honourable and dedicated manner and, yet, who experience systemic and individual racism from within the very society to which they have dedicated themselves.

Cpl. Desmond experienced racism in his time in the military and those experiences deserve consideration in the course of this Inquiry. It is important that we examine the extent to which race may have factored into enrolment, deployment, and treatment decisions for him.

Given the history of military service in his family, Cpl. Desmond was an eager recruit. How eager might future recruits be? The recommendations from this Inquiry will certainly be important for military recruitment. If we, as a country, do not find better ways to treat soldiers with PTSD, post-concussion syndrome, and other combat injuries, if we do not find better ways to reintegrate soldiers and their families after combat experiences, then recruitment into the Armed Forces is going to become increasingly more difficult.

The public is aware that these kinds of issues can be endlessly debilitating when confronted with the services and treatments currently available. If we, as a society, deem it

important to continue to recruit great soldiers like Cpl. Desmond was throughout his training and active service, then we are going to need to address these serious shortcomings head-on.

I mentioned Cpl. Desmond's obituary earlier. His obituary also said that Cpl. Desmond succumbed to the tortures of PTSD. Think of that simple but powerful sentence. He had PTSD and he acquired it from the awful things he saw and did while serving his country. It was torture for him. As his sister Cassandra has said, his shell came back but that beautiful soul inside of him became a dark cloud. Cpl. Desmond dealt with/wrestled with the symptoms of PTSD every day and every night. It was mental torture, mental torture that turned one of the happiest people anybody knew into someone capable of committing acts of unimaginable violence before finally the PTSD took him, as well.

Now Cpl. Desmond's sisters will have to live each day of the rest of their lives without their dear mother and their one and only brother, without their sister-in-law and their precious and beloved niece. A large extended family has been forever marked by tragedy and sadness compounded four times over. Many people throughout eastern Nova Scotia who have a connection to this wonderful family have been deeply affected and, of course, the Canadian Forces family from across the country has felt the

impact of this tragedy and are watching to see what might take place as a result or in reaction to it. For all of these people, the work we do here is going to be of vital importance both in helping understand what happened and to provide recommendations for systemic improvements.

I look forward to working cooperatively with my colleagues here and with the very capable Inquiry staff and supporting organizations in a professional, diligent, and sensitive manner that this subject matter demands. In so doing, we will assist with the fulfilment of the important mandate with which this Inquiry has been charged. Thank you, Your Honour.

**THE COURT:** Thank you, Mr. Rodgers. Mr. Hayne?

**OPENING STATEMENT BY MR. HAYNE**

**MR. HAYNE:** Good morning, Your Honour. My name is Stewart Hayne. I'm legal counsel to Dr. Paul Smith, Dr. Ian Slayter, Dr. Justin Clark, and Dr. Faisal Rahman. Dr. Slayter and Dr. Rahman have sought standing to participate in this Inquiry. Dr. Clark and Dr. Smith will also be participating to provide any evidence and information they can to assist.

Each of these doctors wish to express their condolences to the family members of Lionel, Shanna, Aaliyah, and Brenda Desmond, and to express their sadness at the unexpected and tragic events that have brought us here today. I'll provide my opening comments relating to each physician and their expected evidence in the order they encountered Mr. Desmond.

Dr. Paul Smith is a family physician practicing in the Fredericton and McAdam areas of New Brunswick. Dr. Smith has been a family physician for over 40 years and during that time worked for the Canadian Forces at CFB Gagetown as a family doctor for military personnel.

Through his experience, Dr. Smith learned that more and more veterans were turning to marijuana to assist with pain and symptoms from PTSD. As he approached retirement, Dr. Smith

shifted into the practice of treating people with pain and PTSD with trials of prescription medical marijuana.

The results from Dr. Smith's practice was published in 2017 in the peer-reviewed academic journal, the **Journal of Pain Management** and the paper entitled, "Medical Cannabis Use in Military and Police Veterans Diagnosed with Post-Traumatic Stress Disorder, PTSD". This article was coauthored with other physicians and with academics from the University of Toronto at Sunnybrook Medical Centre and the Juravinski Cancer Centre at McMaster University in Hamilton, Ontario.

In addition to the medical marijuana trials, Dr. Smith also started to address the need identified for veterans to have an appropriate social element and took it upon himself to open a vacant area near his office to allow veterans to congregate as an informal support group. Dr. Smith also planned fishing trips for veterans and other such events.

Lionel Desmond saw Dr. Smith for a possible trial of medical marijuana on July 2nd, 2015. At that visit, Dr. Smith confirmed that Mr. Desmond had a pre-existing diagnosis of major depressive disorder and PTSD, diagnoses provided by a psychiatrist for the Department of National Defence. Dr. Smith charted that Mr. Desmond reported symptoms associated with PTSD

and provided Mr. Desmond with a prescription for a trial of medical marijuana.

When Dr. Smith saw Mr. Desmond again at the scheduled three-month follow-up visit, Dr. Smith charted that Mr. Desmond reported reduced symptoms of PTSD, including reduced anxiety, reduced depression, reduced anger and irritability, and reduced or almost eliminated suicidal thoughts.

Dr. Smith also got to know Mr. Desmond through the informal support group. Dr. Smith will say that he knew Mr. Desmond to be a gregarious, forthright, likeable, stable and reasonable individual. Dr. Smith last saw Mr. Desmond on February 23rd, 2016. At that time, Mr. Desmond reported that he had ceased use of medical marijuana prior to attending the clinic at the Ste. Anne's Hospital in Quebec.

Mr. Desmond also came with a form for medical assessment for firearms license. That form contained information about an incident involving Mr. and Mrs. Desmond whereby the RCMP had been called due to concerns about Mr. Desmond's behaviour. Dr. Smith also had personal knowledge of an event reported by Shanna Desmond in November of 2015. Dr. Smith will say that Mr. Desmond explained the events as simply instances of marital discord. Dr. Smith will say that Mr. Desmond specifically noted

that he was not suicidal, which aligns with the RCMP records of that event.

With his knowledge of Mr. Desmond from the office visits and from the support groups and with Mr. Desmond's explanation, Dr. Smith felt comfortable completing the form, indicating that he had no concerns that Mr. Desmond posed a safety risk to himself or others with an appropriate firearms license. Dr. Smith will also say that he has refused to sign the same form for other patients due to concerns he had with those other patients. He did not have those same concerns for Lionel Desmond.

Since learning of the events, Dr. Smith had had feelings of sadness that his assessment may have enabled Mr. Desmond to purchase and obtain a gun. However, Dr. Smith will say that he knew Mr. Desmond to be forthright, reasonable, non violent and stable individual and that when he knew him, he had no concerns for Mr. Desmond, as he reported on the firearms license form.

Dr. Ian Slayter is a psychiatrist at St. Martha's Regional Hospital in Antigonish. Dr. Slayter saw Mr. Desmond on two occasions after he had returned to Nova Scotia from the Ste. Anne's program in Quebec. Dr. Slayter has been practicing as a psychiatrist since 1982 and has practiced in the United States

and in Canada.

Dr. Slayter has had a particular interest in assessing patients for suicide risk. As the Clinical Director of General Psychiatric Services for the then Capital District Health Authority, Dr. Slayter spearheaded a program to review how psychiatrists evaluate suicide risk and advocated for a suicide assessment to be conducted at each psychiatric encounter.

On October 24th, 2016, Lionel and Shanna Desmond came together to the Emergency Department at St. Martha's Hospital. They were first seen by a crisis worker, Heather Wheaton. Dr. Slayter saw Lionel and Shanna together and recorded the chief complaint as Mr. Desmond's inability to sleep due to nightmares.

Dr. Slayter recorded that Mr. Desmond felt depressed, that he had frequent outbursts of anger and aggression towards objects. He also noted that Mr. Desmond was sometimes paranoid regarding his wife Shanna and noted frequent conflict with her. Dr. Slayter will say that the Desmonds disclosed a history of aggression where Mr. Desmond would pound a table. Dr. Slayter will say that Shanna Desmond said she was not afraid of Mr. Desmond and that she was more central and vocal during this assessment. Mr. Desmond was more reserved and quiet and that he was generally pleasant, nice, and reasonable.

**OPENING STATEMENT BY MR. HAYNE**

After conducting the assessment, Dr. Slayter adjusted and prescribed certain psychiatric medications to assist with Mr. Desmond's symptoms. In accordance with his practice, Dr. Slayter evaluated Mr. Desmond and assessed his suicide risk as low. Dr. Slayter will say that, at that time, Mr. Desmond was awaiting assistance from the OSI Program in Nova Scotia and he noted that if Mr. Desmond could not soon get help from the OSI Program, that he should get a referral from his family doctor so that he could see Dr. Slayter in a formal consultation.

That referral was made and Dr. Slayter saw Mr. Desmond in consultation on December 2nd, 2016, this time in an office consultation environment by himself. Dr. Slayter will say the consultation took between one and a half and two hours, which is in accordance with his standard practice.

Dr. Slayter conducted the psychiatric consultation and recorded his findings. Dr. Slayter will say that Mr. Desmond presented as a pleasant, depressed man, with a demeanour that was calm and appropriate. His rapport was normal while he affect was depressed. His speech was articulate and normal in rate and amount. His thought process was coherent and rational.

Dr. Slayter charted that Mr. Desmond had nightmares of his wife cheating on him, which Mr. Desmond related to the marijuana

previously prescribed for symptoms of PTSD. Dr. Slayter charted that Mr. Desmond would become angry with her and would believe that she might be cheating on him. At other times, however, Mr. Desmond would realize that Shanna Desmond had not cheated on him.

Dr. Slayter charted that Mr. Desmond remained anxious and tense virtually all of the time and that Mr. Desmond's thoughts of jealousy seemed to be over valued and bordering on delusions. These were not ... Dr. Slayter charted that these were not actually delusions and noted that the origin of the thoughts of jealousy was not clear and needed further elucidation.

Dr. Slayter noted that his jealous thinking developed or worsened after going on marijuana, but that Mr. Desmond had stopped taking marijuana a number of months earlier. To be clear, Dr. Slayter will say Mr. Desmond was not psychotic and that he was not delusional. Mr. Desmond did, however, need intensive psychotherapy for his PTSD and jealousy. Dr. Slayter charted that Mr. Desmond was seeing such a therapist in Antigonish later that same day.

Dr. Slayter also noted that, as a psychiatrist, he would normally see someone like Mr. Desmond only once. The psychiatrist role in this presentation is to confirm the

diagnosis and to make recommendations for treatment; in this case, psychotherapy. However, Dr. Slayter noted that he would go beyond that to see Mr. Desmond again to ensure some continuity of care while he was waiting to get set up with OSI.

A follow-up appointment was set for December 21, 2016 but Mr. Desmond did not attend. Dr. Slayter did not take any action as Mr. Desmond, like any competent patient, was entitled not to attend for the appointment and also given that his suicide risk was assessed as low.

Dr. Justin Clark is an emergency medicine physician. Dr. Clark saw Mr. Desmond on one occasion when he presented to the Emergency Department at St. Martha's Hospital on January 1st, 2017. Dr. Clark's charted assessment was that Mr. Desmond had no acute distress, no suicidal ideation, and no homicidal ideation. Dr. Clark recorded that Mr. Desmond's speech was normal and that there was no evidence of psychosis. Dr. Clark made a call to the psychiatrist on call for a telephone consult. The psychiatrist on call was Dr. Faisal Rahman. Dr. Rahman happened to be in the hospital, so he came down to see Mr. Desmond.

Dr. Faisal Rahman is a psychiatrist practicing at St. Martha's in Antigonish and is the Chief of Psychiatry for the

**OPENING STATEMENT BY MR. HAYNE**

Eastern Zone of the Nova Scotia Health Authority. Dr. Rahman spent six years of residency and fellowship training at the University of Minnesota with practice and training at the Veterans Affairs Medical Centre, the VANC, in the United States, with significant exposure and experience working with United States combat veterans with PTSD.

Dr. Rahman will say that Dr. Clark called him to advise that he intended to take a bed in the mental health ward for a social admission for a veteran. Given his experience with combat veterans and because he happened to be in the hospital, Dr. Rahman offered to come down and see Mr. Desmond, himself. Before heading down, Dr. Rahman reviewed the outpatient hospital chart for Mr. Desmond, which included Dr. Slayter's consultation note.

Dr. Rahman met with Mr. Desmond in an interview room with a couch and chair. And Dr. Rahman's chart note is not a verbatim transcript of their conversations and Dr. Rahman will say that he has a robust, independent memory of meeting with Mr. Desmond.

Dr. Rahman will say that he recalls that he met with Mr. Desmond for 30 to 40 minutes and that he was able to establish a good rapport with him. Dr. Rahman will say that he found Mr. Desmond to be pleasant, forthcoming, engaging, respectful, and a

proud father. Mr. Desmond was not agitated. His affect was appropriately reactive and Mr. Desmond was coherent, logical, and future-looking. Dr. Rahman will say that Mr. Desmond was in no acute distress. He had no suicidal ideation, no homicidal ideation, and had no evidence of psychosis, all as recorded by Dr. Clark.

Dr. Rahman recorded his notes after his meeting with Mr. Desmond. Dr. Rahman charted that Mr. Desmond had a verbal altercation with his wife who apparently asked him to leave the premises until he felt more under control. Dr. Rahman charted that Mr. Desmond has been intermittently asked by his wife to spend the night elsewhere and to return home the next day.

Dr. Rahman charted that Mr. and Mrs. Desmond had an argument last night when their vehicle went into a ditch. He recorded that both continued to escalate until he punched/hit a table, at which point she threatened him about calling RCMP and he left the home voluntarily. Dr. Rahman also recorded that Mr. Desmond denied abusing Mrs. Desmond physically.

Dr. Rahman will say that Mr. Desmond expressed remorse that he had startled his daughter when he hit the table, that Mr. Desmond spoke fondly of his daughter. Dr. Rahman remembered this conversation particularly, as his daughter was the same age

at that time.

Dr. Rahman noted that "Mr. Desmond wishes to stay in the hospital overnight to reflect and regroup. He has an appointment with his therapist through V.A. tomorrow. He denies any suicidal or homicidal ideation. Thought process is coherent, logical, goal-directed."

Dr. Rahman did not believe that Mr. Desmond required hospitalization but offered him a bed on the mental health ward for social purposes. Mr. Desmond then disclosed that his wife, Shanna, was a recent nursing school graduate and that she had recently started as a nurse on the mental health ward and that he didn't want to stay on the mental health ward.

Dr. Rahman will say that he believed that Mr. Desmond was protective and forward-looking, that he was concerned for Shanna and that she would be the subject of gossip if Mr. Desmond stayed on the mental health ward overnight. Dr. Rahman understood and coordinated with Dr. Clark to arrange for Mr. Desmond to spend the night in the Emergency Department observation area under Dr. Rahman's care. Dr. Rahman stayed in the Emergency Department until Mr. Desmond was settled in bed for the night. Throughout the night, Mr. Desmond was periodically checked on by nurses and Dr. Rahman came down to

see Mr. Desmond the next morning, prior to Mr. Desmond leaving hospital.

Dr. Rahman will say that Mr. Desmond did not require voluntary hospitalization and that he did not require involuntary hospitalization. Dr. Rahman will say that he is familiar with the requirements for involuntary hospitalization under the **Involuntary Psychiatric Treatment Act**. Indeed, at any one time, there may be three to four patients admitted to the psychiatry unit under **IPTA** and that Dr. Rahman, himself, may invoke **IPTA** on the order of one to two times per week. Dr. Rahman will say that he would not have hesitated to recommend hospitalization or invoke **IPTA** if he felt it was indicated.

That morning, the morning of discharge, Dr. Rahman reported in his chart, "Patient feeling better, requesting discharge. Will discharge to home. Does not meet criteria for involuntary hospitalization. Slept well." Dr. Rahman recorded that Mr. Desmond had no suicidal ideation, no homicidal ideation, all being chart notes that are part of his standard practice. Dr. Rahman recalls offering Mr. Desmond to stay longer if he wished, but Mr. Desmond left the hospital that morning, according to his expressed wishes.

Each of these physicians, Dr. Smith, Dr. Slayter, Dr.

Clark, and Dr. Rahman, each hope that their evidence and participation in this Inquiry will be of assistance. Thank you.

**THE COURT:** Thank you, Mr. Hayne. Mr. Murray, I return to you to call your first witness. But before we do that, I might suggest that we take a short morning recess. Come back maybe at I'd like to say 15 minutes, but I know how hard it is to keep people to 15 minutes. But at least it's not five. So let's try and come back by 11:30. All right. Thank you.

**COURT RECESSED (11:14 HRS)**

**COURT RESUMED (11:34 HRS)**

**THE COURT:** Mr. Murray?

**MR. MURRAY:** Yes, Your Honour. Inquiry Counsel is going to be calling Dr. Bowes as our first witness.

**THE COURT:** Thank you. Dr. Bowes?

**DR. MATTHEW BOWES, sworn, testified:**

**DIRECT EXAMINATION**

**A.** Good morning.

**MR. MURRAY:** Good morning, Dr. Bowes. How are you this morning?

**A.** Not bad. Am I being amplified, by the way?

**THE COURT:** I can tell you, Dr. Bowes, those microphones, in particular, have a direction associated with them. So if it's right in front of you it picks up your voice as best it can. There is some amplification in the room as well. So I think if you speak in a normal conversational tone you're likely to be well heard throughout the room.

**A.** Thank you, Your Honour.

**MR. MURRAY:** Dr. Bowes, for the record, can you state your name, please?

**A.** My name is Matthew John Bowes. B-O-W-E-S.

**Q.** And Dr. Bowes, you are the Chief Medical Examiner for the Province of Nova Scotia?

**A.** Yes, sir.

**Q.** And you are so appointed as Chief Medical Examiner for

the Province of Nova Scotia pursuant to Section 3, I believe, of the **Fatality Investigations Act**?

**A.** Yes, I think so.

**Q.** Okay, and you've been the Chief Medical Examiner for the Province of Nova Scotia since 2006?

**A.** 2006, yes.

**EXHIBIT P000012 - *CURRICULUM VITAE* OF DR. MATTHEW BOWES**

**Q.** All right. We have marked as Exhibit P12, I believe, your *curriculum vitae*. So we're able to bring that up on the screen and ...

**A.** Oh.

**Q.** ... I think, also, you have a paper copy in front of you there, whichever you prefer.

**A.** Well, as long as I don't have to do anything.

**Q.** You can open the paper copy as well and have both if ...

**A.** That's probably better.

**Q.** I'm a paper person, myself, but ... it's number 12, I think.

**A.** I have it here, sir.

**Q.** All right. I'd like to just briefly, I guess, ask you a couple of questions about how you got here as the Chief

Medical Examiner for the Province of Nova Scotia. So Dr. Bowes, you did your medical degree at Queen's University and received that in 1998, did you, sir?

**A.** Yes, sir.

**Q.** All right, and then you came to Nova Scotia and did a residency at the Queen Elizabeth II Health Sciences Centre in anatomical pathology, and that was from 1998 to 2003.

**A.** Yes, sir.

**Q.** Right? All right, and perhaps you can just tell us what you did from there. You went to work in the United States, I believe, for a period of time, did you, Dr. Bowes?

**A.** Yes, sir. I did a forensic pathology fellowship with the Miami Dade County Medical Examiner Department.

**Q.** All right, and you were in Miami Dade for approximately a year, was it?

**A.** Just one year, yeah.

**Q.** Okay, and how did you find that experience, Dr. Bowes?

**A.** Oh, it was a tremendous experience. I think it's still the best place in the world to learn how to do that.

**Q.** Okay.

**A.** Yes.

**Q.** From there in the United States, you came back to Nova

Scotia?

**A.** Yes, sir.

**Q.** All right, and worked for a period of time in the Nova Scotia Medical Examiner's Office as a medical examiner?

**A.** Yes, sir.

**Q.** All right, and in 2005 you became the Acting Chief Medical Examiner?

**A.** Yes, sir.

**Q.** All right, and you performed that function for a year before taking over as the permanent Chief Medical Examiner for the Province of Nova Scotia in 2006?

**A.** Yes, sir.

**Q.** And you've had that position for approximately now 14 years?

**A.** 14 years.

**Q.** All right. The Nova Scotia Medical Examiner's Office is currently located where, sir?

**A.** Well, it's over in Burnside now. We used to be located on the campus of the Victoria General Hospital but we moved over to our dedicated facility a number of years ago.

**Q.** Right. And that facility has, I think, significantly expanded the space and maybe a little better quarters to work

in, did it?

**A.** Oh, yes. We're very proud of it.

**Q.** All right. Very good. As Chief Medical Examiner, perhaps you can give us an idea, in a general sense, of the work that the Nova Scotia Medical Examiner Service does for the Province of Nova Scotia.

**A.** Certainly. Well, there's about 10,000 deaths a year that occur in this province, and not all of them actually fall within the mandate of the Medical Examiner Service. We are called upon to investigate a subset of those deaths, and you know, we could go through the section of the legislation later but, by and large, I think it's simplest and easiest to think of it as any death that is sudden, unexpected, unexplained, or by violence generally comes our way.

In order to do that, we employ a number of forensic nurses who act as investigators in our office. We work very closely with police, obviously, but the final sort of authority to do a death investigation and to do an autopsy rests in one of four medical examiners who are all forensic pathologists.

So the kinds of deaths that we might investigate include all suicides, drug overdoses, motor vehicle crashes, and obviously homicides. Those fall within our mandate for sure.

Some people sort of have a general impression that we're homicidologists, that homicides occupy all or most of our time. But actually, homicides occupy about three percent of our time, actually. Most of the ... well, actually, the most common kind of case would be sort of a middle-age person who collapsed suddenly and died without any real reason to do so, and virtually all of those end up being some kind of heart disorder.

**Q.** I see, and you said in the Medical Examiner's Office there are four forensic pathologists in total? Four ...

**A.** Yes, sir.

**Q.** ... medical examiners. Does that include yourself, sir?

**A.** That includes me.

**Q.** All right, and in addition to that, you said you have other employees who assist the medical examiners and the work they do?

**A.** Yes. So we have, again, the forensic nurse investigators who do the investigative side, but we also have a tremendous group of forensic technicians who help with the autopsy.

**Q.** All right, so forensic nurse investigators. What type of work do they do to assist you and the work you do?

**A.** Well, they would be on the intake side of ... of our activity. So if a death is reported to us - and most commonly, it's the police, actually, who call in a death - the first person they talk to in the Medical Examiner Service is typically one of the nurses or paramedic invest- ... I should add that we ... there are ... a few of them are paramedics.

**Q.** Yes.

**A.** So that paramedic or nurse would accept the call, accept a short description of the death, and the first sort of level of decision-making about ... that they're expected to make is, does this fall within our mandate or does it not? So if a person dies of cancer at home after a lengthy illness that is well documented, typically we would not get involved in that death. Those kinds of deaths are certified generally by the last attending physician.

**Q.** Okay.

**A.** So the next level of decision-making is what to actually do with the death, and for a typical case the body must be removed from the scene and if the case is going to go for autopsy that body would have to be brought to our facility in Burnside.

**Q.** I see. So you had said a moment ago, Dr. Bowes, that

you are sometimes perceived or your service is perceived as only investigating homicides but that that's really, perhaps, a small percentage of the deaths that you're called upon to investigate?

**A.** That's correct.

**Q.** All right. The legislation, the **Fatality Investigations Act**, actually, I believe, outlines the specific circumstances in which certain deaths need to be reported to the Nova Scotia Medical Examiner Service and where you are called upon, then, to draw certain conclusions?

**A.** Yes, sir.

**Q.** All right. I actually have a copy of the **Act** there on the desk there for you. I think the sections that we're referring to where the deaths need to be reported to your office are in sections 9 through 12 of the **Fatality Investigations Act**. Is that correct?

**A.** Yes, that's true.

**Q.** All right, and perhaps you want to open to those sections. There are certain ones that I would assume are more common than others. I don't know if the bulk of deaths that are reported to you come out of or flow out of section 9 of the **Act**?

**A.** Oh, very much. Yeah, this is really the heart of the **Act** for us from a practical perspective.

**Q.** Yes. All right, so deaths that are "As a result of violence, accident, or suicide ..."

**A.** Yes, sir.

**Q.** "Unexpectedly when a person was in good health." That seems a rather broad category, is it?

**A.** Well, it is and it occupies, as I said, more than half of our activity, actually ... is just that. It's a bit unfortunate, but for one in six Canadians who have atherosclerotic coronary artery disease, their first clue is that they die. So ...

**Q.** Yes.

**A.** ... that occupies a very large percentage of our business.

**Q.** Right. Okay. "Where a person was not under the care of a physician." So any person who passes away who is not under the care of a physician, that death is to be reported to your service?

**A.** Yes, and that sort of speaks, really, to cause. You know, if the person doesn't have a physician they probably don't have a well-documented cause of death.

**Q.** Okay. "Where the cause is undetermined." Where, perhaps, a treating physician is unable to determine a cause of

death?

**A.** Yes, and that happens, too.

**Q.** Okay. All right, and/or, "As a result of improper or suspected negligent treatment by any person." Again, a potentially challenging category to ...

**A.** Very much.

**Q.** In addition to those in section 9 of the **Act**, you are called upon to investigate deaths according to section 10, "Where a person dies while in a healthcare facility," under certain circumstances. Can you tell us just about that?

**A.** Well, in some respects, I think that this section's a bit redundant. Because if a person died as a result of violence, accident, or suicide the place of their death really doesn't change the reasoning that much.

**Q.** Right.

**A.** But I would call your attention to 10(d), which is stillbirths or neonatal deaths where the maternal injury has occurred or is suspected. So if a pregnant woman gets into a car crash and she loses her baby as a result of that instance, then the baby becomes a case for us.

**Q.** I see. All right. Section 11 of the **Act** calls you to investigate deaths where a person dies in various forms of

custody, either in a correctional institution or in other circumstances?

**A.** Yes, sir, it does.

**Q.** And are you called upon to deal with those types of deaths very often?

**A.** Oh, rarely, only a handful of times a year. They're thankfully rare, and some of them are certainly natural deaths. But they still warrant some oversight for sure.

**Q.** Right. Section 12 of the **Act** relates to deaths that are related to a person's employment or occupation.

**A.** Well, and for practical purposes, the vast majority of those cases are actually coalminers that contract various kinds of lung disorders from their times in the mines. So that category is about 40 or 50 cases a year, actually.

**Q.** Interesting. Are there other cases involving deaths related to employment that you see or are they primarily coalminer-related deaths?

**A.** Primarily lung diseases. Well, actually, mesothelioma deaths due to asbestos exposure would fall within our purview in that as well.

**Q.** I see. All right. So in circumstances where a death comes to your attention, perhaps you can tell us ... first of

all, how practically does that happen? How does a death come to your attention?

**A.** Okay. Well, it is, really, as I described before, we depend upon people to report deaths to us and that it's typically a police officer or a paramedic at a scene who calls our central number and then one of our investigators has a conversation with the paramedic or police officer and starts to make decisions about how that case is managed.

Just to make the thing easier suppose we have a suicide, death by hanging. Those cases are all autopsied in our facility. So based upon the preliminary information, my investigator would begin a file, order the body removal system to be deployed to that scene, start interviewing family, and then ask for medical records.

So by the time that I get to work in the morning, typically the investigator has written several excellent notes about what the investigation has so far. Medical records usually follow in a number of hours and then usually I have the police account of what they believe occurred and then I take that and I put it to one side and then I look at the body. The dreaded outcome of a suicidal hanging is that we miss a homicide, which is why we put them under such tremendous scrutiny.

So I know what to look for in a suicidal hanging, and I take a look at the body and I do the autopsy and if my anatomic findings align with the investigative findings, and if everything seems to line up, we'll issue a death certificate. And that says, usually, hanging as the cause of death and suicide is the manner. And perhaps I should just explain what those mean. So the ...

**Q.** Or ...

**A.** The cause of death is the disease or injury that starts into motion a chain of events that ends in a person's death. So, for example, gunshot wound to the head, pancreatic cancer, HIV infection. These things are diseases or injuries that started in motion a chain of events that end in death.

The chain of death is referred to as the mechanism of death, and the manner of death is just a classification system. And there are only five: natural, accident, suicide, homicide, or undetermined. And those are sort of categories of death that we use for statistical purposes only. Generally speaking, the natural deaths are all the ones where a disease was responsible for the death, and all the injuries belong in the categories of accident, homicide, suicide, and undetermined, depending upon the setting.

**Q.** Okay. And many people, I think, might have the perception when they think about the work that you do, that the conclusions that you have to draw are based primarily on postmortem examinations or autopsies but, in fact, you look to a number of other factors when you're making the determination that you're called upon to do under section 5 of the **Act**.

**A.** Oh, absolutely, and actually, you know, there's a very clever chapter in a textbook, I can no longer remember where it is, but the author of that chapter sets out a set of anatomic findings and then tells six or seven stories with the same anatomic findings.

Because as you can imagine, if a person is in a car crash their anatomic findings - their injuries and the head injuries and rib fractures and stuff - are all the same. But that car crash may have been a homicide, accident, or a suicide depending upon the setting, and that is why it is very important for me to understand what the police investigators found, what my own investigators found, if there are any areas of disagreement, what are they, how can we resolve them, what hypotheses can we test objectively, which ones can we not address with current methods?

So there's actually quite a bit more to it than simply an

autopsy.

**Q.** Right. And when the deaths that we've referred to, those that may fall within the categories of sections 9 through 12 of the **Act** are ...

**A.** Mm-hmm.

**Q.** ... referred to you, the **Act** calls upon you in section 5 to draw certain conclusions. And you mentioned those a moment ago, some of those, but you're required to, where possible, establish the identity of the person who is deceased, the date, time, and place of death, the cause of death and manner of death. I would assume that in some circumstances, for example, the identity of the person who is deceased is very straightforward. Other times it is very difficult to determine.

**A.** Well, and you're exactly correct. I mean much of the time the identity of the person is trivial in that there is really no reason to doubt about who that person is, but actually, if those of you who follow the media know that we just had a recent success in identifying an unidentified body. So sometimes the whole crux of the investigation is simply attaching a name to a body and, you know, there's chapters that have been written about that kind of thing.

I did want to respectfully draw your attention to the time

of death thing. You know, in fiction, for those of you who read murder mysteries, there's always somebody who says, Well, based on me looking at the wound that person must have died between 5:17 and 5:22 last Tuesday. And this is absolutely not true. We cannot do that. Or perhaps you should hire that person. I don't know.

But that kind of thing is not possible with current methods and, unfortunately, a lot of the public has the view that we ought to and can do that, when we really can't.

**Q.** There are limitations on your ability to put an exact time on the death of an individual?

**A.** Yeah, and that sort of segues into a broader discussion, I guess, about the limitations of science. You know, there's a whole category of baby deaths, unfortunately, where the current science doesn't allow us, often, to come to firm conclusions about the nature of those deaths. But of course, we keep trying and science progresses every day. So soon we will.

**Q.** As best you can, section 5(1)(b) requires you to, I guess, come as close as you can to do the date, time, and place of death. Is that a fair statement?

**A.** That is true. As close as we can.

**Q.** All right, and a moment ago you defined for us "cause" and "manner" of death. So a cause of death, that category could be very, very broad.

**A.** Yeah, it's essentially the entire universe of different ways that a human being can either have a failure of their physiology or become injured by some kind of physical force or object or circumstance, and sometimes there are more than one cause, actually.

**Q.** Yes.

**A.** Or a whole group of diseases may become equally sort of co-responsible for a person's death. It's not that infrequent where we have a person who has two or more plausible causes of death and it then becomes a matter of trying to piece together the last 24 hours of the person's life.

**Q.** Right.

**A.** But in any case, the cause of death is sometimes not trivial and sometimes are very complex.

**Q.** Yes. All right. And the manner of death, as you said, it's basically a system of categorization that's used by your service and I assume others? So our categories were homicide, suicide, accident, natural, and ...

**A.** Undetermined.

**Q.** ... undetermined. All right. And we hope not to have too many undetermineds, but occasionally, we do, I assume.

**A.** Occasionally we do and the rate at which an investigation agency comes to an undetermined determination is quite variable but for us it's less than five percent.

**Q.** Okay. As you go about your work, the **Act** gives you certain powers. I think section 7, in particular, makes reference to some of those, but can you describe for us what some of the tools are that are at your disposal, what powers you have as you conduct an investigation?

**A.** Well, you know, I think the special, unique contribution that the Medical Examiner Service makes to our own investigative apparatus is really the autopsy. We have the ability to take a body and do an autopsy on that body, not only without the consent of the family but sometimes over their objection, and we take that power very seriously and we try to apply it with some wisdom.

But that's really a very extraordinary power, I think, to have in a democracy, but there's some real sense to that, obviously. Sometimes the people closest to that person have a powerful interest in obscuring the cause of death. So it is a necessary element of our business. The other thing ...

**Q.** Although it's not one you always have to use, I take it.

**A.** Oh, no, indeed. There are some deaths where, upon a review of the medical reviews, the cause of death is clear enough to certify without even seeing the body. Elderly people with hip fractures, for example. The record there is usually fairly detailed and includes imaging. So if there is excellent imaging of the hip fracture and a very clear and well-documented downward course an autopsy is not really needed in those circumstances. We do try to spare ... you know, this is an extraordinary power. We try to use it sparingly and with wisdom.

**Q.** Yes.

**A.** Yeah. The other extraordinary thing about what we can do is we can get medical records without a warrant. That is really a practical requirement of our activity. If we had to write warrants for all the different times we needed medical records we wouldn't be able to function.

**Q.** And obviously, examination of medical records for a deceased are an important part of the information gathering process for you.

**A.** Absolutely. Well, sometimes they can give us the

cause of death and spare the family an autopsy.

**Q.** And beyond that, you have other powers, as well, to assist you in attempting to draw the conclusions required of you in section 5? You can understand, photograph, and inspect documents, retain experts, take certain actions at the scene of a place where a deceased is found?

**A.** Yes, and those are very ... you know, they're quite ... how should I put this? Very common in this kind of legislation. The other provinces and territories have very similar powers that way.

**Q.** All right. Despite the tools that are at your disposal, and the information that you're able to gather using those, sometimes, I take it, the conclusions in section 5 cannot be drawn and you ...

**A.** Correct.

**Q.** You consider the possibility of an inquiry under the **Fatality Investigations Act**?

**A.** Correct.

**Q.** And that's not something that you consider in every case obviously. It's something that's used very sparingly, I take it?

**A.** Oh, no, you're absolutely correct. The longstanding

tradition and history of my office is to use that power sparingly and I think that there's a good reason for that.

**Q.** All right. In this case, obviously, you thought a lot about it and today we're going to talk about the process that you went through in coming to the conclusion that a fatality inquiry was appropriate in this case. In general, can you say what value you think an inquiry can bring to this whole process that may not be available with the tools that you have just at your own disposal?

**A.** Well, and I think that in answering that question, I think you're really correct to zoom in on section 5 of what the public expects of me in the course of my job. I have to discover the identity, date, time, and place of date, cause and manner. But it's silent on the issue of ... well, for example, are there gaps or are there improvements that could be made in public policy that would prevent death? That's not a specific mandate under section 5 and, of course, I would propose the point of this inquiry and the great hope is that there would be improvements made in our system.

**Q.** Okay. Since you've been Chief Medical Examiner can you say if there have been other fatality inquiries or are you ...

**A.** The Hyde Inquiry happened under my watch.

**Q.** Which was now a number of years ago.

**A.** Yes, about ... is it ten now? Perhaps longer.

**Q.** Thereabouts.

**A.** So in giving consideration to the possibility of an inquiry here, you no doubt have reference to section 26 of the **Act**, and as I read it, it says:

> Where the Chief Medical Examiner is of the view that it is necessary that a fatality inquiry be held regarding one or more deaths that occurred under circumstances referred to sections 9 through 12, the Chief Medical Examiner may recommend to the Minister that an inquiry be held.

So as I read that section, it says simply where you are of the view that it is necessary. You would agree that that's rather broad wording.

**A.** It is very broad, and I struggle with that quite a bit.

**Q.** Right. All right, so ultimately, over the period of time from January 3rd, 2017 to when the recommendation to the Minister was made, you went through a process of determining

whether an inquiry was appropriate or necessary. Can you tell us just a little bit about that in general, what types of things you thought about and the individuals to whom you spoke?

**A.** Well, I was certainly able to access information that appeared in the public record. So there was quite a bit of media attention obviously given to this matter. Appropriately so.

**Q.** Yes.

**A.** You know, I had access, obviously, to my own investigative record and I had a very detailed view of the last couple of days of this man's life. I was able to do that. I knew a little bit about him by the investigative record. I was able to go online and access a number of resources, you know, to look at what people's policies were and to try and come to some conclusions about what they were and what they did, what was their intent and this kind of thing. I had obviously had poked around the issue of what were the mechanisms in place that were meant to look at that, that situation, and were they a plausible substitute for inquiry?

I proposed in, you know, various correspondence that a judicial inquiry should be close to the last thing that we do when it comes to examining the circumstances of death. I still

endorse that point of view. I think that if there were other mechanisms that would plausibly deliver better policy faster, then I think that we should take those, but those are sort of some of the things I considered.

**Q.** You had contact with the families or certain members of the families of the deceased and spoke to them about their views?

**A.** I did, and I feel privileged to have done so.

**Q.** And there was a sense that they felt questions needed to be answered? Is that ...

**A.** Well, they certainly did, and I won't speak for them. But I certainly got the sense that they felt that there was a number of unanswered questions that could probably be asked in this kind of forum and they took that rather firm line, and as you can see, I ended up agreeing with them.

**Q.** All right. At some point you communicated with the Minister of Justice, and the **Act** actually indicates in section 27: "Where the Chief Medical Examiner recommends to the Minister under section 26 that a fatality inquiry be held, the Minister shall order that an inquiry be held."

So if you were going to make a recommendation to the Minister there was going to be an inquiry?

**A.** That was certainly my understanding.

**Q.** All right. And various correspondence were exchanged between yourself and the Minister's office in the period of time leading up to when you made your ultimate recommendation for the inquiry ...

**A.** Yes, sir.

**EXHIBIT P000014 - LETTER FROM DR. MATTHEW BOWES TO MINISTER M. FUREY DATED OCTOBER 13, 2017**

**Q.** ... and perhaps we can have a look at some of that correspondence. If you want to turn to Exhibit P14.

**A.** 14. This is my letter of October 13th?

**Q.** Yes.

**THE COURT:** So P14?

**MR. MURRAY:** P14, Your Honour.

**THE COURT:** Thank you.

**MR. MURRAY:** And that correspondence, Dr. Bowes ... I guess I'm looking at the second page just below where the sections of the **Act** are quoted. You said:

> There is an appearance of overlapping authority as between sections 26 and 27 that is causing families and advocates to call on both the CME and Minister when they are

> seeking a judicial inquiry. Grieving families would be better served by a fatality inquiry process that is clearly explained, easy to navigate, and devoid of unnecessary bureaucracy. Families also deserve clearly communicated decisions that are consistent, reasonable, and reproducible. Poorly explained decisions add unnecessarily to a family's pain and risk undermining public confidence in the independence and impartiality of the Office of the Chief Medical Examiner.

I take it from that, Doctor, that you saw, I guess ... well, perhaps you can elaborate. But a void in the process for determining whether a judicial inquiry should be called?

**A.** Yeah. I mean sections 26 and 27, as you can see, are very brief, and really, the only thing that the **Act** tells me is that I should form the view that something is necessary, whatever that means, you know, and the word "necessary" can encompass a lot of different things, I guess. And so later on in 27(2), you know, the Minister can call an inquiry himself if he or she thinks that it's in the public interest or in the

interest of public safety.

So those things are obviously very broad and this was kind of my attempt to bring some parameters, I guess, to the reasoning.

**Q.** Okay, and ultimately, you formulated a process that involved a five-step framework, I guess, or five questions.

**A.** Yes, sir.

**Q.** That process of developing those five questions, I guess, that took you some time. What was involved in that?

**A.** Well, I really had to wrestle hard with this. You know, as I said, the **Act** doesn't give a whole lot of guidance as to what it means when it says "necessary", and what I tried to do is look back in the history of my office. I tried to look at what other jurisdictions do. I tried to do some research in how that power is applied in other circumstances and I think what I've come up with is a pretty reasonable interpretation of the word "necessary".

**Q.** And the five-step framework that you outlined first in your letter of October 13th, that's a framework that you will contain to use in the future if you're being asked to consider a judicial inquiry under the **Act**?

**A.** Yes. I mean unless the legislature gives me contrary

instructions, which of course ...

**Q.** Sure.

**A.** ... I would respect. But, yeah, I intend to use this in the future.

**Q.** Okay, so perhaps we can just have a look at those five questions or five criteria. So the first question you posed is, Is the death reportable under section 9 to 12 of the **Fatality Investigations Act**? That's perhaps straightforward. Because if it's not a death reportable under one of those sections it's not within your purview. Is that correct?

**A.** Well, that is correct, and I think that ... I know that sounds trivial, but I think that you could imagine deaths that are not reportable to my office still being of sufficient importance to merit some kind of inquiry or similar process.

But I felt like if I was being asked to make the decision it really should be a death that falls within the purview of my office and having been investigated by my office. There's also a practical consideration here. I mean if I never heard about a death there isn't any practical chance I'm going to do anything with it. So ...

**Q.** Right. Okay. Now the second question you ask, obviously, is having received ... or I should say, In assessing

the result of the medical examiner's investigation of the death, was the medical examiner able to answer the questions set out in section 5 of the **Fatality Investigations Act**? If not, is it necessary to do so?

So that goes to the issue of whether your office is able to answer the questions in section 5.

**A.** Correct.

**Q.** That's not a prerequisite, though, for a judicial inquiry. Because I think ultimately in this case those questions were answered.

**A.** Oh, yes, but I can certainly, you know, imagine deaths where we were unable to do that and where a judge with subpoena power would. So I think that suggesting that it may be used as an investigation tool, I think, is sensible here.

**Q.** Okay. You give certain examples when you're referring to that. Just you say: "In my view, the wording 'and where possible' in section 5(1) recognizes that even with a full investigation, a medical examiner may not be able to answer every question. Examples of this occur." And you give several examples.

**A.** Mm-hmm.

**Q.** And go on to say, "Even with the power to compel

evidence, it would not be possible for a judge to make these findings." So certain questions that can't be answered, can't be answered by a judicial inquiry either.

**A.** Absolutely. And, you know, the judge with subpoena powers is constrained by the same limitations of science that I am. So there isn't any point in subjecting a death to this process if there's no reasonable hope for a good output.

**Q.** Okay. The third question you posed, Doctor, is, Do we need an evaluation of the circumstances that led to the death to find out if it was preventable? So the concept of preventability is an important one in your work I take it?

**A.** Yeah, and it sort of speaks to the broad intent, not only of my agency but of all agencies of similar type the world over. You know, these ... death investigation agencies generally in the western world ... well, some of them are coroner systems and some are medical examiner systems. Just about all of them have preventability. It's kind of the heart of the reason why we do our work.

So, you know, and part of that is simply statistical. You know, if I do, you know, 150 autopsies on suicides per year, simply reporting that statistic to Vital Stats will show or develop the evidence base for epidemiologists and scientists who

are interested in that phenomenon. So without good data there's no good policy, you know?

**Q.** All right.

**A.** And so comparison of year-by-year numbers will permit statements like, Suicide seems to be increasing, or, Suicide seems to be decreasing, or, It's level except for this population. And this kind of thing.

**Q.** And keeping those statistics and being able to share them is a key component in that happening.

**A.** I think it's foundational, yes.

**Q.** All right. When you view the concept of preventability you limited the definition to "reasonable preventability". Can you explain what you meant by that?

**A.** Well, I think that, you know, there's some deaths that ... I think I've given some examples here. There are some deaths that are simply not preventable with changes in public policy. Sometimes people die, and you have to sort of admit to yourself that there's a component of personal choice that caused the hazard that may have caused the person to die and the connection between public policy and that person's death is a little bit less strong.

So I think that you have to be careful about how you use

this power and I think that asking an inquiry to delve into a death where public policy really didn't play a role is just not a reasonable use of this power.

**Q.** Okay. And you say in your letter that reasonable preventability involves some tangible connection to the failure of the conduct or policy of a public body or large enterprise such that future deaths under similar circumstances might be reasonably preventable on the basis of change in legislation, regulation, or policy?

**A.** Yeah, and I've chosen to be a little bit focused here but I think that's reasonable.

**Q.** The fourth question that you put forward is, Is it necessary that a judicial inquiry make findings and recommendations regarding the death? So there are obviously pluses and minuses with a judicial inquiry. What are your thoughts on that?

**A.** Well, I think that, you know, when you look sort of in the history of ... well, 150 years of history of Canada there have been advances in systems about public policy renewal. You know, there's now a very good Department of Labour investigation into workplace deaths that was absent before it began.

There are other mechanisms of public policy renewal that

operate more quickly after the death, and frankly, with application of public resources. And I think that if you put all of those interventions on a sort of spectrum a judicial inquiry would definitely be superior in its thoroughness but it does have inherent limitations of time and expenses that make it, I think, more logical to place the public policy renewal closer to the event and closer to the people who are able to make those changes.

So I think that what I'm proposing here is do we put a judicial inquiry into play when there might have been three or four things we could have done before? And I think that this is just a sensible read of this situation. It's gentler, frankly, on the public pocketbook and produces better policy, probably.

**Q.** Some of those mechanisms for public policy renewal, short of a judicial inquiry, do you see some of those as perhaps lacking or things that we need to improve on?

**A.** You mean in a general way or for ...

**Q.** Mm-hmm.

**A.** Oh, absolutely. You know, I think that we could improve in all kinds of ways. I don't think anybody working in government proposes it's perfect and I think that there's plenty of ways that we can make it cheaper, better, more effective,

improve this or that. And I think we should have the courage to go there and to do it.

**Q.** You finally, your fifth question is, Could the public reasonably expect a judicial inquiry to make findings that could inform practically implementable recommendations? So perhaps you could elaborate on that, but I take it that the recommendations have to be something that can actually be put into practice.

**A.** Absolutely. You know, and part of this is, well, really jurisdictional. I'm sure that you and all of your colleagues have begun to wrestle with the fact that some of the aspects of this case, for example, occur or have occurred or touch upon the jurisdictions of other governments.

**Q.** Yes.

**A.** You know, if a person from Maine stayed in the United States, came here and died of a preventable death and he happened to be routed to the QEII there is zero chance, I think, that a judicial inquiry that's based in Nova Scotia could meaningfully effect policy change in the State of Maine. And that's just a practical consequence of how things work.

The same general problem, I think, is present here to some extent, although I'm still optimistic that there will be some

positive output here.

**Q.** Okay. Having developed those five questions - the framework for analysis for whether a judicial inquiry is warranted or not - I guess you provided those to the Minister and outlined your thinking in your letter of October 13th, 2017, and you followed up two weeks later with a more detailed letter that applied those criteria to the Desmond case and that was in your correspondence of October 27th, 2017, which is Exhibit P15?

**EXHIBIT P000015 - LETTER FROM DR. MATTHEW BOWES TO MINISTER M. FUREY - OCTOBER 27, 2017**

**A.** I have it here.

**Q.** And I'd like to just go through this in the manner in which you applied those questions to the Desmond case. But when you approached your thought process on this, I guess, perhaps you could just describe for the Inquiry how you saw this playing out. Did you expect to get information back from the Minister with respect to what services or polices would be in place before you made your final recommendation?

**A.** Well, I think I even proposed in the letter that, you know, from a process perspective I think it was reasonable for me to tell him that I was thinking about an inquiry. Because for all I know, you know, the government may have had several

things on the go that would make this redundant. You know, so I thought it was reasonable, actually, to propose to myself that I should inform the Minister and see what was contemplated by government and maybe then to make some assessment of its likelihood of addressing the issues that I saw. And I think as you see at the end of the letter, that's what I did. And he did make a reply to that.

**Q.** Yes, so you said to the Minister, you outlined the materials that you had considered and you indicated you looked at Mr. Desmond's provincial healthcare records. You spoke at length, you said, to members of the Desmond family who wished to meet. You said you reviewed literature about domestic violence fatalities. I'm sorry, I'm looking at page 2 of your letter there.

**A.** Oh, yes.

**Q.** I was just curious if you recalled what literature about domestic violence fatalities you had considered in examining the case.

**A.** Well, I read a fair bit about it and the one that I'm ... unfortunately, I didn't make a detailed inventory of those materials, but one I do remember is the materials that come out of the Ontario domestic death ... I'm going to mess it up.

Domestic Violence Death Review Committee.

**Q.** Yes.

**A.** And they do a ... I think a really wonderful job at looking at that group of deaths with the specific intent of improving public policy. I think it's important for all of us to remember that government agencies have mandates and they generally fulfill just those mandates. We can't expect them to fulfill mandates they were never given.

So the Ontario domestic death violence ... death review committee has a specific purpose, you know, bringing these things to light and trying to make some recommendations for improvement of public policy. I have a great deal of admiration for that model, which we can get into later, but a lot of the literature that they've collected and a lot of the stuff that they've written I think is very compelling and worth reading if some of you have not read it yet.

**Q.** There were certainly materials to which you did not have access, police records that do not pertain to the death investigation. That would be any police records not relating to January 3rd, 2017?

**A.** Correct. I don't have the mandate to get those.

**Q.** Okay. The quality review undertaken by the Nova

Scotia Health Authority which is, I believe, protected under provincial legislation?

**A.** Oh, yes. There's very strong protections on that.

**Q.** Okay. And even you are not able to access that material.

**A.** No, sir.

**Q.** All right, and Mr. Desmond's federal healthcare records. You did not have access to his federal healthcare records, anything from his time in the military or in relation to Veterans Affairs?

**A.** No, I have no authority to get those.

**Q.** Okay. And the family was not able to provide those to you or ...

**A.** They did not and I don't know if they have them. But it didn't seem to be necessary in the end.

**Q.** Okay. In some cases are federal health records something that would be of benefit for you to review in conducting your investigations?

**A.** Well, I think so. I mean sometimes the health record, as I've said before, can give you the cause of death. I'm going to give you a practical example here of where we would use them. Well, let's propose a drug overdose death of which we have more

than a hundred a year in this province. Sometimes the issue is not whether the death is an intoxication. Sometimes the issue is was it a suicide or was it an accident.

And sometimes the health record can tell you, you know, this person has been admitted to hospital with drug overdose with a specific suicidal ideation. So in that setting, it is more likely that that person's drug overdose represents a suicide rather than a simple accident. So sometimes the health record can provide powerful context for our findings.

**Q.** Any health records that ...

**A.** Any health record.

**Q.** Okay, so you did apply your framework, the framework you had developed and communicated to the Minister in your October 13th letter to the Desmond case, and you first asked the question were these deaths ... and you looked at all four deaths, not just the death of Lionel Desmond?

**A.** Correct. There were four.

**Q.** Okay, but your thought process with respect to the inquiry applied to all of the deceased?

**A.** Absolutely.

**Q.** And you asked yourself were these deaths reportable under section 9 through 12 of the **Fatality Investigation Act**

and/or did the deaths result from a circumstance listed under sections 9 to 12 of the **FIA**? And I take it that question was fairly straightforward to answer in this case.

**A.** There can be no dispute about that. These deaths were absolutely reportable.

**Q.** Okay, and in the case of three of the deceased they would be classified as homicides ...

**A.** Absolutely.

**Q.** ... or as a result of violence?

**A.** Yes, sir.

**Q.** And I guess all as a result of violence. Three as homicides, one as a suicide?

**A.** Yes, sir.

**Q.** Okay. And then in assessing the result of the medical examiner's investigation of the death, was the medical examiner able to answer the questions in section 5 of the **Fatality Investigations Act**? Ultimately, the medical examiner who conducted the investigation was Dr. Mont of your office?

**A.** Yes, sir.

**Q.** Okay. And you would have reviewed his reports, obviously, and the results of his postmortem investigations of the deceased?

**A.** Yes, and he was able to fulfill its mandate in a general way.

**Q.** Okay. That was not a challenge in this case.

**A.** No, sir.

**Q.** Okay. In discussing the second question, you did say and you may have touched on this already, but you said, generally speaking, the findings that flow from section 5 support important medical, social, and legal goals. Perhaps just generally you can indicate what some of those are.

**A.** Well, I mean first of all, statistical. You know, there can be no discussion at all about domestic violence deaths unless we know how many there are and whether they occur. So from a statistical point of view, this is foundational work. We must identify that these, in fact, have occurred, and all discussions of prevention turn on reducing the number. So if we don't have an accurate number we can't assess how well our preventative measures have worked.

So number one, statistical. But of course there's other reasons why we would do this exercise, and those have to do with support in the criminal court and its various proceedings. You know, there's not a murder trial without a murder and that set of findings really comes out of our office.

But also, you know, insurance. You know, a lot of people have life insurance and whether that life insurance pays out often turns on the cause and manner of death. So there's a lot of things that actually turn on what we're able to find in section 5. Although they sound trivial, they have a tremendous importance.

**Q.** Okay. The third of your questions in the framework is, Do we need an evaluation of the circumstances that led to the death to find out if they were preventable? So again, the concept of preventability, and I think here is perhaps where you spent a good deal of your time and thought in determining whether a judicial inquiry was appropriate to address the issue of preventability?

**A.** Well, that is really the heart of this document, you know, assessing these cases with a view to ... whether they are preventable and, you know, as you can see at the end I've said that they are reasonably preventable. I think in my assessment anyway.

**Q.** Mm-hmm.

**A.** I mean acknowledging that it's not up to me to make the finding. It's up to the inquiry to make that finding, but for me the mandate was "could it be" rather than "is it"?

**Q.** Okay. You touch on, in assessing reasonable preventability, the tangible connection between the deaths and the appearance, at least, of a failure of policy or practice. I guess in addressing that, you felt that ... ultimately when you went through this exercise that recommendations might inform public policy changes to legislation that could reasonably prevent feature deaths. That was the ultimate conclusion that you drew?

**A.** Yes, and I think that you have to do what I've done here to really understand how that could be, and I've broken it down into sort of individual aspects of this case. And I think that when you do that exercise I think that the potential for a better public policy becomes a lot more clear.

**Q.** I guess you did touch on, in considering that, the jurisdictional issues. You had said ... I guess this is at the bottom of page 3 and onto page 4. There are larger calls for a public examination of Mr. Desmond's death for reasons other than assessing preventability, but rather as an examination of the overall quality and sufficiency of the care being provided to CAF members, veterans, and their families.

These, you said, in your view, were better left to government?

**A.** Yeah, you know, and again, I've sort of ... that stems from how I've chosen to analyze it at the beginning. I've chosen to put this through a relatively narrow view of how I should administer that part of the **Act** and I think that, you know, other aspects outside of preventability really do belong within the purview of the Minister and the legislature.

**Q.** Okay, and in assessing the question of preventability, you're very clear that you don't have to draw a conclusion to make a recommendation for an inquiry that the deaths were actually preventable or reasonably preventable, just that there is the possibility of that that would warrant an examination?

**A.** Absolutely. I didn't want to arrogate to myself the position of the Inquiry, you know, that is the function of the Inquiry, drawing a conclusion. I felt like my job was to see if there was enough of an issue to merit an inquiry, which is a lower standard, a lower threshold, I guess.

**Q.** All right. And in assessing that, you looked at the information you had with respect to Mr. Desmond and also with respect to his family, the other deceased.

**A.** Yes, sir.

**Q.** So in assessing Lionel Desmond's situation, you make reference to his diagnoses, some of which are recognized as, you

say, occupational stress injuries.

**A.** Yes.

**Q.** Did any of the diagnosed conditions stand out to you as being of particular import or particular concern?

**A.** Well, if we propose that, you know, he did have PTSD, then that would certainly stem from ... well, I would think that it would stem from his career as an active service member. He also had, if I remember correctly, possibly a traumatic brain injury and a sequela of that which is a slightly different thing, but I think that the important part of that is that he had that group of disorders and that the subsequent actions and events in this file certainly stem from that. I think that you could propose causation that way and I think that's what the importance of that is.

**Q.** And you note his various conditions to include major depression, PTSD, post-traumatic brain disorder, borderline delusions about his wife, and possible attention deficit disorder. And you say that: "Some of these conditions are recognized by the RCMP, CAF and Veterans Affairs Canada as occupational stress injuries." I'm reading from page 4 of your letter, just under the heading "Lionel Desmond."

**A.** Oh yes. Yeah.

**Q.** "OSIs are said to include a broad range of problems, (you say) such as anxiety disorders, depression and post-traumatic stress disorder, PTSD, as well as conditions that can interfere with daily functioning and relationships."

That was all information that you had and factored into your thought process about the question of preventability?

**A.** Well, and that's kind of central to my thinking, actually, because I think that if you take this man and you take away this set of pathologies, he probably doesn't kill three members of his family and then himself. I think that there is, for me at least, a plausible causation between that set of mental disorders and the actions on January 3rd. So I think that that is central to my reasoning actually.

**Q.** In addition to that, and I'm quoting from your letter at the top of page 5, you say:

> Mr. Desmond's records reveal that provincial health care providers tried to inform and align his health care with the services being provided through VAC (or Veterans Affairs Canada). His physician was unable to secure Mr. Desmond's federal health records directly from the federal

government. Despite suffering from an acute mental health crisis, Mr. Desmond was responsible to secure his own personal health information by way of a formal written application for records using federal legislation.

I guess that alignment of various health care providers and services was something that you viewed as problematic or something that needed some consideration?

**A.** Well, I think that, you know, anytime two different governments or government agencies happen to interface, there's the possibility for error. You know, as a head of a government agency myself, I can tell you that it's relatively easy for me to effect change within my own organization. It's easy for me to interface among all the different parts of my agency, but when it comes to interfacing with other governments, other government agencies, I think that there is a possibility for adverse events, errors, and a simple lack of, you know, an understanding of how that should go.

You know, we can write excellent policy in the Medical Examiner Service, but if it doesn't help in these specific circumstances, it hasn't helped the public.

**Q.** There were other factors that I think you reference here that weighed on your mind when you were considering the issue of preventability in relation to Mr. Desmond. The fact that, you say: "On January 1st, 2017, he suffered an acute mental health crisis and then presented at St. Martha's Hospital."

That was also something that factored into your thinking, was it, Doctor?

**A.** Yes, it sure did, you know, you couldn't really propose that this man had been completely lost to follow-up by health care. He had recent contact in the hours and days before the events of January 3rd.

**Q.** All right. And I'm just touching on the factors that you considered in your letter when you were determining these questions. Also, his acquisition of firearms was something that caused you some concern or thought.

**A.** Absolutely. You know, this is a man who ... I think if somebody had known his whole story, I just can't believe that he would've been able to lawfully obtain a firearm in that moment, you know.

Again, if we expect public servants to make good decisions and good choices, we have to make sure that they're equipped

with the best information. So I thought that that was a reasonable sort of topic, I think, for the Inquiry to look how that is done.

**Q.** With respect to the issue of occupational trauma and occupational stress injuries suffered by Nova Scotians, you consider that and its interrelationship to any increased risk of suicidality, and can you comment on how you think an examination of Lionel Desmond's death may help to identify risks faced by Nova Scotians who are in occupations with a high rate of occupational trauma?

**A.** Well, I think that this really speaks to how there may be different governments and different government agencies in Canada, but we're all faced with similar kinds of problems. An RCMP officer in Nova Scotia, or a Halifax Regional police officer here in Nova Scotia, or a paramedic here in Nova Scotia, or an emergency room doctor in Nova Scotia may be faced with a similar set of challenges as active service members in the armed forces. It is these people all fall within the purview of different levels of government, but it's the same kind of general challenge and I think that lessons that are learned in one theatre should be disseminated to anybody with an interest in meeting that kind of challenge.

So I felt like, you know, irrespective of any other consideration, if we're able to draw lessons from the death of Mr. Desmond and his family, it may help hundreds or even thousands of Nova Scotians in jobs that are stressful.

**Q.** And you had said, which I thought was interesting, you said, "There may be a high risk of suicidality that is with respect to people who are suffering from occupational trauma, but this is not known because these data are not tracked or analyzed by the Nova Scotia Medical Examiner Service or any other government agency that I'm aware of."

**A.** Yeah, and, you know, this isn't meant to say that they're not effective at all. I mean perhaps there are government agencies that do track that internally, but it's hard to really track that down and make sure that it's actually going on, and I think that one of the issues here that I respectfully put to you is that there may be a dissonance between public perception of the performance of government and the actual reality, and this has to do with the fact that governments, for good reasons of privacy, may be reluctant to show what they're doing, you know.

Quality review is one sort of example of that. For privacy reasons, some of that information cannot be disseminated. But I

think that the government, or I think that the public, if they knew that those mechanisms were occurring, I think they'd have more faith, but here, I think in this case, we have a definite sort of discordance between the public faith in these processes and perhaps as they are actually occurring. That's one kind of issue I sort of detected.

**Q.** You had some concern, or at least you raised the issue, of the sufficiency of the training of medical professionals to assess and to treat occupational stress injuries in certain patient populations. Do you perceive that as at least potentially something that requires some consideration or is of some concern?

**A.** Well, just to let you know, that was really thoughts that I've heard from veterans, you know, they see themselves as being distinct sort of culturally, I guess, in that military members are trained. Well, either trained indirectly or enculturated, I guess, to hold back, to not share their emotions, to be macho to say, I'm okay. And they felt like they were a distinct patient population where health care providers maybe weren't picking up on the difference between how they were acting and how they actually were.

So that concern is one that I heard from veterans that I've

chosen to place on the radar of the Inquiry. I mean I don't have any view on the sufficiency of the training of a psychiatrist because I'm not an expert in that, but really when you think about that, that issue is interesting no matter how the answer is. I mean either the service members are correct so they are correct in thinking that health care providers don't get them. That would be interesting. Or they're incorrect and their perception of the health care system is at odds with the actual reality. So both outcomes of that thought have some potential interest, I think.

**Q.** Right. A question then worth exploring.

**A.** I think so.

**Q.** Irrespective of the answer.

**A.** Yeah.

**Q.** You did say in your thought process that Mr. Desmond, at least in retrospect, displayed a concerning number of indicators associated with a high risk of domestic violence brutality which warranted some examination, I guess. What was your thought that led that to be one of the considerations you addressed?

**A.** Well, in my sort of review of the literature on domestic violence, you can go online and find all kinds of

papers about this and one of the more interesting tools, I think, is the tool used by the Ontario Domestic Violence Death Review Committee. If you sort of go through and look at the criteria, the risk factors for domestic violence, I think that you'd have to be, in retrospect, concerned about Mr. Desmond's conduct and really, again, acknowledging all of the drawbacks of trying to do this analysis in retrospect, but I think that may have, or ought to have, triggered some kind of intervention at that point and, again, there's all kinds of different risk assessment tools and, again, full disclosure. I'm not an expert in how to apply those, but it certainly seemed to me that Mr. Desmond showed warning signs that either weren't picked up or could not be.

**Q.** Ultimately, you determined in assessing question number three that there were reasons to evaluate these deaths with the aim of discovering whether they were preventable and, if so, what needed to be done and, again, you leave the question to us, but you determined that the issue of preventability was one that warranted perhaps further exploration here?

**A.** Yes, and I still endorse that.

**Q.** You then had to move the question of whether it was necessary that a judicial inquiry make findings and

recommendations regarding the deaths. So as you've said earlier, you viewed the judicial inquiry as kind of the highest level or last resort of inquiry?

**A.** I would say highest level.

**Q.** Okay.

**A.** Yeah.

**Q.** Perhaps "last resort" is not the right phrase. And you make reference to a couple of things. The fact that in Nova Scotia, "We don't have colonial ..." Or at least at the time of the writing of your letter, "We don't have colonial inquests, fatality review boards, death review committees, or other similar bodies able to examine deaths, as they might in other provinces."

I know there's been some changes to our **Act** recently with respect to, I believe, death review committees. Is that correct?

**A.** Well, and that's an important thing to call the Inquiry's attention to. We have just passed through the House just a few months ago, changes to the **Fatality Investigations Act** that will make death review committees possible and, actually, two have been stood up. The child death review committee and the domestic violence death review committee and,

in case you're wondering, I think that this case would've triggered both, actually, for different reasons. But at the time I wrote this letter, this was so.

**Q.** Those two death review committees, just for everyone's benefit, who sits on those or how are they configured and what work do they do?

**A.** Well, the exact rules are still being worked out, actually, but I am to be Chair of both, and the general purpose of a death review committee is to do something like what this Inquiry will hope to do here. To examine the circumstances and hopefully make practical, reasonable public policy renewal recommendations. Actually, it has two sort of jobs.

The other job that it does have that the Inquiry will not do, I don't think, is to make annual statistical reports about trends in deaths which I think, too, has a value unto itself, you know, if we have a hundred child deaths this year and 200 next year and 250 the next year, the number itself would have an importance that would be outside of the circumstances of any one of those cases. So the child death review committees or the death review committees will have that dual purpose.

**THE COURT:** Dr. Bowes, I just have a question for you.

**A.** Certainly, Your Honour.

**THE COURT:** The Ontario Death Review Committee looks at all deaths. Is that correct?

**A.** Well, it depends upon which one, Your Honour. If I remember correctly, Ontario has a Domestic Violence Death Review Committee. It has a Child Death Review Committee.

**THE COURT:** I'm talking about ... sorry, I should have targeted the Domestic Violence Death Review Committee.

**A.** Yes. It would look at all the domestic violence deaths in the Province.

**THE COURT:** And so how many do they have in the course of a year? Do you know whatever the latest report was? Do you recall?

**A.** You know, I can't recall, Your Honour, I'm sorry.

**THE COURT:** I saw a report that suggested maybe 440-odd but leave that aside. That might be from one of the other reports, but when you look at the present committees that are being set up, are they going to look at all deaths within those categories or when you talk about working out the rules, you know, are they going to be selective or are you going to look at all deaths in a particular category so that you have all the various factors, parameters, so that when you look at it statistically, you haven't kind of artificially left some out of ...

**A.** My understanding is all deaths, Your Honour, in that category.

**THE COURT:** In those category.

**A.** And, you know, you could argue a little bit about what definition you use, but if I remember correctly, we've used a pretty broad definition, and so all those deaths would hopefully be routed through that committee for lessons learned.

**THE COURT:** Okay. Sorry, Mr. Murray, I just wanted to ask.

**MR. MURRAY:** You said, Dr. Bowes, that had either or both of those death review committees been in place at the time, you would consider in the Inquiry here that they would've been ... I don't know what the correct phrase is, routed through the death review committees or referred to them initially?

**A.** Yeah and, importantly, that doesn't take a judicial inquiry off the table. It merely means that that process, at least, would occur.

**Q.** Okay. And it's perhaps unfair to ask a hypothetical, but had they been in place, would we be here today, do you think, or are you able to say?

**A.** Well, you know, in some ways, the death review committee might provide, as one of its outputs, it might

actually provide the reasons for the Inquiry. So it may highlight things, actually, and make an inquiry more likely.

**Q.** Mm-hmm.

**A.** Or if that death or that set of deaths didn't have much connection to a policy, it might actually end there. So both possibilities are actually in play and may make additional inquiry more likely in some deaths in that they are detected and analyzed, but it may make some less likely.

**Q.** Okay. You said, in considering the appropriateness of, or the necessity of, a judicial inquiry to make findings, obviously, you were not, or did not have access to the Nova Scotia Health Authority quality review.

**A.** Correct.

**Q.** Or as protected by law or privileged by law, but you said that even if you had access to it, it only looked at certain things, obviously. The actions of the Nova Scotia Health Authority that would not have answered all of the questions that you thought were appropriate for us to consider?

**A.** Well, and there I have to acknowledge that it was good that I educated myself on that process, you know, its scope is necessarily narrow, you know. It has a mandate to improve clinical care, not the firearms acquisition system, so really

it's not fair to make that quality review as a potential mechanism to examine those other things.

**Q.** You commented under question 4 of your framework, and on page 7: "The federal government has the authority to convene an inquiry into issues surrounding the federal supports provided to Mr. Desmond and his family. The Ministers of Defence and Veterans Affairs have declined to do so." Or at least at that point had declined to do so.

In your thought process, were you awaiting some final decision with respect to whether there would be a federal inquiry before you made your final decision on a provincial recommendation?

**A.** Well, I think that I turned my mind to a joint provincial and federal inquiry which I thought might be the best possible case scenario and I gathered, eventually, that that was not going to occur, so I thought that this would be the best venue absent that.

**Q.** And in that same paragraph, you said: "Several important initiatives have been launched that promise to make significant improvements to the post-release care received by veterans such as Mr. Desmond."

Do you recall what those were at this time?

**A.** Well, there were several things talked about at the time that have since come to fruition. For example, I think that there is, just a month ago, there was an initiative launched as a joint initiative between VAC and Department of Defence with respect to the post-discharge care of veterans, and I think that they promised to work with vital stats to develop some statistics on this phenomenon, but I think it's fair to say that at the time I made my recommendation, I think that all those things were either rumour, conjecture or in the very preliminary stages of being considered.

So I can't really ... I don't know. You can't really place your faith in something that may occur in the future. I think that you have to play the cards you're dealt at the time you have them and so I chose not to assign undue significance to that, but I am pleased to see that they've carried forward with some of those.

**Q.** And really, at this stage of your correspondence with the Minister, you were, I guess, putting the Minister on notice that you were considering making the recommendation, and you say in the next paragraph:

> This letter analyzes and identifies issues that, in my opinion, necessitate in-depth

> examination. Consultation with the Minister of Justice at this stage of my decision-making is intended to provide notice that a judicial inquiry is being considered, communicate the issues under consideration and to provide government with an opportunity to share information that may be relevant. If no further information is provided, I anticipate forming the view that a judicial inquiry is necessary.

So at this stage, I guess you were quite frank that you were hoping to hear something from the Minister with respect to what initiatives might be in place to see if that would change your thinking with respect to a recommendation? Is that ...

**A.** Well, yeah. I mean if government had already set out a comprehensive plan to meet all of the challenges that I thought had to be met, then it would be pointless to call a judicial inquiry for this matter, so I wanted to hear what was being planned, what was underway, what could we reasonably expect from those things, and I think that was reasonable. I think that, again, judicial inquiries should be used sparingly, and if there's truly no point to that exercise, I think we

shouldn't do it. So I felt like I should give government notice and see what they had going.

**Q.** And your fifth question relates to the issue of whether any recommendations could be practically implementable and, here again, you had the jurisdictional issues, I think, in mind that you referred to earlier about whether recommendations would fall within the scope of the federal government, and also whether there might be the possibility of a joint federal/provincial inquiry into these matters?

**A.** Yeah. That really worried me, you know, and it still worries me that, you know, a lot of the aspects of this case fall squarely within the purview of the federal government, and I'm given to understand that provincial inquiry, or inquiries constituted under provincial law, really have a potentially limited role with, or potentially no role at all in getting information from other governments and then making recommendations that could change those governments' behaviour. And I'm still worried that I've given the Judge an impossible task here. However, I think that when you look at all of the different sort of components of this, I think that there is still a very reasonable hope that absent, or even despite that, I think there's some really good public policy rule that will

come out of all this.

**Q.** And you say, "In particular, relevant issues ..." This is on the last page of your letter. "... relevant issues of this case including mental health care, suicide prevention, the acquisition of firearms by mentally-ill people, and the prevention of domestic violence fatalities all have a provincial aspect."

**A.** Yeah, they sure do. Yeah, and I think that I place my hope that at least in those arenas, we'll have a judicial inquiry that will output some positive changes.

**Q.** So you provided this correspondence to Minister Furey and you received a response in a letter, I think that was dated November 21st, 2017, which is I believe Exhibit P19?

**A.** 19. Oh yes.

**MR. MURRAY:** I don't know when you want to take the lunch break, Your Honour.

**THE COURT:** I was just going to ask you if this would be a convenient spot to take a break, Mr. Murray.

**COURT RECESSED (12:57 HRS)**

**COURT RESUMED (14:04 HRS)**

**THE COURT:** Just before Mr. Murray continues, I had asked Dr. Bowes a question and, Counsel, I am going to read

something, I am just going to clarify something I said to Dr. Bowes a minute ago when I was asking some questions. And I am reading from, it is the Office of the Chief Coroner, it is the Domestic Violence Death Review Committee 2017 Annual Report, released December 2018. You can find it on the web. I am just going to ask because I had asked Dr. Bowes a question about numbers and things so I just wanted to set this record straight.

Under the executive summary it says: "Cases reviewed from 2003 to 2017 ..." so clearly they have an ongoing process of identifying risk factors and continue to analyze them as they are proceeding. I intend to come back to that at some point in time even if Mr. Murray does but not today. And so from 2003 to 2017, the DVDRC has reviewed 311 cases involving 445 deaths and I refer to the 440, the number that I had thought that was there. In 2017 there were 22 cases, 12 of them were homicides, ten were domestic suicide. Sorry, 12 were homicide cases, ten were domestic suicide cases resulting in 35 deaths, and the review resulted in 33 recommendations generated through that review process.

So as I said, I do have an interest in the legislative changes in Nova Scotia at some point in time but I interjected but I wanted to straighten part of my interjection out a little

bit and we will, if Mr. Murray or Mr. Russell do not get back to it or counsel do not get back to it, I will get back to it with you but if we are going to have a discussion about that report or any other reports as there's a number of other reports available online as well, I will make certain that counsel are aware of it and we will get them into Dr. Bowes' hands so he can have a chance to see them in advance all well. All right?

Mr. Murray?

**MR. MURRAY:** Dr. Bowes, before we broke for lunch we were looking at the Minister's letter in response to you, his letter of November 21, 2017 which is Exhibit 19.

**EXHIBIT P-000019 - LETTER TO DR. BOWES - NOVEMBER 21, 2017**

**A.** Yes, sir, I have it here.

**Q.** So I take it this letter was in response to your request in one of your earlier letters for some information about what initiatives might be in play that might affect your thinking on whether to make the recommendation or not?

**A.** That is my understanding, yes.

**Q.** Okay. And the Minister's letter makes reference to a number of the general areas that you had been thinking about, I guess, in your investigation, the health services provided to veterans, issues of domestic violence, occupational stress

injuries, firearms issues. That letter and the information contained therein, while helpful, was not sufficient to sway your thinking, I guess, on the issue of whether to recommend an inquiry or not?

**A.** Yeah, I mean I think that's a fair way to put it, Mr. Murray, for sure.

**Q.** Okay. The particular initiatives and programs that are outlined in the Minister's letter, you have his letter, did you had any additional information with respect to those or it's fairly comprehensive I guess, but ...

**A.** Well, I mean with respect to the provincial base initiatives, I think his letter was very comprehensive. With respect to federal issues, of course I had access to anything the public had access to so, of course, there's many sort of federal initiatives over the last six or seven years preceding these events so I certainly had access to them. I think that the summary of the Minister's letter I think is that, you know, this is all an excellent first start, you know. All of it seems to be in the very preliminary stages and what is absent I think from it is any kind of a description of a process whereby Mr. Desmond's case would be specifically analyzed with respect to improvements of public policy.

I mean these are all excellent initiatives and I think they'll serve Nova Scotians very well but I think what might have swayed my thinking if that was your next question is, you know, if the government's position was going to be, Well, we're going to hire a consultant to make a detailed analysis of these events and come up with recommendations, well that might well have swayed my thinking but these, while excellent, really don't do that.

**Q.** You had received the Minister's letter, at least it's dated on November 21, 2017?

**A.** Yes, sir.

**Q.** And you responded with correspondence dated December 1, 2017 which is Exhibit P16.

**EXHIBIT P-000016 - LETTER TO MINISTER FUREY, DECEMBER 1, 2017**

**A.** P16. Yes, sir, I have it here.

**Q.** So this was in response to or at least came after the Minister's letter to you. You indicate that, well, you did receive the response I think and you also had a meeting with the Minister it would appear on the 30th of November to discuss what might happen in the circumstance?

**A.** Yes, sir.

**Q.** Okay. And you ultimately, in your correspondence of December 1st, I think you still are holding out hope and are writing to the Minister to suggest that he consider a joint federal/provincial inquiry under the **Public Inquiries Act** and I think the penultimate paragraph in the letter on page three you say:

> I am therefore writing to suggest that you consider a joint federal/provincial inquiry under the **Public Inquiries Act** and its counterpart federal legislation. I hope you will consider contacting your federal counterparts to invite them to participate in a joint inquiry, one which will be able to canvass the interconnected federal and provincial issues involved in

these deaths with a view to preventing such tragedies from occurring in the future.

Ultimately that did not come to fruition though?

**A.** No, but as I pointed out earlier in the letter, the Minister of Veteran Affairs had indicated a willingness to cooperate with our Inquiry so I continued to hold that hope that that will be sufficient.

**Q.** And subsequently then on December 28th you wrote again to the Minister of Justice and that is Exhibit P17.

**EXHIBIT P-000017 - LETTER TO MINISTER FUREY, DECEMBER 28, 2017**

**A.** Yes, sir.

**Q.** And it was in the letter of December 28, 2017, that you ultimately do make the recommendation for a fatality inquiry?

**A.** Yes, sir.

**Q.** Now in terms of the recommendation, ultimately when you do this process it's at the end of the year that you make the recommendation to the Minister and you received a response from the Minister fairly quickly, I think it was the 8th of February 2018. I don't know if you have that letter or not but

...

**A.** I remember seeing the letter.

**Q.** Okay. It was within approximately one to two weeks that you received correspondence. I don't believe we have it marked as an exhibit but the Minister indicated that he would be proceeding with the terms of reference for a fatality inquiry?

**A.** Yes, sir.

**Q.** The terms of reference that were ultimately constructed here, I guess, or formulated, those were the Minister's terms of reference?

**A.** Yes, although I think that I was heavily influential in that they appeared to be lifted more or less from my letter.

**Q.** Well, that was going to be my question, if you thought that the terms of reference under which we're operating today addressed the concerns that you raised in your correspondence to the Minister and were in line with those?

**A.** Oh, I think so.

**Q.** We have the terms of reference actually marked as an exhibit, P11. So our terms of reference, obviously they touch on the Section 5 considerations obviously, the date, time and place of death, the cause of death and manner of death of the individuals who are deceased. Section 3(d) of the terms of

reference, each of these particular terms of reference relate to issues that you had identified as being of concern and which would or, I guess, where there might be some value in us investigating?

**A.** Yeah, I think that these are pretty good.

**Q.** Okay. Dr. Bowes, as we go forward in this process, obviously we are going to be hearing from a number of witnesses, we're going to be addressing a fairly wide-ranging set of subjects ...

**A.** Yeah.

**Q.** ... that flow from these terms of reference. I don't know if you have thoughts, Doctor, on issues of particular concern or issues that we may wish to address or things that stand out for you as of particular importance?

**A.** Well, you know, when I'm reflecting upon all of these circumstances and, you know, begin expressing the hope and I think reasonable hope that there'll be some tremendous good come out of this Inquiry, I'm also given to reflect upon the thousands of deaths that occur in this province for which there won't be any process at all and I will tell you that I think that the way we deal with mortality generally in our society, you know, not just Nova Scotia but across the country, is not

where it could be, you know. I would think and I would say that at least with respect to the deaths that flow through the Medical Examiner Service, there's probably some simple lesson that could be derived from any of them and that's certainly the inspiration behind the death review amendments that you've seen pass the House in the fall. But I think that in a more general way I hope that, you know, we reflect more upon death and how we could extract lessons from all of them and I think you could start by looking at the way deaths are certified, you know.

Death certificate data is of really very poor quality. The academic literature on this suggests that the error rate on death certificates is as high as 50 percent. That's not a good foundation upon which public policy can rest. I would hope that maybe one output of this Inquiry could be to look again at how that process is done with the specific intent of just improving mortality statistics in the province because they're all important and especially with, we talked a little bit about the importance of just counting them, you know, making sure that when we count a suicide that those data are accurate. I think as citizens we sometimes criticize our politicians for making this or that wrong decision but I think that we owe them the possibility of making a good decision by providing them with

good data and I think that we could collect, not just Nova Scotia, all across Canada and actually all western jurisdictions, I think we could do a better job of mortality statistics generally.

**Q.** And those statistics in particular as they relate to some of the issues that we'll be addressing here such as suicidality, with respect to occupational stress injuries, domestic violence deaths, anything in particular that you see as needing to be or would have value from being addressed?

**A.** Well, that group of deaths certainly and I'm really quite glad to see that the death review things passed through the House but suicides generally, you know. I think that suicide is a multi-factorial complex subject for sure but I think that that group of people deserve a little bit more scrutiny from the circumstances of their death too and I think that we could draw some valuable lessons. I mean, to the extent that data are fed back to the health care system at all, it's really rather *ad hoc*, you know. I mean, the head of the mental health asks me for statistics and that is given but the Medical Examiner Service collects really rich data on all of those circumstances and I think that that should be put to better use.

**MR. MURRAY:** Okay, thank you, Dr. Bowes. I think those

are the questions that I have for you.

**A.** Thank you, Mr. Murray.

**THE COURT:** In terms of cross-examination, do counsel have a preference as to how to proceed? In the normal course of events I would turn to Ms. Ward and then Mr. Anderson. I understand Mr. Anderson to be here on behalf of the Attorney General and thereby with Dr. Bowes and if you choose to cross-examine at this point in time, after all other counsel have asked their questions, I would give you the opportunity to go back and deal with any issues that might arise if you happen to take the opportunity to cross-examine at this time. All right. And generally I would say that to all counsel, that there is going to be no hard and fast rule. I tend to be flexible to allow for all the questions that are important to be asked, to be asked whether they kind of get overlooked or maybe asked out of turn. Now, there will be a point where I will stop it but don't feel that you're absolutely locked into where you are in the order of cross-examination and you can't go back if there's something important to return to. Thank you.

**CROSS-EXAMINATION BY MR. ANDERSON**

**MR. ANDERSON:** Thank you, Your Honour, just a couple of questions.

Dr. Bowes, I understand from your testimony that your recommendation for the Inquiry was the letter of December 28, 2017?

**A.** Yes, I think that's the way it works.

**Q.** Okay. And that's Exhibit 17 if you want to just confirm that.

**A.** I have it here, sir.

**Q.** And I understand your evidence is that within a couple of weeks the Minister called the Inquiry?

**A.** I believe so.

**MR. ANDERSON:** Thank you. Thank you, Your Honour.

**THE COURT:** Ms. Ward?

**MS. WARD:** We have no questions for Dr. Bowes at this time.

**THE COURT:** Thank you. Mr. Macdonald?

**CROSS-EXAMINATION BY MR. MACDONALD**

**MR. MACDONALD:** Thank you, Your Honour. Good afternoon, Dr. Bowes.

**A.** Hello, sir.

**Q.** So I'm Tom Macdonald and I'm the counsel for the Borden family just so you know who I am.

**A.** Thank you.

**Q.** Dr. Bowes, I just wanted to take you for a moment to Exhibit P16 and that's your December 1, 2017, letter to Minister Furey.

**A.** Yes, sir, I have it here.

**Q.** And at page three, about the middle of the page, you have a paragraph that begins in my view?

**A.** Yes, sir.

**Q.** And in your last sentence you say: "Not only is it in the public interest to inquire into these fatalities but also to take steps to ensure that any systemic failures that may have contributed to these fatalities are addressed as soon as possible so that further tragedies may be prevented." Is it your view that there were systemic failures in this case that brings us to the Inquiry today?

**A.** Well, I think there sure could be, you know, and I will tell you that, you know, when I approached this problem, I set a relatively low bar on myself in terms of coming to conclusions about what I saw. I felt like I should only conclude that there was an issue rather than making the ultimate conclusion that there was. But I think that we look at these circumstances with so many government agencies and to be clear, everybody seemed to want to do good and, you know, caring but still these terrible events happened. I think that when you look at that, I think that that provides some compelling sort of reason to think that there might have been some systemic failures here.

**Q.** Can you share with us your view this afternoon and point to what you think may have been systemic failure specifics?

**A.** If it please the Court I can.

**Q.** It pleases me, it's up to the judge of course.

**THE COURT:** No, please go ahead.

**A.** Well, I mean the transfer and exchange of information seems to have been problematic here. I mean, I'm not a psychiatrist and I'm not going to tell you that the psychiatrists would have done anything differently had they had

the information they had, but the transfer of information seemed like, to me, like it was just too complicated and may have been a barrier to Mr. Desmond's care so that would be one systemic issue that I would respectfully propose you should look into.

The fact that our system placed a gun in this man's hands for me is problematic. You know, this man had, at least to my inexpert eye, had plenty of reasons why a reasonable person would take the gun from his hands and yet he had it. So, you know, I understand personal liberty and all that stuff but nonetheless, I think that most reasonable people would propose that somebody who is acutely mentally ill should not have access to a gun.

Now, I did hear from family and from some members that they were not pleased with the care that they got and it seemed to be primarily matters of access and I will not speak for them. But, you know, whenever there is a need for something and a shortfall in the provision of that, I think that that is plausibly at least a potential for systemic failure. But for me, the way that information flows is one of the big issues in this inquiry and I think that actually you could propose that the firearm issue is really a subset of that in that if that firearms officer had had access to the big picture, they may well have

elected not to put a firearm in that man's hands.

**Q.** As I understood your evidence when you answered some of Mr. Murray's questions and if I got it wrong, please tell me because I'm not trying to put words in your mouth.

**A.** No, indeed.

**Q.** You thought cases like this case that brings us here today could be reasonably preventable. Is it your view today that if there was a lot of information sharing and were recommendations that there should be more information sharing and if there was a system failure with respect to the reacquisition of the firearm and there were recommendations that fix may be too strong a word but addressed that, does that then bring you into the territory of these types of cases being reasonably preventable?

**A.** Oh, I think so if I've understood you correctly.

**Q.** Could you encapsulate for us and I know Mr. Murray brought a lot of this out but and again I'm paraphrasing, but the warning signs with Lionel Desmond that either were missed or could have possibly been picked up, can you specify a little more what those warning signs were in your view?

**A.** Well, I mean, he acquired the firearm if I remember correctly on or about, was it the 2nd or the 3rd, I can't

remember. It was the 2nd I thought.

**THE COURT:** On the 3rd.

**A.** Was it the 3rd?

**THE COURT:** The 3rd.

**A.** So he had an admission as an acutely mentally ill person the day before. Now, again I want to be upfront with you and tell you that I'm not a psychiatrist and I don't propose that, you know, that I'm an expert in that. An acutely mentally ill person in the hours to couple of days before getting a firearm, that should be something we look harder at I think, you know. This is also a man who knows how to use a firearm, he has military training. He has a long, well-established history of mental illness. These things together I think should have prompted more reflection on that. I'm sorry, did I answer your question?

**MR. MACDONALD:** You did. I have one more question and that leads to your evidence in terms of the prohibitions on the Nova Scotia Health Authority and the sharing of quality control information, I'm paraphrasing once again.

**A.** Of course, of course.

**Q.** Do you have an understanding you can share with the Inquiry today in terms of what is the basis behind that,

prohibition is my word, but that lack of sharing, that lack of revealing that information?

**A.** Well, if I've understood those documents correctly and I read some things about that process, my understanding is that, first of all, the content of that process necessarily involves a lot of personal information so that suppose you sketched out the system differently and said that, you know, the quality review has to be made public then someone's private, personal, and very sensitive information may be made available and so there's a privacy issue.

But if I've understood the documents correctly also, the fear of litigation might well make it difficult for health care workers to be frank when they need to be frank about some adverse event in medicine and I get that, you know. We want to make sure that people are able to speak very frankly about errors so that they can get to the root cause and hopefully prevent them from happening again, but I can certainly see from the family's point of view how that might be frustrating because it's then very opaque. So my understanding then, to answer your question in summary, is that there's private personal information involved and that the fear of litigation would otherwise make it difficult for health care providers to be

really frank.

**Q.** Balancing your understanding of the rationale behind the policy if you had had access to quality control information in this particular case or in any cases going forward of a similar nature then would it help you in your job if you had access?

**A.** Well, that's an interesting question. I think that it might potentially. I could imagine some scenarios where the content of those reviews might give rise to a manner of death determination that was different. I'm going to have to give you a few minutes' worth of background on that if that's okay.

**THE COURT:** Fine.

**A.** So in the medical examiner world, if you die of a disease your death is natural. Sometimes people ask, Well, what happens if you die of a complication of therapy for that disease so I'll give you an example. Suppose you need chemotherapy and you need a line, a PICC line say, and you need to, you know, and in the process of putting the line in, you get an infection and you die of an infection so is that an accidental death is the question. Well, in my world, that would be certified as complications of therapy for whatever cancer it was and are natural.

Now it gets a little more nuanced though because let's suppose that that line was placed by a medical student, a very junior medical student, and was not given the proper degree of supervision. I think that you could propose to yourself that that complication was not a reasonably foreseeable complication of the therapy. And so a medical examiner or coroner might think about that case as being accidental on the basis that it isn't a reasonably foreseeable complication.

So the quality review might output something really bizarre that I might not otherwise be aware of that might cause me to think about the manner of death differently. But in fairness, I think that would be a relatively rare outcome and, in fairness, that kind of detail really ought to have come out in the chart which I would have read anyway. So I think what I'm telling you is the answer is yes, but really unlikely.

**MR. MACDONALD:** Understood. Those are my questions, Dr. Bowes. Thank you very much.

**A.** Thank you.

**THE COURT:** Just before we move on, when the Nova Scotia Health Authority conducts their quality review and that is not shared by legislative bid, they go to charts, they go to people, they get information, they collect the information. I guess at

the end of the day we know all of the individuals that are involved and all of the paperwork that's involved, all those people could, in theory, wind up here with all the paperwork here and we should be able to discover exactly the same information that would be in the quality review would you think?

**A.** I would agree with you.

**THE COURT:** Or is there going to be more candor in the hospital administrative setting than there would be in a hearing room under oath?

**A.** Well, that's an interesting question, Judge, and I'm not sure I'd be the one to answer that actually to be honest.

**THE COURT:** Okay, thank you.

**A.** Interesting though.

**THE COURT:** Mr. Rogers. Not to suggest that there would be any lack of candor at all.

**CROSS-EXAMINATION BY MR. ROGERS**

**MR. ROGERS:** Good afternoon Dr. Bowes, I'm Rory Rogers, I'm one of the counsel for the Nova Scotia Health Authority.

**A.** Hello, sir.

**Q.** I want to explore with you what your roll and mandate

was. I think you made it clear in responses to the questions from Inquiry counsel and Mr. Macdonald but you commented on Section 26 of the **Fatality Investigation Act** as being the heart of the assessment you need to undertake to determine whether an inquiry, in your view, is necessary, is that fair?

**A.** Well, that's the whole thing actually.

**Q.** And your role is not to make conclusions as to whether there are public policy recommendations that can come out or there is a need for change in public policy, but really your role is to see whether that's possible. Is that a fair assessment?

**A.** Actually I think you put it better than I did.

**Q.** So the question as you framed it I think in your own words, if you look at Exhibit P15 and page four of those materials.

**A.** Yes, sir.

**Q.** So that's page four of your October 27 letter and if you go to the third full paragraph of that, Dr. Bowes, starting with the words "to form".

**A.** Yes, sir.

**Q.** So the second line says: "To warrant an inquiry, there should be reason to believe that findings and recommendations

would inform public policy changes to legislation, regulations, policies, or practices that could reasonably prevent future deaths." So you're talking about a standard that you're looking at in relation to your recommendation as to whether there's reason to believe that findings or recommendations could inform public policy, is that fair?

**A.** Yes, that's correct.

**Q.** And then I think you make it clear that the ultimate determination as to whether there were any public policy issues to use the word, you employed or any possible recommendation is ultimately for Judge Zimmer to be making and you say that in the next paragraph where you say: "I wish to make clear that I need not decide that Mr. Desmond's death and those of his family were actually preventable. In Nova Scotia, these kinds of findings are to be made by judicial inquiry alone."

**A.** Yes, I endorse that still.

**Q.** Okay. And so I think in the words you used with Mr. Macdonald is your role in making a recommendation to this inquiry was to identify whether there was an issue to be dealt with in terms of public policy change but you were making no conclusions, fair?

**A.** Yeah, I agree with that.

**Q.** Okay. Next I want to turn you to another passage from your October 27th letter, again that's exhibit P15, and it's page five of that letter, Dr. Bowes.

**A.** Yes, sir.

**Q.** And in it you said, sorry I'm looking at page four, that's why I can't find it. Page five at the top paragraph, four lines down, you say: "Mr. Desmond was responsible to secure his own personal health information by way of a formal written application for records using federal legislation." I want to turn you to that because I know again in response to questions Mr. Macdonald put to you you raised that issue or question with respect to access to records. You'd agree with me, would you not, Dr. Bowes, that health care records are private, in fact one of the most private form of records that can exist?

**A.** Oh absolutely.

**Q.** And that your legislation allows you and your office to bypass those privacy concerns and secure a copy of medical records when your office is commissioned to investigate a death, correct?

**A.** Only in the province though.

**Q.** Fair enough and I was going to ask you that question. So you have no ability, for example, if someone arrives in

Halifax or Sydney on a cruise ship from the U.S. and is a U.S. citizen, you have no access, no legislative ability to access records outside of Nova Scotia?

**A.** No, and regrettably sometimes we have to do autopsies in those cases, we can't get those by consent.

**Q.** And that would equally apply restricting your ability to secure records from another provincial jurisdiction in Canada outside Nova Scotia, correct?

**A.** Correct.

**Q.** So those are the limits that you have even with your super ability to get medical records from a legislative standpoint. But a standard health care provider, a family physician, emergency department, again is dealing with private health care records of a patient that the patient have control over, correct?

**A.** Undoubtedly.

**Q.** And so if, again, that cruise ship patient comes in presenting an injury to an emergency department, there's no ability for the health care providers in that Nova Scotia facility to get or compel production of health care records from another jurisdiction, correct?

**A.** Oh, of course.

**Q.** And the only way that can be done is to be getting the patient involved, where necessary where the records could be helpful, because I guess in some cases they would be helpful and maybe other cases they wouldn't, but to have the patient take a role in securing health care records from another jurisdiction, fair?

**A.** Correct

**Q.** So that would apply in my example where someone is looking to access health care records from another country, correct?

**A.** Yeah, it must be by consent, yeah.

**Q.** Right. And, similarly, it would apply if the attempt is to get health care records from another province or from a federal source such as Veterans Affairs or the Canadian Armed Forces, correct?

**A.** Correct.

**Q.** So you understand there's no ability for a physician or a hospital or the Nova Scotia Health Authority, the clinicians to be on their own securing or compelling production of health care records that might assist a patient, correct?

**A.** Oh well, here I must apologize if I've left the impression that I think that health care providers should have

the power to compel records. I never meant to say that and please excuse me if you thought that I did. I guess what I'm suggesting is perhaps we could have made it a little easier for Mr. Desmond here.

**Q.** Okay. And so we've talked about the barriers that exist and obviously the means to secure those records is to have the patient have some initiative or role in securing health care records from another provider, fair?

**A.** Yeah, I think so.

**Q.** And I guess that would equally apply when a patient has health care records that would be coming from someone outside the hospital system, whether it's a family physician or a private psychologist or a private social worker or a counselor, once again it's incumbent upon the patient to take some role in securing those materials to be provided to the current health care provider, fair?

**A.** Agreed.

**Q.** Okay. So in Mr. Desmond's case, I know from seeing some of the notes that you have in your file and your testimony, that you've identified that there may have been some issues with respect to some of those federal records being made available to health care providers in Nova Scotia, correct?

**A.** I think so.

**Q.** And when you did your review and made your recommendation for a report, I think I've heard you say that you didn't have access to any of the federal records. You had no records of access to Veterans Affairs or the Canadian Armed Forces, correct?

**A.** Correct.

**Q.** So you, when you made that recommendation and maybe even here today, didn't have available to you any information that would suggest whether Mr. Desmond or his wife, Shanna, or anyone on behalf of the family had actually made those requests or attempts to secure health care records. You simply didn't know one way or the other, is that fair?

**A.** Yes, I think you're being fair.

**Q.** Okay. And have you had a chance to look through any of the records available now to show what steps Mr. Desmond or his family members took in order to access records from the federal source or from any other source?

**A.** No, I didn't do any of that. But I must tell you that, you know, I had thought about trying to go down that road but I didn't think in the end that it would make any difference to my ultimate decision.

**Q.** Okay. And so when you made your recommendation you didn't know one way or the other as to whether any requests had been made by Mr. Desmond or his family to access those federal records?

**A.** What I had understood from the family and from what I was able to get is that he'd had a tremendous amount of difficulty and what the nature of that difficulty was I really can't tell you.

**Q.** Okay. As a result of those discussions with his family, did you have an understanding that he knew health care providers in Nova Scotia were requesting that he take those steps to access federal records, federal health records?

**A.** If I remember correctly, one of Mr. Desmond's clinicians talked to him about this but I don't know what Mr. Desmond himself thought about that.

**Q.** Okay. Maybe I'll just take you to a couple documents and see whether that would affect your view or would be relevant to this question of access to documents. So the first document that I'd like to show you is document ELD3.07.

**A.** Is that in the big book or is that ...

**Q.** No, I think it's going to show up on your screen once we pull that up. I think that was in one of the package of

materials that we advised Mr. Russell that we thought might be relevant to the examination.

**A.** So I don't have to do anything?

**Q.** You don't have to do anything, Dr. Bowes.

**A.** Perfect.

**UNIDENTIFIED VOICE:** (Inaudible due to distance from microphone).

**MR. ROGERS:** It was not. And, again, so that was ELD which we think is the Desmond Estate documents, 3.07.

**UNIDENTIFIED VOICE:** (Inaudible).

**EXHIBIT P-000092 - ELD 3.07 - THIRD DISCLOSURE OCTOBER 9**

**MR. ROGERS:** Third document and the seventh page. At the top it should say print date Thursday, June 6, 2019, and visit date October 13, 2016. Document 3.07 so we think it's seven pages. That's it, thanks.

So, Dr. Bowes, as you see at the top it says visit date Thursday, October 13, 2016. At the bottom you see a reference to physician Luke Harnish, and obviously somebody more qualified that I can speak to this but it looks like a family physician note of a visit with Mr. Desmond on October 13, 2016.

**A.** Just to let you know, Counsel, my screen only shows about the top third of this document.

**Q.** Thanks, I think we just highlighted on that so we could read it better.

**A.** No, that's fair, I just want to let you know.

**Q.** We'll scroll, I see you weren't seeing the very bottom part, I understand.

**A.** Oh yes, here we go.

**Q.** So I will go to three passages so we can sort of highlight the top third if we could now.

**A.** Okay.

**Q.** And you'll see it says: "Recently moved back to Guysborough after being away for approximately 11 years. Here with wife today." And then a couple of lines down: "He reports that he was discharged at some point due to depression, stress and PTSD. Was recently admitted to a military hospital in Montreal, Ste. Anne's Hospital, for three months due to nightmares."

**A.** Those are symptoms.

**Q.** Yes, and symptoms of PTSD and then two lines down: "He believes they were supposed to set up FU (which I assume is follow up) in Nova Scotia, however so far has received none. He had been home for two months and does not have a copy of his chart to verify treatment, diagnosis and plan." And then if we

look down to the bottom half of the document under the heading of Impression.

**A.** Yes.

**Q.** And we have impression: "Likely does have PTSD given story." And then under Plan and that's what I want to take you to, it says: "Need old chart from Ste. Anne's Hospital, will request." And so I guess what we see from this is that other health care providers were saying there might be some value in seeing some prior health care records from another institution and that steps would be taken to request that document. Is this a document that you would have had available to you as part of your review, Dr. Bowes?

**A.** I can't recall. We have a good bit of Mr. Desmond's medical, I can't remember whether this page was in it.

**Q.** Okay.

**A.** But there's nothing surprising here.

**Q.** Fair enough. And then can we go to the next page in the same document so again this would be ELD3 now .08. And it is a note that has Corporal Desmond's information in the upper left-hand corner.

**A.** Mm-hmm.

**Q.** And then there's some handwritten material and if you

see at the very top note it makes reference to Guysborough Medical Clinic and Dr. Ali Kapur (sp?).

**A.** Yes, sir.

**Q.** And then there's some handwritten material there if we scroll down a little bit, please. You see the handwritten material.

**A.** Perfect, yes.

**Q.** Thanks. We see a reference to Quebec contact information for chart and medical history and there's no date there but if we now scroll to the bottom entry, we see an entry that says: "Spoke with Shanna Desmond October 24, 2016, she indicates it's being taken care of." So did you get any information from the family indicating that or confirming that Shanna Desmond was also engaged in the process of securing Lionel Desmond's health care record from federal sources?

**A.** That detail I cannot recall.

**Q.** Okay. But if that information is correct then it's clear that Lionel Desmond and Shanna Desmond knew that they were being asked to take some steps to secure federal health records, fair?

**A.** It would appear that way.

**Q.** Okay. Just a couple more documents to take you to,

Dr. Bowes, that again deal with this question of the Desmonds taking steps to secure some federal health records relating to Mr. Desmond.

The next document is, it's Exhibit 42. It's one of the documents from the photographs, I believe, from the contents of the vehicle. And we only need page 24 of that, which is a handwritten note that says Recommendations at the top. That's it. Thank you.

**THE COURT:** I'm sorry, which photograph is it?

**MR. ROGERS:** It's a photograph, it says Recommendations. It's a handwritten note, at page 24 of Exhibit 42.

**THE COURT:** Thank you.

**MR. ROGERS:** And we probably don't need to go to it, Dr. Bowes ...

**THE COURT:** All right. Thank you.

**MR. ROGERS:** Thanks. Dr. Bowes, we don't need to go to it unless you want to, but I know that the production of your files had included some handwritten notes that you did on this matter, and included in it was a reference that Dr. Slayter could not just ask for a veteran's records, and we don't actually know if he asked for them. Do you remember making that note?

**A.** Oh my goodness, I'm sorry, sir, I don't.

**Q.** Okay. Fair enough. And I think that was found in the handwritten records, but my expectation is that we'll hear evidence as to whose note this is that was in Mr. Desmond's car, but as I look at it and I compare the recommendations with Dr. Slayter's note from his visit with Mr. Desmond on December 1, there seems to be a correlation. It's not my role to be giving evidence as to whether this is Dr. Slayter's, but what we do know is this was found in Mr. Desmond's car on January 6th. And you'll see it makes reference to "Get medical records".

**A.** Yes, it's at the bottom, I see that.

**Q.** Right. And so, I guess, would it be fair to say you agree with me that if that's sitting in Mr. Desmond's car and had been provided to him, it's clear that he knew that he was being requested to take some steps to get medical records? Fair?

**A.** I think that's a reasonable supposition.

**Q.** Okay. And, lastly, again in terms of dealing with this question of access to records, because I know that you indicated in response to questions from Mr. Macdonald that's one of the areas that you thought the inquiry could be exploring, you know, whether there's an issue in terms of accessing health

records and material and as between the federal system and the provincial system, and I'd like to take you to another document that's not an exhibit, so it's the federal production, so it's CAN 17958, 1-7-9-5-8. Again it's 17958, and I think it's the only page of that document.

**UNIDENTIFIED VOICE:** It's 017958.

**MR. ROGERS:** Oh, yeah, sorry, there's a zero in front, thanks, 017958.

**EXHIBIT P-000093 - DOCUMENT CAN017958: EMAIL FROM MICHAEL BENNETT TO LIONEL DESMOND, DECEMBER 7, 2016**

I think that's on your screen now, Dr. Bowes. I'll let you take a look through that for a moment. It's really the top third of the document I want to take you to.

**A.** Okay.

**Q.** So we see at the top, we see it's from an individual named Michael Bennett, at a Canadian Armed Forces email address, to Lionel Desmond. The date appears to be December 7, 2016. And you'll see it says: "Lionel, as requested, please complete and mail to the address on the form. Cheers, Michael Bennett."

**A.** Um-hmm, yes, sir.

**Q.** And again as part of your discussions with the family did you learn anything with respect to whether any steps had

been taken directly by Mr. Desmond to complete any of the forms necessary to secure any of the federal health records?

**A.** That, I do not recall.

**Q.** Okay. So this is as news to you that Mr. Desmond is taking steps on his behalf dealing in any way with health records, if that's what this turns out to be?

**A.** Well, I've not seen this document before.

**Q.** Okay.

**A.** At least, I don't think so.

**Q.** And do you know what the process is for an individual to secure health records from Veterans Affairs or from a facility such as the Ste. Anne's facility in Quebec, you know, what the paperwork is and the legislative route is for individuals to secure those materials?

**A.** Well, I had understood there was a good deal of forms involved and that it was complicated and difficult for Mr. Desmond. And I think that when I think about it, I focus more on what his, what his sort of take on it was, because I think that, you know, we can expect, you know, mentally ill people to do some things, we can't expect them to do other things. And, you know, for people with mental illnesses some of them have a tough time just living their lives at all and, you know, saying

that there's only five or six forms to fill out isn't, may not be an insurmountable barrier for anyone in this room, but it might well be for a person who's mentally ill. And I think what I would prefer to focus on is what his experience of it was rather than the actual mechanics. But just for clarity, I will tell you I don't know what the actual mechanics of it are.

**Q.** And if we look through the document that I put to you, at the very least it shows that Mr. Desmond or Mr. Desmond, together with the assistance of his spouse, Shanna, were taking some steps to secure federal health records, fair?

**A.** It would certainly appear to be the case.

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

**A.** Thank you.

**THE COURT:** Just one question for you, Dr. Bowes, during the course of all of your review and the documentations that you'd seen, did you ever see anyone who was in the health care profession step up and offer to help Mr. Desmond fill out any of the necessary forms so that he could access his government health records or VA records?

**A.** No, sir, I don't recall that.

**THE COURT:** Okay. That's the other side of that coin, I guess. Thank you.

Ms. Miller?

**CROSS-EXAMINATION BY MS. MILLER**

**MS. MILLER:** Dr. Bowes ...

**A.** Good morning, Ms. Miller.

**Q.** ... I want to take you to Exhibit 13, P-000013.

**A.** P13.

**THE COURT:** I'm sorry, Ms. Miller, 13?

**MS. MILLER:** P13.

**THE COURT:** Thank you.

**MS. MILLER:** This is in keeping with the questions that Mr. Rogers was asking you about accessing records and your recollection. These are, as I understand it, these are your handwritten notes based on a meeting with family members, is that fair to say?

**A.** Yes, sir. Yes, ma'am, sorry.

**Q.** Okay.

**A.** Sorry about that.

**Q.** No worries. If we turn to page 2 of P000013 ... Let me back up a little bit. First of all, this meeting would have been in June, June 28th, 2017?

**A.** It's dated that way, yes.

**Q.** Okay. And it looks like it was a meeting at the Claymore Inn and Suites?

**A.** Correct.

**Q.** And I can read most of your handwriting, Dr. Bowes, but ...

**A.** Then you are alone in that.

**Q.** I can't read it all. It says 137 Church Street and then what does it say next to ...

**A.** Three sisters, plus Albert.

**Q.** Right. Family member with PTSD?

**A.** Yes, that's right.

**Q.** Okay. So did you meet with Mr. Desmond, three of Mr. Desmond's four sisters at this point with another family member, Albert?

**A.** Yes.

**Q.** Okay. And as I read through these notes, I appreciate that you were asked about your recollection about efforts that the family understood that Mr. Desmond was making to secure medical records.

**A.** Yes.

**Q.** On page 2, midway through, there's reference, halfway

down the page, "October 24th, first visit Dr. Slayter."

**A.** Yes.

**Q.** "Given some time to get records." Dr. Slayter needed his records?

**A.** Yes.

**Q.** Would that have been information that you had or that the family would have shared with you?

**A.** These are things I understood from the family.

**Q.** Okay. And that leads down to the final third bullet point up from the bottom, "If a serviceman wants his own medical records, it's a ..." What is that word?

**A.** I'm sorry, Freedom of Information application, FOI.

**Q.** Freedom of Information application, "Could be approximately 18 months."

**A.** Yes, that's what I understood.

**Q.** Okay. So you don't know, yourself, here today, I think you indicated, any independent information about the process and time it takes to get records.

**A.** No.

**Q.** But you understood from the family ...

**A.** Correct.

**Q.** ...that it could take, it would result in a Freedom

of Information application to get his own records?

**A.** That's what I'd understood.

**Q.** And that that could take up to 18 months?

**A.** (No verbal response.)

**Q.** Then, the next line says, "But the fact that a therapist was engaged (something) contact with Veterans Affairs."

**A.** Implies.

**Q.** "... implies contact with Veterans Affairs." Do you have any recollection about what that was in reference to?

**A.** That, I don't know.

**Q.** Okay. And then "Sydney office of Veterans Affairs closed."

**A.** Was closed, yeah.

**Q.** Was closed. Okay. Okay. Thank you, Dr. Bowes. Those are my questions.

**A.** Oh. Thank you.

**THE COURT:** Mr. Rodgers?

**MR. RODGERS:** Thank you, Your Honour.

**CROSS-EXAMINATION BY ADAM RODGERS**

**MR. RODGERS:** Dr. Bowes, I'm representing the personal representative of Lionel Desmond.

**A.** Okay, sir.

**Q.** Adam Rodgers is my name. I will pick up where my friend left off there and I wanted to ask you about that meeting. You've gone through some of your decision-making factors when you were answering questions from Inquiry counsel, but perhaps you can discuss this meeting with the family and how that impacted your decision or your determination.

**A.** Well, you know, the family right from early on had been tremendously vocal in their advocacy for Mr. Desmond, which is to their credit and I think that, you know, I had to ... I felt like I should hear them out and hear their perspective on it. And I was interested in this for a number of reasons, but, I mean, I think that what matters a lot, and I think I alluded to this earlier on, is that it doesn't just matter how systems are built and how we think they're performed. I think that it really matters how they are perceived by the public. And so I think that meeting with the Desmond family was important to see how it was perceived, and I think that it was a valuable

experience and I think it really helped to focus my efforts on certain areas of inquiry, and I think it was very influential with how I put the case together at the end.

**Q.** And you've had some other contact with the family members, as well, with Cassandra Desmond maybe, in particular, speaking to her on the phone and communicating on occasions, is that fair to say?

**A.** Yes, sir.

**Q.** Yes. And have you benefitted from that contact, as well, in making your determination that you ultimately made to recommend the inquiry?

**A.** Oh, I think so, again for the same reasons. It's important, I think, to listen to how the public perceives things.

**Q.** Dr. Bowes, you're fairly familiar with the legislation, that's clear from listening to your testimony here, and I just want to ask you a few questions about what you understood to be different government authority, different levels of governmental authority.

The federal government, for example, you were familiar with the **Inquiries Act**, which is a piece of federal legislation on public inquiries that the government and I'll just read the

section: "The Governor-in-Council may, whenever the Governor-in-Council deems it expedient, cause inquiry to be made into and concerning any matter connected with the good government of Canada or the conduct of any part of the public business thereof."

**A.** Um-hmm.

**Q.** Given the significant federal components of this, I know you, and that you've spoken to this. Were you awaiting or did you consider the possibility that the federal government might call an inquiry into this?

**A.** Well, in my letters I told the Minister that, you know, he should perhaps pursue this as a potential avenue, because I felt like if these issues were going to stand astride the two jurisdictions, it might be better to have a joint federal/provincial inquiry, which I'd understood was possible.

**Q.** And have you received any communications to that effect from any representative of the federal government?

**A.** No, the federal government never contacted me.

**Q.** Nobody asking for your viewpoint or your insight into the situation?

**A.** No.

**Q.** Provincially, you'd be aware, I suppose,

provincially, that the provincial government has the ability to call an inquiry of their own of their own volition?

**A.** Right.

**Q.** And of course under the **Act** which we've been discussing, the **Fatality Investigations Act**, there's two streams that that could take, one where the Minister calls an inquiry of their own volition again, and then another where he takes your recommendation and then is, shall call an inquiry?

**A.** Yes, sir.

**Q.** Well, you explained this in your letter to the Minister of October 13th, explaining your interpretation, at least, of the jurisdiction and your decision criteria in coming to whatever decision you might make?

**A.** Yes, sir.

**Q.** Had you been aware or were you considering at the time some media reports suggesting or quoting the Justice Minister and Premier saying that they didn't think an inquiry was necessary? Were you conscious of that or contemplating that as you wrote these letters?

**A.** No. I had to shut that out. I had to decide on my own.

**Q.** Okay. So what I read and this is Exhibit 15.

Perhaps we can go to that, which is ...

**A.** Is this my letter of October 27th?

**Q.** Correct, yes, of October 27th. I was going to draw your attention to page 4 of that letter, sorry, section (4) on page 7.

**A.** All right. I have it here.

**Q.** When I look at this, Dr. Bowes, it seems like you're telegraphing to the Minister that this is what I'm going to do, I'm going to call an inquiry, and perhaps deliberately or subtly giving the Minister an opportunity to do it himself, to call the inquiry, himself, without being forced into it.

**A.** Well ...

**Q.** Was that in your mind when you explained it in that manner?

**A.** I didn't think I was that subtle. I said here: "I anticipate forming the view that a judicial inquiry is necessary." So if it was subtle, then I messed up.

**Q.** Well, I didn't think it was subtle either. I guess I was trying to get into your mindset there and determine whether that was the case. And you even provided your preliminary findings to him in a way that, I think, would have given him a means of justifying his own inquiry. Was that part of your

thinking in drafting it with that much detail?

**A.** Well, I, maybe I should be thinking about these things harder but, no, that wasn't my intention at all. My intention was to set out my reasoning so that it was clear to everybody because, of course, I had known by now that one day I'd be sitting in a courtroom exactly like this explaining it to everybody, so I wanted it to be clear.

**Q.** In response to your letter, the Minister did write back and outlined a number of the initiatives, and you've gone through them already in your, I was going to say in your direct testimony, but in your questions from Inquiry counsel: the OSI clinic, that there were four other things in the early stages and that sort of thing that were initiatives underway. Have you taken some initiative to learn about those programs or figure out what impact they might have?

**A.** Well, I think that the principal importance of all those things ... If you sort of step back from the letter and sort of ask yourself what's there, I think that what's there is a lot of excellent stuff in a very, very preliminary kind of stage, which is instructive in itself. But I think that one of the things that we have to, I think, look at is what's not there, and I think I alluded to it before, and what is not there

is some formal attempt to learn the lessons from Mr. Desmond's case. So I think that those two observations made me think that we'd have to go the route of an inquiry.

**Q.** Did you have the impression that the Minister was trying to persuade you not to call an inquiry?

**A.** No, I never formed the impression.

**Q.** Okay. I want to ask you a little bit about your thoughts on the scope or the breadth of the mandate and that has gone into your recommendations and, ultimately, the terms of reference. Would you be interested in learning about or do you think we should be interested in learning about the psychological preparation that Canadian Forces members get before they go into combat that might prepare them perhaps to deal with their experiences?

**A.** Well, I think that would be a really excellent thing for the Inquiry to look into, but I think I'd expressed before how I was worried, frankly, that the Inquiry may or may not be able to delve too far into the dealings of the federal government but I think that's a fantastically interesting issue. I just don't know if you can lawfully get at it.

**Q.** And also with respect to the preparation that the family receives before their soldier comes home to understand

better what's in place that would help a family understand what new issues they might be facing or what they might be facing when this person walks through the door?

**A.** Absolutely. I think an end-to-end kind of approach is what is needed.

**Q.** And you've said you're not a psychiatrist, but I guess I'll ask you if you can answer this question, which is do you think knowing what happened in Afghanistan itself, I guess, to learn how the memories or the PTSD symptoms, how they came about, you know, do you think we should be trying to learn what happened in the theater to Corporal Desmond?

**A.** Well, I am going to interpret your remarks to mean do I think we should get into the basic science of perhaps brain chemistry and neurology, is this what you mean?

**Q.** Well, that ...

**A.** Or psychiatry, this kind of thing?

**Q.** Well, that is something I'm thinking about, but maybe we'll come to that in a moment, but I guess just some insight into the operations in Afghanistan, what missions was Corporal Desmond, in what missions did he participate, what did he do, what brought this on.

**A.** Well, I think if you, speaking generally in a public

health kind of way, I think if you're looking to study the incidence of anything, whether its trauma or any kind of disease, you need to understand its risk factors and its pathophysiology. So I think that, you know, if we propose that the experiences of a military member might compose a set of risk factors for later getting PTSD then, yeah, I think it's a great idea to look at that.

**Q.** I think in the disclosure it seems that Dr. Wendy Rogers, one of the treatment providers for Corporal Desmond, may have recorded some of his descriptions of what he did over there. I don't know whether those still exist, but would that kind of, I guess, description from Corporal Desmond, himself, be valuable in your determination or in your line of thinking?

**A.** Well, I mean, it ... Well, let's start at the beginning. It certainly wouldn't change the cause and manner of death or any of the section 5 kind of things and I'm sure you knew that right off.

**Q.** Yes.

**A.** Whether it changes my thinking about whether an inquiry was necessary, I still think, on the face of what I've had to deal with, I think I've made the right call and I don't think that that set of recordings would have caused me to come

to a different conclusion. I will say that, you know, an academic study of the experiences of soldiers might provide some real insight into PTSD.

**Q.** Mm-hmm. And I didn't mean to ask it in the terms of whether you would have revised your decision to recommend the inquiry but, rather, in, I guess, furtherance of that decision. When we're exploring different issues in this inquiry would you think that would be valuable information for us to review?

**A.** Well, I guess I should tell you I'm not sure.

**Q.** Okay.

**A.** You know, without knowing what the content of that can be. I think of these things as a doctor and an academic, and my mind immediately goes to the academic study you could do on soldiers with PTSD and how you could maybe construct some risk factors and things like that. But I want, I don't want to step out of line here because I think you're going to hear from a psychiatrist who's going to give you a much better answer than I would.

**Q.** Yeah. And I didn't want to push you beyond your expertise, Dr. Bowes, but I guess one of the questions I have is just in your experience having dealt with I don't know how many different cases over the years, but are there patterns you've

observed or lessons from elements, I guess, from murder/suicide incidents that we should be thinking of that, that come to mind for you?

**A.** Hmm ... Well, for one thing, I've observed that they're relatively rare. You know, murder/suicides in the setting of domestic violence are rare happenstances, so one thing to keep in mind is that although mortality is arguably the most important end point of domestic violence, it's not the only one.

**Q.** Yes.

**A.** And you might turn your mind to other sets of data about domestic violence, like hospital admissions and the testimony of people who, social workers, people who work with couples in the domestic violence kind of sphere. I always like to remind people at these big government meetings I go to that you're interested in mortality, that's great, but it's only one end point and, numerically, at least, it's so rare that it would be difficult to draw any really firm statistical conclusions from it, so what I would encourage you to do, if you want to get an even better grip on the problem of domestic violence or suicide or anything like that, you might turn your mind to other kinds of end points, like hospital admissions.

**Q.** Yeah. And when you talk about domestic violence in this context, I guess would it be fair to say you're not presenting yourself as an expert on domestic violence.

**A.** Correct.

**Q.** You're, I guess, advising that this is an area to explore, for this Inquiry to explore.

**A.** I agree with that.

**Q.** Yeah.

**A.** Yeah.

**Q.** I mean, anyway, the different kind of symptoms that ... It's difficult to dissect the indicators perhaps of domestic violence from those that would be tied to PTSD or is that something you can even comment on?

**A.** Well, I think we're now squarely outside of my expertise.

**Q.** All right.

**A.** But, yeah, I think you will hear from a psychiatrist who will be able to fill you in on that.

**Q.** And just a couple more questions, and these might be more for Dr. Mont, but I'll ask you if you have a comment, which is the chronic traumatic ...

**A.** Encephalopathy.

**Q.** Encephalopathy, thank you for how to pronounce that. Would the manner of Corporal Desmond's death, does that make testing for that impossible or is that something that you would consider, if it was possible, with somebody with concussions or a history of concussions?

**A.** Well, just so you know, I did send brain tissue to Boston, to that famous study group, once, where I had an intact brain.

**Q.** Yeah. But that's what it requires and that wouldn't have been possible here. Is that something that you would consider, I guess, if you were advised if somebody had a history of concussions in the course of your analysis?

**A.** Well, if the family really expressed a need to explore that. Some don't. Some families would really prefer to have that aspect of their experience wrapped up quickly and without any real contact with us.

**Q.** Yeah.

**A.** Which surprises me, but every family is different.

**Q.** Sure.

**A.** But for families who are really very curious about not just that but the genetic aspect of their loved one, we try to facilitate this to the extent we can.

**Q.** Okay. Okay. Thank you, Dr. Bowes, those are the questions I had.

**A.** Thank you.

**THE COURT:** Mr. Hayne?

**MR. HAYNE:** Thank you, Your Honour.

## CROSS-EXAMINATION BY MR. HAYNE

**MR. HAYNE:** Good afternoon, Dr. Bowes.

**A.** Sir.

**Q.** My name is Stewart Hayne, I'm counsel for the physicians who are participating in the inquiry. I just have a few questions for you, if you don't mind.

**A.** Sure.

**Q.** You used the term acute mental illness, and I just want to clarify, if I may, that illnesses, is it fair to say that illnesses may be classed as either acute or chronic or maybe sometimes both?

**A.** Yes, I think so, and that's true of all illnesses, I think.

**Q.** Right. And that was, and just so we can put some terminology or definitions around that, a chronic illness may be

something that's long existing or a long-developing type of illness?

**A.** I think that's correct.

**Q.** And an acute illness may be an illness that has a sudden onset of the illness or the symptoms associated with the illness, is that fair?

**A.** That is true although there is obviously a spectrum in between, but yeah.

**Q.** You're reading my mind.

**A.** Yeah.

**Q.** And that there'd be a spectrum from, in terms of acuteness versus chronicness and ...

**A.** And there's acute exacerbations of pre-existing chronic illness, right?

**Q.** Fair enough. Exactly.

**A.** Yeah.

**Q.** And as you said, that would be applicable to any type of illness, including mental illness?

**A.** I think so.

**Q.** And in the spectrum, the severity of the symptoms associated, whether it be acute or chronic, those would exist on a spectrum, is that fair to say?

**A.** Well, I agree and, furthermore, you might turn your mind to the fact that with respect to mental illness the symptoms are really put through the lens of the person's statements to you.

**Q.** Right.

**A.** So just to clarify, you couldn't fake an extra noise in your heart, you can't fake that, but you could, in a conversation with a psychiatrist, you could portray your illness, you know, in some different ways.

**Q.** Right.

**A.** Right.

**Q.** And but for that reason and for many reasons, would you agree that it's the psychiatrist who sees a patient who'll be likely in the best possible position to evaluate the severity or nature of mental illness of any particular patient at any particular time?

**A.** Oh undoubtedly, yeah.

**Q.** Yeah.

**A.** I want to be clear, I don't propose that I'm an expert in psychiatry.

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

**A.** You're welcome.

**THE COURT:** Ms. Ward?

**MS. WARD:** Thank you, Judge Zimmer. We do have a few questions, as it turns out.

**CROSS-EXAMINATION BY MS. WARD**

**MS. WARD:** Dr. Bowes, if a patient, any patient, civilian patient moves from one province to another, their new doctor can write to their old doctor, with their consent, to get their records, is that true?

**A.** Well, it depends upon the kind of record. I may not be able to answer that for you, actually, because I don't know what the recent law on that is. I'd always understood that via the patient's consent, that the record could be shared.

**Q.** Okay. If I told you that that's ... it works the same way with military doctors ...

**A.** Okay.

**Q.** ... in that a civilian doctor can write to the military, with the patient's consent, and get those records, would it change your view of the systemic issues that you had in mind with respect to information sharing?

**A.** Well, that would be, so I'm going to accept that that is true and tell you that that is very interesting to me because the perception among the clients seems to not be that. The perception that I detected was that it was a far more complex affair and so, supposing that the policies and procedures are well written and simple, it certainly appears that there's dissonance between what the policies are and how the people actually perceive them, which may be of interest to you.

**Q.** Right. And I understood that from your previous testimony because, in particular, because you said you had learned from the family that they held the view that they needed to make a Freedom of Information request and that they had been told it would take 18 months. Is that ...

**A.** That is what I have in my notes.

**Q.** So if I told you that ... Well, first of all, in the federal realm we have the **Privacy Act**, not the Freedom of Information, but under the **Privacy Act** if a request is made, that it has to be complied with within 30 calendar days ...

**A.** Oh.

**Q.** Which can be extended, that under the legislation the requester needs to be provided with an explanation for any extension. Would that change your view of the systemic issues?

**A.** Well, again, just a mismatch between the perception and the reality would be of interest. I'm glad to hear that it seems to be simpler than what was expressed.

**Q.** And, lastly, on the issue of what's a federal health care record and what's a provincial health care record, because I think we've been talking a lot about federal records, are you aware that Veterans Affairs is not a health care provider, *per se*, that they're not the holder of a person's health care records?

**A.** No, I did not know that.

**Q.** So if I told you that once a person releases from the military and they're a veteran and they're in the care of provincial providers, health care providers, doctors and therapists and such, and that their records can be sought like any other civilian, would that surprise you?

**A.** Well, that's different from what I understood, so, yeah.

**Q.** Okay. Thank you.

**THE COURT:** Mr. Murray, do you have anything further?

**MR. MURRAY:** We do have a couple of questions. Mr. Russell will ...

**THE COURT:** Mr. Russell?

**MR. RUSSELL:** Yes, Your Honour, if I may.

**THE COURT:** Certainly, go ahead.

**RE-DIRECT EXAMINATION BY MR. RUSSELL**

**MR. RUSSELL:** I wonder if we could bring up Exhibit 42. I believe it was page 28. 24, sorry. Dr. Bowes, you were shown this earlier by my friend. It wasn't confirmed exactly who it was written by, but my question, if you see, say, number 5, it says neuropsychological assessment, reference cognition, it says, "Problems, PTSD, post-concussion syndrome, jealousy, questioning DD."

**A.** Um-hmm, yes.

**Q.** And then at the bottom it says, "Get medical records." My question is, Doctor, and you don't have the benefit of knowing who this was written by or if it was provided to Mr. Desmond, but my question is do you have a concern, after your review, with a system that seems to be dependent on the abilities of a military veteran with a number of significant mental health issues to navigate a process where the obligation is on them to get the record?

**A.** Well, yes. You know, as I may have said before, in

previous testimony, things that may seem easy to the rest of us may seem insurmountable to a person suffering from mental illness, and I think that the ultimate test of a system is not whether we think it's reasonable, it's how the clients actually experience it. And I think it's clear from, at least the stuff I was able to get, that Mr. Desmond experienced difficulty with the system.

**Q.** And would that concern be heightened in Desmond's case, where he's trying to sort of make his way out of the military setting back into sort of civilian life?

**A.** Yes. And I think that we should do the thing that makes it easiest for service members.

**Q.** And can you think of a possible sort of mechanism where, whether it's the Nova Scotia Health Authority or a system where the mental health provider offers assistance in some way to a person such as Mr. Desmond, to navigate to get those records, rather than simply send him away with a note and say, Go get it?

**A.** Well, I mean, one thing that I would suggest just off the top of my mind is, if I was Mr. Desmond's care provider, I would have a form pre-filled out with his name on it and say, Here, sign this, this is going to let me get all this stuff for

you. And then all Mr. Desmond does is he signs it, and I do the rest.

**Q.** And so that would be sort of at a point of initial entry, whether it's in the sort of public health care system or even with a private facilitator such as a counselor?

**A.** Yeah. And you know, I'm not an industrial engineer but, you know, industrial engineers can tell you everything about processes and that kind of stuff, but what I would do is look at that as, you know, that's the handover: so this guy is in the care of this individual and now he's going over here, let's look at all aspects of the handover, let's put it on a form, Mr. Desmond, just sign this, and all the stuff that needs to happen to migrate him from there to there would occur as a result of that one form.

**Q.** Okay.

**A.** Now I'm not an expert in forms.

**Q.** I'm sure, Doctor.

In terms of my other question, you made two comments earlier, and I'll just paraphrase them back, I don't have them exact word for word, but you talked about history being important and you were talking about medical history, and you said health records can provide powerful context for findings,

and then you followed up later and you said transfer and exchange of information seemed like it was too complicated.

So my question is, Dr. Bowes, and you don't have the benefit, I guess, of knowing what some of us now know after meeting with a number of witnesses ..

**A.** Um-hmm.

**Q.** But in a context where we have ER physicians, we have ER psychiatrists, we have family practitioners, we have private counselors through insurance, it would appear as though we may hear evidence that people assess this person in the here and now, so, for example, Desmond had attended the ER, he's assessed for suicidal ideation, homicidal ideation in that moment, do you see any barriers or difficulties when we have different - and not that anyone is doing anything wrong ...

**A.** Um-hmm.

**Q.** ... but everyone has to assess someone just in the here and now. He presents himself at the ER, we have to assess him now. And the suicidal risk assessment is really based on the here and now. Do you have any concerns with that or a system, I guess, that operates in silos that way?

**A.** Well, I can tell you that context is incredibly important for me as an investigator. And, you know, medical

school isn't that long ago for me, I remember that context is important for everybody in medicine. You know, it's unfortunately true that the patient in front of you may actually not even be conscious, you know, so they may not be able to tell you anything useful and certainly they may not even be able to sign a form or give consent or something like that. I think that one electronic medical record, I think, is the dream in this province and I think that there's been some plans towards it, I think that will really improve care and I think that the more transparently and instantly that these things flow the better off our doctors are.

**Q.** And was there, would there be any sort of concern if you were to learn that, in terms of health care records, an ER doctor is presented with a series of charts and sometimes the charts are uploaded digitally, sometimes they're not, and the psychiatrist could go to another floor, access another system or another set of charts and get other information that wasn't available on another floor? Is there any concern there that you would have in terms of this history of information?

**A.** Oh, we face it all the time in an investigative context, you know, records may be in different places. And I think that if we want our doctors and nurses to be successful,

we have to set them up for success, and giving them all the information we possibly can is a way to do that.

**Q.** And, Doctor, my final series of questions relates to firearms, and you expressed having a concern as to how the system as it is could allow someone such as him in his position to end up with a firearm. I'm not sure how much you know about medical assessment forms that are completed, so I'll put a scenario to you where a firearms officer for a province would reach out to the person who has the license under review, would contact them and say, Look, there is a medical assessment form that is to be completed by your physician, just says physician...

**A.** Um-hmm.

**Q.** ... and that physician can indicate whether or not they feel as though the person would be fit to possess firearms, whether there's a concern or risk. Do you have any questions or concerns with respect to, I'll phrase it as qualifications, and what I mean by qualifications is two-fold - qualifications in terms of a doctor with a specialty, which may be psychiatry as opposed to just general practice; and two, qualification in terms of history with the patient, rather than, Oh, I saw him for a few months, I can fill out the form, versus, I've seen him

for four years. Do you have any comments on that?

**A.** Well, I think that ultimately, you know, we teach medical students and we try to live our lives this way, we teach people that we should go with the evidence, the best evidence-based practice is the one that should be followed. And what I would put back to you is has there been an evidence-based assessment of that practice? Do we know that that is the optimal practice? I mean, for all I know, for all the Inquiry knows, that is the best evidence-based practice. But I would propose that, you know, this seems to be an area where we could reasonably ask the question what is the best evidence-based practice in the context of assessing somebody as a risk and are we following it and, if not, why?

**Q.** And the question to that is, when you're looking at evidence-based, when you're looking at assessing risk for suicidal ideation, homicidal ideation, would a psychiatrist, in your opinion, be more suited to make that sort of evaluation as opposed to a family practitioner?

**A.** Well, again that's out of my expertise, but again I would go right back to what is the best evidence-based practice. I mean, we all think of psychiatrists as being the content experts in psychiatry, for obvious reasons, but if you actually

exposed that to a randomized control trial, you might find something very different. I guess what I'm pleading for is to go with whatever the medical evidence says is best.

**Q.** Do you have any suggestions as to what sort of level of inquiry or level, and I know it's case by case, level of detail in such a firearms review on a form that's returned by a physician, what it should delve into? Is there sort of a minimum criteria, you think? Should it simply be checking off a box that says, No, I don't think he's a risk? Or should it elaborate more and explain why?

**A.** Well, you know, I'm not sure I'm suited to answer that question, but I do know that there does seem to be, in the literature I was able to access, there are risk factors for suicide and homicide and an assessment of those risk factors might be an important tool with respect to not only making the right choice, right decision but in documenting that decision for, you know, if things go wrong.

**Q.** And would there be a benefit to sharing that sort of exercise when it's ultimately returned to the firearms officer that sought the opinion?

**A.** Well, I would certainly hope that there is some kind of audit step in that activity.

**Q.** Thank you.

**THE COURT:** Does anyone have any further questions for Dr. Bowes? Okay.

**EXAMINATION BY THE COURT**

**THE COURT:** Dr. Bowes, I raised the issue of domestic violence, the death review committees in Ontario, in particular, and I know that you had made some comment that as far as the Nova Scotia legislation goes and the regulations, I understand a lot of it is going to be put into effect by regulation, that that is an ongoing process, it's a work in progress at the present time.

**A.** Yes, sir.

**Q.** And just like when you did your front-end analysis, you know, you say to yourself, well, you know, if there's another process in place, why do I, why would that necessarily be effective for me to turn my attention to that and, in particular, as it would be, would result in the recommendation for an inquiry.

**A.** Um-hmm.

**Q.** So the regulations that will eventually come into

effect are something that I would be interested in seeing.

**A.** Okay.

**Q.** And particularly in the context of when you look at the Ontario report, in particular, and I don't know, there are reports from other provinces, as well.

**A.** Um-hmm.

**Q.** And how they've gone through their, you know, analysis from 2003 to 2017, identifying the risk factors and applying the various factors to the percentages of domestic violence deaths they see. So any recommendations that might fall to me to make at the end of the day would, in part, I think, be informed by whatever regulations might come out at the end. If at the point in time where I'm looking at making recommendations and that has not happened and there's no meaningful feedback that can be brought to this Inquiry in that regard, then I think I would look at inviting you back.

**A.** Fair enough.

**Q.** Would that be fair?

**A.** That is fair.

**Q.** Rather than take our time today, because it may not. It may, at the end of the day lead, lead to naught, and I know everyone's time is important. And if it turns out that I am

going to invite you back, I think I'll advise counsel of all the material that I would like to discuss with Dr. Bowes in that context, so that everyone will have it available to them, as well, and certainly I would send copies to you and give you fair warning that we were going to invite you back to have that discussion, and at that point it would be pretty much focused on that area, I think.

**A.** Sounds good.

**Q.** All right.

**A.** Your Honour, I think we would welcome any input that you had to make in that ...

**Q.** Well, I'd very much like to see how the regulations flush out the intent.

**A.** Okay. Will do.

**Q.** If I can put it that way.

**A.** Yeah.

**Q.** And what the long-term prospect is, because I think, you know, from the Ontario experience, you can see they have a decade plus of data, you know, where you can see, when they can give you percentages of cases that have seven or more identified risk factors in them. It seems to me that people in health care professions, the people who do interviews or assessments should,

you'd want to have them aware of that so that that becomes part of their background consideration when they're looking at whether a person presents a risk to themselves or to anyone else.

**A.** I agree.

**Q.** Okay. And I know that you, that that was part of your consideration earlier on in your evidence. So I thank you for raising that and we may have you back but you'll get lots of notice of it.

**A.** Thank you, Your Honour.

**Q.** So we appreciate your time today, then, Dr. Bowes.

**A.** Thank you.

**THE COURT:** You're free to go. Thank you.

**WITNESS WITHDREW (15:43 HRS.)**

**THE COURT:** As far as the day goes, I guess this concludes the day, Mr. Murray?

**MR. MURRAY:** Yes. We had basically just slotted Dr. Bowes in for today. I was a little uncertain how much time we would use, so that is what we have for today.

**THE COURT:** All right. Thank you. Thank you, everyone. Then we're adjourned until tomorrow morning at 10 o'clock. Thank you. **COURT ADJOURNED (15:43 HRS.)**

**CERTIFICATE OF COURT TRANSCRIBER**

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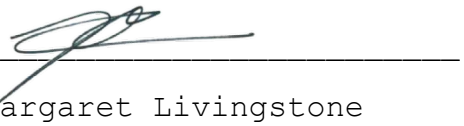

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**DARTMOUTH, NOVA SCOTIA**

**January 29, 2020**